SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 9 JUNE 2014, 1.30PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

						Page No.
1.30pm	**1**	**APOLOGIES FOR ABSENCE –** Peter Hill				
	2	**DECLARATION OF INTERESTS**				
	3	**MINUTES**				**1**
		Public Board Meetings held on: 24 March 2014 7 April 2014				
	4	**MATTERS ARISING**				
1.35pm	**5**	**CHIEF EXECUTIVE**				
		1. Chief Executive's Report	MC	SFT 3531		**13**
1.45pm	**6**	**STAFF**				
		1. Voluntary Services Annual Report	AK	SFT 3532		**17**
		2. Staff Survey Action Plan	AK	SFT 3533		25
2.10pm	**7**	**PATIENT CARE**				
		1. Quality Indicator Report to 30 April (month 1)	CB/FH	SFT 3534		**33**
		2. Customer Care Report - Quarter 4	FH	SFT 3535		39
		3. Hospital Cleanliness Report to include Infection Prevention and Control report	FH	SFT 3536		47
		4. National In-Patient Survey Results 2013	FH	SFT 3537		111
		5. Publication of Ward Staffing Information – update	FH	SFT 3538		123

2.30pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Update on Planning Process – verbal report	NM/LA	SFT 3539	-
		2. Finance Committee minutes from meeting on 22 April 2014	NM	SFT 3540	129
		3. Financial Performance to 30 April (month 1)	MC	SFT 3541	133
		4. Progress against Targets and Performance Indicators to 30 April (month 1)	KH	SFT 3542	143
3.00pm	**9**	**PAPERS FOR NOTING OR APPROVAL**			
		1. JBD Minutes from Meeting on 16 April 2014 Evidencing Presentation of Assurance Framework and Risk Register	MC	SFT 3543	**149**
		2. Clinical Governance Committee minutes from meeting held on 27 March 2014	LB	SFT 3544	151
		3. Council of Governors draft minutes from meeting held on 12 May 2014	NM	SFT 3545	161
		4. Capital Development Report	LA	SFT 3546	165
3.45pm	**10**	**ANY OTHER URGENT BUSINESS**			
	11	**QUESTIONS FROM THE PUBLIC**			
	12	**NEXT MEETING**			

The next ordinary meeting will be held on Monday 4 August 2014, 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 24 March 2014 In the Boardroom, Salisbury District Hospital

Board Members Present:	Dr N Marsden	Chairman
	Mr P Hill	Chief Executive
	Mr S Long	Non-Executive Director
	Reverend Dame S Mullally	Non-Executive Director
	Dr L Brown	Non-Executive Director
	Mr I Downie	Non-Executive Director
	Mrs A Kingscott	Director of Human Resources & Organisational Development
	Mr M Cassells	Director of Finance & Procurement
	Mr A Freemantle	Non-Executive Director
	Miss T Nutter	Director of Nursing
	Dr C Blanshard	Medical Director
Corporate Director:	Mr L Arnold	Director of Corporate Development

In Attendance:	Mr D Seabrooke	Head of Corporate Governance
	Mr P Butler	Communications Manager
	Mr C Wain	Governor
	Mr A Lack	Governor
	Mrs C Collins	Governor
	Mrs C Martindale	Lead Governor
	Mr B Fisk	Governor

1953/00 INTERESTS

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

1954/00 APPROVAL OF THE TRUST'S OPERATIONAL PLAN 2014/16

The Board received a report from the Director of Corporate Development setting out a further draft of the Operational Plan 2014/16 which was required to be submitted to Monitor by Friday 4 April.

The Chairman reminded the Board and Governors present of previous discussions including the joint meeting held on 24 February to consult the Council of Governors on the Draft Plan. The current draft was based on those earlier iterations.

Concerns highlighted in the report included the effects of the tariff deflator and the risks posed by moves towards reducing the number of units providing specialised services in localities. There were however no specific concerns to raise at this stage.

In this regard the Finance Committee had been discussing the Trust's targets and indicators for 2014/15 which was among the financial information required to be submitted with the Operational Plan. The Committee had not identified any particular targets or requirements to declare at risk at this stage. It had focused on the 2014/15 target for C-Diff and had noted that a ceiling of 18 attributed cases had been set. This latest target continued a trend of previous reductions in the ceiling. TN informed the Board that she was comfortable with the target of 18 and that no risks to its achievement should be declared. New techniques and initiatives continue to be rolled out within the Trust and it was noted that the CCG was advertising for an infection control team to support GPs. It was felt that improved stewardship of antibiotics in the community would be of great help to acute hospitals in controlling infections.

It was felt that the statement of intent could be more challenging and LA undertook to review the drafting of this. LA

Although no specific comments had been received from NHS Wiltshire at this stage alignment and partnership working was continuing.

It was noted that the financial projections supporting the Annual Plan had not made any assumptions in relation to the effects of the full implementation of the Better Care Fund due to take place in 2015/16. It was suggested that the comments on 7 day working should be linked to the projection in relation to staffing requirements.

LA undertook to circulate to all present a revised executive summary. LA

The Board approved the draft as the basis of the Trust's submission to Monitor.

1955/00 TRACEY NUTTER

The Chairman thanked Tracey Nutter for her contribution to the Trust during her time as Director of Nursing as this was her last Trust Board Meeting.

1956/00 DATES OF FUTURE MEETINGS

The next meeting of the Council of Governors was on 7 April at 1.30pm.

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board
Held on Monday 7 April 2014
In the Boardroom, Salisbury District Hospital

Board Members Present:	Dr N Marsden	Chairman
	Mr N Atkinson	Non-Executive Director
	Dr C Blanshard	Medical Director
	Dr L Brown	Non-Executive Director
	Mr M Cassells	Director of Finance & Procurement
	Mr A Freemantle	Non-Executive Director
	Ms K Hannam	Chief Operating Officer
	Mr P Hill	Chief Executive
	Mrs F Hyett	Interim Director of Nursing
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Mr S Long	Non-Executive Director
Corporate Director:	Mr L Arnold	Director of Corporate Development
In Attendance:	Mr P Butler	Communications Manager
	Mr D Seabrooke	Secretary to the Board
	Mr M Wareham	Staff Side
	Mr C Wain	Governor
	Mr J Carvell	Governor
	Dr A Lack	Governor
	Sir R Jack	Governor
	Dr E Robertson	Deputy Lead Governor
	Mrs C Noonan	Governor
	Mr J Markwell	Governor
	Mrs C Martindale	Lead Governor
	Mr R Polkinghorne	Governor
	Mrs J Griffin	Governor
	Mr S P Wells	OMS Battersea
	Mr L Thomas	CGI/IT Services
	Mr M Knipe	Salisbury District Hospital

Apologies:	Revd Dame S Mullaly	Non-Executive Director
	Mr I Downie	Non-Executive Director

1957/00 DECLARATIONS OF INTERESTS

Members were reminded that they had an obligation to declare any interest which might impact on the business of the Trust, to avoid any conflicts of interest and to declare any matters that could affect their status as fit and proper persons to hold office. No board member present declared any such interest or impediment.

1958/00 THE MINUTES OF THE MEETING OF THE TRUST BOARD AND THE JOINT MEETING WITH THE COUNCIL OF GOVERNORS

The minutes of the Trust Board 3 February 2014, were accepted as a correct record.

The minutes of the Joint Meeting with the Council of Governors held on 24 February 2014, were accepted as a correct record, subject to the inclusion of apologies from Dr C Blanshard.

1959/00 CHIEF EXECUTIVE'S REPORT - SFT 3507 - PRESENTED BY PH

The Board received the report of the Chief Executive and PH highlighted the following principal points -

The financial year 2013/14 had been a successful one with the Trust having met its key financial and operational targets.

The Open Day on 5 April had been a tremendous success and PH thanked all the staff who had taken part and supported this.

The rollout of the new coloured scrub uniforms was well under way now, aiding identification of different staff for patients and improving appearances.

Work was underway with University Hospital Southampton and University of Southampton on a collaborative approach to the national reconfiguration of genomics services in England.

The Trust was also working closely with University Hospital Southampton on the further development of the Plastic Surgery Trauma Service which we provide to the Wessex Trauma Centre based in Southampton.

He highlighted work underway to improve the Trust's energy usage following a £800,000 award from the Department of Health Energy Efficiency Fund.

Finally the NHS change day on 3 March had yielded a number of pledges from individual employees.

1960/00 STAFF

1960/01 Staff Survey Results 2013 - SFT 3508 - Presented by AK

The Board received a report summarising the findings of the 2013 Staff Survey, together with an action plan to maintain and sustain the Trust's performance. The results were very positive for the Trust, underpinned by a good and improving response rate.

Two concerns were highlighted:

First the high proportion of staff reporting witnessing potential errors, near misses and those reporting experiencing physical violence from patients, relatives or the public. The Board reflected on the

benefits of a strong reporting culture and it was suggested that it would be more helpful if the question referred to cases of actual harm. Secondly work continued to address the findings in relation to physical violence.

The Board noted the survey results and the development of targeted action plans.

A further report would be brought to the June and December Meetings of the Board.

1961/02 Values and Behaviours - SFT 3509 Presented by AK

The Board received a report proposing the final set of corporate values for adoption by the Trust. It was noted that the behaviour grid supporting the four values proposed now included behaviours around safety and general improvements to the wording.

The Board approved the four values of Patient Centred and Safe, Professional, Responsive and Friendly, and requested that a further report be made on means to integrate the values and behaviours into the day to day working of the Trust and the Trust Board.

1962/00 PATIENT CARE

1962/01 Quality Indicator Report 2014 – SFT 3510 - Presented by FH and CB

The Board received the Quality Indicators Report.

The Chairman welcomed Fiona Hyett to her first meeting as Interim Director of Nursing, with effect from 1 April 2014.

The following principal points were highlighted:

- For C-Diff the figure was 20 cases in February. There had been further case in March which had brought the total to 21 attributed cases which was in line with the 2013/14 ceiling of 21. It was noted that C-Diff target for 2014/15 was 18.
- Two patient falls that had resulted in fracture/major harm were under investigation.
- The response to the Friends and Family Test continued to be strong and positive. The rollout was continuing to Day Surgery and Out-Patient areas.
- The number of escalation bed days reported in January and February 2014 reflected winter pressures.
- CB reported that the standardised hospital mortality index was now 106 and that the hospital standard mortality rate was now declining and was at January within the expected range at 107. The review of most deaths in the hospital was continuing.
- The failure to meet the 90% target in relation to time spent on the stroke unit had been due to one patient and work was underway with GPs to improve TIA referral rates.

The Board noted the Quality Report for February 14.

1962/02 Customer Care Report – Quarter 3 – SFT 3511 – Presented by FH

It was noted that the report presented to the Board had been reviewed by the Clinical Governance Committee and that it was continuing to develop. Feedback from the Directorates was now included in the report and the benefits of the restructured Customer Services through the Directorate Patient Experience Facilitators was now evident. The Trust continued to work through patient transport incidents and complaints with Arriva and the CCG.

The Board noted the Customer Care Report for Quarter 3.

1962/03 National Maternity Services Survey 2013 – SFT 3512 – Presented by FH

The Board received a report analysing and summarising the benchmark report on the National Maternity Survey carried out by the Care Quality Commission. The report included an action plan to address the issues raised. The survey was based on the experiences of 300 mothers and it was noted that part of the report would appear on the Care Quality Commission website.

The Board noted the report.

1962/04 Ward Based Skill Mix Review paper - SFT 3513 – Presented by FH

The Board received a report setting out the findings of the most recent Skill Mix Review as well as the background including earlier Skill Mix Reviews and the Government's response to the Mid-Staffordshire enquiry.

The National Quality Board had now published detailed expectations for providers that would include a monthly report to the Trust Board on staffing levels, daily ward based reporting and twice yearly skill mix reviews.

It was noted that NICE were reviewing the available evidence on staffing levels and were expected to produce guidelines on this later in the year. It was noted that ward staffing had previously been the subject of £200,000 investment and that it remained protected in terms of the Trust's cost improvement requirements.

The current Skill Mix Review had found that staffing levels were generally satisfactory when the hospital was running normally. However most wards only had one or two ward leaders and there was in most instances insufficient time dedicated to supervisory activity for these. Because of the staffing profile, which included many longer serving staff with greater leave entitlements a higher headroom level was believed to be required.

It was noted that at month 11 the expenditure on "Specials" remained high which was due to a number of high care patients admitted to the wards and also confused/wandering patients.

It was noted that in the revenue estimates for 2014/15 an additional sum of £800,000 had been identified as further investment in ward staffing. It was felt that there needed to be more information about the effects of changes to staffing levels on the quality of patient care. It was noted that the benefits should include improved working between nursing and medical staff. However this should be supported by the directorate senior nurses managing the performance of all the ward sisters.

It was agreed that in view of the Trust's financial situation £800,000 represented an appropriate balance between overall viability and the safety and quality of the Trust's clinical care. The Board approved the principles outlined in the paper:

To provide additional staff into wards prioritised in the Skills Mix Review, to implement full time band 7 supervisory ward sisters in all ward areas subject to the performance management measures discussed, to strengthen the senior cover and to make senior cover available for longer.

It was also agreed:

1. To continue the work to support the development of a pool of nursing assistants to meet the requirement for specials
2. To keep the headroom under review in light of the implementation of the electronic rostering system.
3. Continue to work towards publishing planned and actual staffing numbers on a monthly basis via the Allocate rostering system.
4. To develop key performance indicators to assure the Board that the investment was sustainable and leading to improved outcomes.

1963/00 PERFORMANCE AND PLANNING

1963/01 Update on Planning Process

The Chairman informed the Board that the two year operational plan had been submitted in accordance with the 4 April deadline. The submission had signalled concern about the effect in 2015/16 of the implementation of the Better Care Fund.

Work was underway to complete the five year plan in accordance with the 30 June deadline which was based on a review of the existing strategy.

1963/02 Finance Committee Minutes 24 February – SFT 3514 – Presented by NM

The Board received the approved minutes of the 24 February Finance Committee. The Committee was reviewing the relationship

between increased income and increased costs during 2013/14. The Committee had received a useful presentation from the Chairman of Salisbury Trading Limited.

The Board noted the Finance Committee minutes.

1963/03 Financial Performance to 28 February 2014 – SFT 3515 – Presented by MC

The Board received the Financial Performance for the first 11 months of the financial year.

The Trust was operating above plan and MC expected to achieve the 2013/14 plan. The Continuity of Service Rating under the Risk Assurance Framework remained 4. The Finance Department was collecting payments from outlying CCGs so cash was slightly down. Good settlements had been achieved with Wiltshire CCG and with Dorset. There was work to understand slight underperformance on West Hampshire's CCG.

In-patient activity was down on the preceding financial year however there had been more day case and out-patient activity.

There was concern that although £3m had been spent on nursing during 2014/15 it was unclear if the Trust had a £3m benefit in return. The rate of cost improvement savings achievement was 78%. However there were a number of cost recurring savings from 2013/14 and as a result the 2014/15 target £9m. About £3m of this was currently accounted for by transformation schemes.

Contracts for 2014/15 were in the main agreed and a reduction in the increase to the CNST premium had been agreed.

There was concern however about changes to VAT rules which would adversely effect NHS organisations.

The Board noted the month 11 Finance Report.

1964/04 Performance Report to end of February 2014 – SFT 3516 – Presented by KH

The Board received the summary information on performance with regards to key activity and quality indicators. KH highlighted the following principal points:

- 2 week cancer waits (breast cancer) work continued with GPs to ensure that patients with symptomatic breast symptoms were seen within the 2 week period.
- The directorate was undertaking a capacity and demand review for the neuro physiology service which had experienced increased demand and extended waits.

Additional capacity had been deployed to audiology to manage demand.

Delayed transfers of care were at 23 and t he CCG and Wiltshire Council were undertaking a s ystems review of the relevant processes.

Staff appraisal rates were now at 91%.

The Chairman congratulated the Executive on the 2013/14 performance.

1964/05 Financial Estimates - SFT 3517 – Presented by MC

The Board received the summary of the base estimates for 2014/15 and the Source and Applications of Funds Statement – this report had been c onsidered by the Joint Board of Directors and F inance Committee.

The following principal points were highlighted:

- Internal costs pressures were at 5% resulting in a £9m saving target for 2014/15.
- The planned surplus for 2014/15 was £0.8m which based on the Trust's turnover was not considered to be sustainable in the long term.
- The figures included assumptions about inflation and the likely pay settlement and t hat CQUIN money would be earned.
- The Wiltshire CCG was proposing QIPP savings of £2m which could have an impact of £1.25m on the Trust.
- Figures did not include the revised contribution to the CNST.
- Cost pressures of £4m identified in the report continued to be reviewed by the Executive.
- The investment in nursing on wards to include specialing of £800,000 had been included.
- £3m of transformation schemes have been included leaving a 3% saving target for the non-protected areas.
- No assumptions had been m ade in the estimates for the VAT changes that had been discussed in the Finance Report earlier in the Board meeting.

The Board approved the base estimates as presented.

1965/00 MATTERS FOR NOTING OR APPROVAL

1965/01 Joint Board of Directors Minutes from 15 Jan uary 2014 r e Quarterly Review of Assurance Framework and Risk Register – SFT 3518 – Presented by PH

The Board received an extract of the regular review by the JBD of the assurance framework which had i dentified gaps and pos itive assurances in respect of impact of poor performance on t he Trust and failure to deliver the IT strategy.

The Board noted the minute extract from the JBD.

1965/02 Revised Informatics Strategy – SFT 3519 – Presented by LA

The Board received a report updating it on progress against the refreshed Informatics Strategy and outlining the programme of work over the next 2 to 3 years to achieve the Trust's vision for its informatics services.

The need to ensure that development saved people's time and gave better access to clinical information was emphasised. Further work on the implementation of electronic patient records which would reduce paper usage and also improve communications with patients and GPs would be getting underway.

The Board noted the update on the Informatics Strategy.

1965/03 NHS Foundation Trust Code of Governance – SFT 3520 – Presented by NM

The Board received a report giving a statement of the Trust's compliance with the Code of Governance published on 1 April 2014.

There were new requirements in the Annual Reporting Manual for compliance statements and these were appended to the report together with a summary of the new matters introduced in the 2014 Code. A number of public statements required to be published by the Trust under the Code were also appended.

The Board approved the Trusts responses to the various sections of the NHS Foundation Trust Code.

1965/04 Wessex Academic Health Science Network – SFT 3521 – Presented by PH

The Board received a report detailing a proposal for the Trust to become a voting member and a guarantor of the Wessex Academic Health Science Network which had been formed as a company limited by guarantee.

The report described the aims of the AHSN and it was noted that the delivery vehicle would be a company limited by guarantee. The Trust was required to put forward a guarantee of £1. There was an annual membership fee which the Trust would be committed to pay for the first two years of its voting membership. The sum in year one was £10,000.

The Board agreed the following:

That the Trust become a voting member and guarantor of the Wessex Academic Health Science Network.

That the payment of £1 in the event that the AHSN Company is wound up while the Trust is a guarantor or within one year of it ceasing to be guarantor.

Ratified the completion and signing of the Deed of Adherence for the voting members agreement an application for admission as a guarantor.

Approve the payment of the year 1 membership of £10,000 with subsequent years fees to be set by the AHSN Board on a 2/3 majority basis.

Approve the appointment of the Chief Executive to act on the Trust's behalf in this regard and the Director of Finance and Procurement as Deputy.

1965/05 Clinical Governance Committee Minutes 27 February 2014 – SFT 3522 – Presented by LB

The Board received for information the approved minutes of the Clinical Governance Committee 27 February 2014.

1965/06 Draft Minutes Audit Committee 10 February 2014 – SFT 3523 – Presented by NA

The Board received for information the draft minutes of the 10 February 2014 meeting of the Audit Committee.

1965/07 Draft Minutes Council of Governors Committee 10 February 2014 – SFT 3524 – Presented by NM

The Board received for information the draft minutes of the Council of Governors Meeting held on 10 February 2014.

1966/00 QUESTIONS FROM THE PUBLIC

- LA undertook to follow up a concern from Chris Wain about communications to patients from a referrals management centre.
- In response to issues raised by John Carvell KH commented on staff shortages in clinical physiology, FH reported that a chart for patients of the new staff uniform was being produced and that noise on wards at night was being addressed.
- Raymond Jack asked about overspends on locum doctors and MC indicated that the process for approval for locums was stronger than it was felt to be in many instances for nursing agency. It was also noted that there was a number of clinical areas where there was continual recruitment difficulty and it was confirmed that agency use was only initiated where rotas were at risk.
- In response to a concern about nurse staffing shortages from June Griffin FH confirmed that the Trust was continuing to step up its recruitment of band 5 nurses and was holding open days for prospective trainees.
- Alastair Lack welcomed the Ward Staffing Review and the progress shown in the Informatics Strategy.
- It was requested that the item on the Code of Governance

should be submitted to the 12 May meeting of the Council of Governors for further consideration.

- PH undertook to investigate a c oncern from Eric Gould, volunteer that the Trust's normal public advert in the Salisbury Journal had n ot appeared in the newspaper the week before the meeting.

1967/00 DATE OF NEXT MEETING

It was noted that the next public meeting of the Trust Board will be on Monday 9 June 2014, in the Board Room at 1.30pm.

CONFIDENTIAL ISSUES

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

CHIEF EXECUTIVE REPORT

MAIN ISSUES:

NEW DIRECTOR OF NURSING

Lorna Wilkinson has been appointed as our new Director of Nursing. Lorna was our Deputy Director of Nursing before leaving here in 2012 to take up the post of Deputy Director of Nursing and Head of Patient Safety at Portsmouth. Lorna started her nursing career in London and has extensive nursing and managerial experience having moved into clinical audit and clinical governance at St Mary's NHS Trust in London, and here in Salisbury where she was our Head of Risk Management before taking up the Deputy Director of Nursing role. Lorna will take up her position in the first week of August.

NEW ORGANISATIONAL VALUES AND BEHAVIOURS

We have refreshed the values and associated behaviours for the organisation, which were developed through staff focus groups and wider staff consultation. The values and behaviours describe what is important to staff in their day to day work and have already been integrated into the design of the Trust's new appraisal system and will form an important part of the appraisal discussion. We will also be looking at how they can be used to recruit new staff, and will also be incorporated in Human Resources policies. The core values and a description of the three supporting areas are as follows:

- **Patient Centred and Safe:** This centres on patient safety, team work and continuous improvement
- **Professional:** This focuses on being open and honest, efficient and acting as a good role model.
- **Responsive:** The expectation here is that staff will be action orientated, with a "can do" attitude and that they innovate, take personal responsibility and listen and learn
- **Friendly:** We would expect staff to be welcoming, treat people with respect and dignity and value others as individuals

ELECTION OF TRUST GOVERNORS

Four Governors have been elected to the Council of Governors following elections held in our public constituencies. Jan Sanders, Katherine Sanders and Lynn Taylor were newly elected, with Alastair Lack successfully re-elected. In total we have 21 public and staff governors who 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. Celeste Collins, Robert Coate and Paul Goldman, who completed their final term of office this year, were part of the first Council of Governors elected in 2006.

SUCCESSFUL CONSTITUENCY MEETINGS

There was an excellent turnout at both constituency meetings we held recently in Tisbury and Warminster. The constituency meetings gave Sir Raymond Jack (South Wiltshire Rural) and Carole Noonan (West Wiltshire) an opportunity to engage directly with members from their areas and for members to ask us questions about the hospital and our services. What was clear from both these meetings was the significant interest people from these areas have in our hospital and their appreciation of the services we offer in both Salisbury and other parts of the county. We will be planning more constituency meetings for later in the year.

THERAPY REVIEW

The Trust has been undertaking a review of its occupational therapy and physiotherapy services in order to ensure that we continue to deliver good quality, affordable services. The services have grown over time and it is essential that these are delivered by multidisciplinary teams that can respond appropriately and flexibly to patient demand both now and in the future. The proposals, which will be subject to staff consultation, include changes to the management structure, with a new post of Head of Therapy Services. This will help provide greater strategic and operational therapy input and high level specialist therapy support. We also aim to introduce a 7-day week service that will ensure that patients have access to a therapist on the day of admission or within 24 hours. This will result in a small cost saving and a more flexible and cohesive service that will benefit patients. The staff consultation will end on July 11.

STAFF FRIENDS AND FAMILY TEST

From June 2, staff will be able to give their feedback on whether they would recommend the hospital to friends and family as a place to work or receive treatment through the Staff Friends and Family Test (FFT). Staff will be able to complete the test once a year, giving us a further opportunity to gauge their views in this area. Staff are also asked for their views as part of the national staff survey. We will update staff on how we are responding to the feedback we receive from the FFT, and any supporting developments and improvements we make following the test. The Staff FFT follows the FFT for patients that was introduced last year.

TOY BOX DAY NURSERY GRADED AS ‘GOOD’ BY OFSTED

Our day nursery (Toy Box Day Nursery) at Salisbury District Hospital is celebrating after being graded as ‘good’ by Ofsted following an inspection by the regulatory body at the end of March. The day nursery provides staff with on-site childcare for children aged between three months to five years. This is the nursery’s first inspection under Ofsted’s new and more rigorous inspection framework and, in its report, Ofsted said: “all children are valued for their uniqueness” and staff “support children to make good progress in their learning and meet their individual needs well”. This is an excellent achievement which reflects the commitment and quality of our staff in this area. The full inspection report can be viewed on the Ofsted website. Following publication of the report we will make minor improvements and these will be included in our action plan.

TRUST DOES WELL ON REGIONAL ANTIBIOTIC PRESCRIBING AUDIT

We have continued to make good progress in the area of antibiotic prescribing. While antibiotics are an important treatment for our patients, more antibiotic use worldwide is leading to antibiotic resistance and can lead to an increase in the incidence of C. difficile in some patients. Following an audit of antibiotic prescribing, Salisbury had the second best results out of 17 Trusts across the South West of England, highlighting the wide range of work carried out in Salisbury to provide good quality safe care.

HOSPITAL STAFF OFFERED END OF LIFE ADVICE AT GUILDHALL

Local people had an opportunity to speak to staff and find out what steps they can take to make their end of life experience better for them and for their loved ones at a special event at the Guildhall. The event coincided with Dying Matters Awareness Week and encouraged people to take five simple steps to plan for the future such as writing a will, recording funeral wishes, planning future care and support, considering registering as an organ donor and telling loved ones their wishes.

CHIEF SCIENTIFIC OFFICER'S WORKFORCE INNOVATION 2014 AWARD.

Well done to Christine White and Nicola Monks who reached the final of the Chief Scientific Officer's Workforce Innovation 2014 award. Nicola is a senior embryologist in the Salisbury Fertility Centre and Christine White a technical manager in pathology. While healthcare scientists take up around 5% of the NHS workforce, around 80% of patients' diagnosis can be attributed to their work. To reach the final of this prestigious award is a significant achievement for Nicola and Christine.

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

PAPER: SFT 3532

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 2013/2014.

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 2014, 697 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 moved to a new location within the Human Resources Department. As a result, Voluntary Services feels it is more involved with issues around the Trust and hears more quickly about changes, for example to recruitment procedures.

Applications. In the twelve months to 31st March 2013, 316 application packs had been sent out. 45 applicants did not return their application form, 38 applicants who returned their form later changed their mind or were refused a placement due to either health checks or Disclosure & Barring checks. 157 new applicants started during the year and 76 applicants are currently completing their recruitment paperwork.

Training. Volunteers are offered all Trust mandatory training via the Managed Learning Environment and those who are not use to this training method are offered the opportunity to attend specific face to face training sessions.

Meet the…. The Volunteer Governor, Brian Fisk has started to run some 'Meet The' sessions for volunteers. The first held was Meet the Chairman. Volunteers heard a little bit about Nick Marsden, his experience where he sees the hospital heading in the future. Volunteers were given an opportunity to ask the Chairman questions and challenge him.

Brian is planning one session each quarter and it's hoped that management will become visible to volunteers and that volunteers will feel more involved and have an understanding as to why changes are happening. One good outcome from this session was volunteers asking to be provided with more communication; we therefore now email out to the volunteers the Chief Executive's message, the Chief Executive's Spotlights, Cascade Brief and other Broadcasts which we feel will be of interest. So far feedback from volunteers has been positive.

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.

Young Volunteer Award. The 'Young Volunteer of the Year' award for 2013 was presented to Holly Smith who volunteered on the Maternity unit. Holly secured a placement to study midwifery at Southampton and was very grateful for the time she was able to volunteer with us and to the midwives who helped by sharing their knowledge.

30 Years of Service Awards. Two volunteers were presented with a very special award for giving the hospital 30 years of service in their volunteering role. Margaret Smith volunteers at various departments such as Whiteparish, Tisbury and the Spinal Unit and previously the Hospice.

David Langrish was also awarded for his 32 years service to Radio Odstock. He first joined RO to visit patients on the wards and to collect their 'requests' to be played on air later that day. He soon became a presenter of his own show and became a very active member of their committee having taken on various roles and is now the President of RO.

Staff Awards. Volunteers are included in the annual Staff Awards. The winner can be either an individual or a team of volunteers. There were 9 nominations received and a judging panel of 3 decided on the winners. It has hard for the panel to make a decision so they decided to have one team winner and one individual winner and no runner ups.

The individual winner was Julia Chute a volunteer for BUGS. She was one of the founder members of BUGS and after 13 years of service decided it was time to more on and let new members take over. The team winners were Joan Phillips and Anne Harding who volunteer at the Hospice. They have worked together as a team since 1991 and both feel it is a privilege to help at the Hospice.

National Association of Voluntary Service Managers (NAVSM). The Voluntary Services Manager (VSM) has attended three regional meetings held in the Wessex area. These meetings give us the opportunity to network, share working practices as we are all affected by the same changes to services. The VSM also attended the annual training seminar for NAVSM members in Birmingham. A talk from The King's Fund about securing a sustainable future for volunteering was included and also the launch of the Guidelines for Inductions, Statutory and Mandatory training for volunteers.

Work Experience. An incident which took place early April 2013 which led us to review the age group of our applicants for work experience placements. We used to include students from the age of 14 upwards, but decided that in clinical areas it would be best to only accept applications from pupils aged 16 and over. We still provide placements to pupils aged 14 and 15 in non-clinical areas. WEXP placements are also available 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.

From the 255 enquiries for placements we received we provided placements for 140 students in over 30 locations around the Trust. 84 applicants didn't return their

application form and 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. It is hoped that Board members will be able to attend to show their appreciation to the volunteers for the services they provide to the Trust.

Future Plans

There seems to be no let-up in the stream of local residents offering voluntary help to our Trust. There has been an increase in volunteer numbers and we aim to maintain the number of highly skilled and dedicated volunteers we have. With the role of volunteers expanding it's important that we keep them informed and engaged in terms of the targets and objectives the Trust is setting itself. Brian Fisk, Volunteer Governor has been working hard to put together a web page for the hospitals' website so that we can promote volunteering and promote specific roles the hospital would like help with.

We hope to have some sample volunteers' uniform available for the volunteer's day event so that volunteers can have a say in which style of uniform they would like. This will give them an identity so that staff, patients and visitors know who they are and we hope will also lead to recognition from everyone.

Conclusion

The number of volunteers currently registered with the Trust stands at 686.

Voluntary Services Department is fortunate to have the full support of the Board members and we would like to thank and the previous Chairman for the Trust, Luke March who always supported the role of our volunteers. Since his departure we are delighted that the new Chairman Nick Marsden continues with this support,.

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 2014

AUTHOR: Jo Jarvis
TITLE: Voluntary Services Manager

VOLUNTARY SERVICES DEPARTMENT
SALISBURY DISTRICT HOSPITAL

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

The Volunteers

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

Direct Voluntary Staff

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

Other Volunteers and Voluntary Organisations

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

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

Their Services

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

ArtCare

ArtCare have 11 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.

BUGS

The Burns User Group Service has changed slightly to adapt to the needs of the Burns Unit. They still play an important role in providing 'emergency pack' to patients as many arrive unexpectedly and volunteers are available to chat to, or just to listen to patients on the Burns Unit. The BUGS group is well respected within the British Burns Association and are often asked to provide talks and lectures at conferences.

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 1 dog 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 30 volunteers who are able to offer comfort, prayers and other spiritual support to patients at their bedside.

Clinical Psychology

The Clinical Psychology department have 51 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 Day and supplied gifts to patients on Pitton, Redlynch, Burns Unit, Sarum, Maternity, and NICU. A special gift was given to 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 35 volunteers who work tirelessly raising funds, for example the Scanner appeal. The Stars Appeal is attracting great interest and volunteers are embracing the campaigns with great vigour.

Horatio's Garden Friends

With the creation of 'Horatio's Garden at the Spinal Unit, 52 Volunteers have been recruited to 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

This service always receives positive feedback from members of the public. We have a team of 11 dedicated and fit volunteers who assist our patients and visitors who enter the hospital either via the Main Entrance or the Springs Entrance, and help direct them to the location of their appointment. It has been known for them at times to help staff, and save them from getting lost!

Information Technology (IT)

IT currently has 2 volunteers who were interested in this field and wanting to gain experience. They have proved to be a success, fitted in well and proved they are very capable with the work.

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.

Magnetic Resonance Imager (MRI) Scanner

The 3 MRI volunteers provide a valuable service manning the reception of the scanner. They provide a friendly face to patients whom are waiting for a scan, often putting patients at their ease.

Pharmacy

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

Readership Panel

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

Radio Odstock

Radio Odstock have 28 volunteers providing live and recorded programmes to our patients. They celebrated their 50th Birthday at the end May 2013 and had a weekend of celebrations including 'live' FM broadcasts which local residents within Salisbury were able to tune in to.

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.

Wessex Community Action

We keep in regular contact with members of the Wessex Community Action, providing and sharing information and support to each other. We also make the use of their volunteering opportunity web site www.do-it.org which enables us to advertise specific volunteering roles.

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 28 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.

St John Ambulance

The Salisbury Branch of the St John Ambulance Brigade continued to help in all parts of the Trust by providing transport and escort services.

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 volunteers 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

They saw a change to their name over the last year. 'Women's' was dropped from their name enabling them to become open to everyone. 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.

PAPER SFT 3533

STAFF SURVEY 2013 UPDATE

PURPOSE : To update the Board on the action plan to address the areas identified for improvement from the results of the 2013 staff survey.

MAIN ISSUES:

The April Board Paper SFT 3508 reported on the Salisbury NHS Foundation Trust results in the national staff survey that ran during the autumn of 2013. Although the results were good overall there were a number of areas identified for improvement.

The areas for improvement were identified as :

Appraisals. Our results show that we have not only sustained but improved still further on our performance since 2010, reflecting the continued management focus in this area. For the first time this meant our scores were better than the average acute Trust, however we are not at the target we have set ourselves and wish to continue to improve our performance on both the quality and quantity of appraisals. We will seek to retain our overall Trust performance to 'above average' compared to other acute Trusts by the time of the next staff survey, with a stretch goal of moving into the top 20% of the benchmark.

% witnessing potentially harmful errors, near misses or incidents in the last month: Our results show that slightly more staff are witnessing potentially harmful errors, near misses or incidents than last year and more than the average acute Trust. Whilst this increase can be interpreted as our staff being very aware of the potential for harm in a culture where ensuring patient safety is paramount this is not how it is interpreted nationally. We need to investigate and understand better the reasons for these results so we can develop a remedy.

% experiencing physical violence from patients, relatives or the public in last twelve months. Any form of physical violence is unacceptable and therefore is an area in which we must continue to strive to improve in keeping with the Trust values. This result is worse than average for an acute Trust and is an area the Trust wishes to improve. The actions developed this year will focus on 'hot spots' and develop more focused remedies for these areas. Our Target for 201 3/1 4 is to reduce the number of instances of violence and to move our scores to at least average compared to other acute Trusts.

% suffering work related stress. This score has increased significantly since 2011 and despite still being in the best 20% of acute Trusts it is unacceptable to have nearly 1/3 of staff saying that they have suffered work related stress. We will continue the work we began in 2013 to provide staff with appropriate support and guidance to improve these results and reduce the overall result.

THE ACTION PLAN

The Deputy Director of Human Resources, together with the members of the Operational Management Board, has developed an action plan to target actions within all of these areas. The action plan is available on the website.

The action plan also identifies specific staff groups or directorates where their results were particularly requiring attention. The action plan includes actions to:-

- Monitoring themes and trends from reported incidents in order to take appropriate remedial action
- Introducing an electronic system for recording incidents (DATIXweb) and associated education of staff
- Target work in those areas of the Trust with incidents of violence to identify risk areas and develop remedies
- Monitor incidents of violence and identify appropriate remedial action
- Seek to employ a Registered Mental Health Nurse within Occupational Health
- Continue to provide workshops for staff on stress management
- Launch the new policy "Psychological wellbeing at work"
- Continue with the focus on ensuring all staff receive an annual appraisal
- Implement and embed the new 'SpIda' performance appraisal recording and reporting system
- Issue guidance and supporting information on using the new 'SpIda' system and good practice appraisal guidance
- Run workshops on how to get the most out of appraisals for staff

Progress with the action plan will be monitored by the Operational Management Board at its July, September and November meetings and it is proposed that the Trust Board will receive an update at its December meeting.

Directorate Action Plans

In addition each directorate is developing its own action plan to address areas where more local improvement is required. These action plans will be monitored at the regular Directorate Performance Review meetings with executives.

.**ACTION REQUIRED BY THE BOARD:**

1. The Trust Board are asked to note the action plan developed
2. To request a further update to the Board at the December 2014 meeting

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE:

Staff Survey Action Plan June 2014

AUTHOR: Jenny Hair

TITLE: Deputy Director of Human Resources

Staff Survey Action Plan 2013

Finding No Eg KF21	Finding Description	Action	Who Responsible	By When	Progress
KF 13	37% of staff witnessed a potentially harmful error, near miss or incident in the previous month compared with 35% in 2012 and a national average of 33%. This was in the worst (highest) 20% of acute Trusts Scores high in nurses, other registered nurses, doctors, Medicine, MSK and CSFS directorates, full time staff, men and those not disabled	Implementation of DATIXweb and associated education relating to the reporting of incidents and escalation within the Trust. Monitoring of near misses for themes and trends.	Head of Risk	September 2014	
KF 16	17 % experiencing physical violence from patients, relatives or the public in the last 12 months. Trust score worse than average for acute Trusts where average score is 15% Occurrences amongst nurses, nursing assistants, mainly in Medicine and MSK directorates, full time staff, and those aged 16 to 30.	1. Set up a task and finish group to scope the problem, review incidents and decide on actions to reduce physical violence. Include management staff in medicine and MSK, Risk. 2. Meet with Nursing assistants and junior nurses from Medicine wards, Spinal, ED, MSK wards to understand the view of affected group regarding the causes of violence and what we can do to reduce the risks. Also seek to understand the impact of physical violence on staff. 3. Monitor incidents of violence through V&A sub-group and set up a system for follow up in areas where this isn't done. 4. Continue to work on 'specialling patients' through the 'Reducing Agency Spend' group.	Directorate Senior Nurse, CSFS	June 2014 July 2014 Ongoing at Monthly meeting Ongoing at monthly meetings	

Finding No Eg KF21	Finding Description	Action	Who Responsible	By When	Progress
KF 11	32% of staff suffering work related stress in the last 12 months (the same as in 2012 and compared to 22% in 2011) 2013 national average of 37% for acute Trusts. Our score is still in the best (lowest) 20% compared with all acute Trusts Scores highest for nurses, other registered nurses, other Scientific and Technical, other allied health professionals, CSFS Directorate, full time staff, staff aged 31 to 40, and white staff.	The Stress Action Team will continue to meet during 2014/15 to explore and offer organisational support to reduce staff stress wherever possible. This will link into the 'Shape up at Salisbury' initiative. Consideration to the inclusion of a Mental Health Nurse in OH will be given dependant on available funding. There will also be closer links made between OH, Staff Counsellor and Clinical Psychology to improve staff support on areas of stress management. The Staff Counsellor will provide workshops on 'stress management' for all staff which will include elements of personal resilience. The SAT will investigate the use of 'i-resilience' tool to complement current offering. Management support in how to identify stress and what to do about it will be offered through HR Managers, Occupational Health, Education and the Staff Counsellor. It will be further strengthened by the launch of the new Psychological Wellbeing at Work Policy which also provides clarity and guidance for both managers and staff. To make a bid to the Charitable Trust Fund to employ a Registered Mental Health Nurse 2 days a week to provide specialist support to Occupational Health on mental health issues, which would include stress. This role could also be developed to provide training for managers on how to identify and manage mental health issues including work related stress.	Director of HR and OD/ Stress Action Team "Shape Up at Salisbury" Initiative	March 2015 Bid due to go to Charitable Trust Fund meeting in May 2014. Implementation would be	

Finding No Eg KF21	Finding Description	Action	Who Responsible	By When	Progress
				dependent upon funding being agreed.	
		To make a bid to the Charitable Trust Fund to fund a series of courses on Acceptance and Commitment Therapy. This type of therapy can be used as an intervention for stress, anxiety, depression, chronic pain and would be in addition to the Staff Counsellor.	"Shape Up at Salisbury" Initiative	October 2014	
		To deliver a series of Mindfulness workshops for staff and to investigate whether there is a need to develop an in-house mindfulness coach.	"Shape Up at Salisbury" Initiative	October 2014	
KF7	86% of staff had received an appraisal in the previous 12 months (68% in 2010 and 80% in 2012). 2013 national average 84% - this Trust now better than average compared to acute Trusts These good rates need to be sustained. In a few areas rates still need to be ie CSFS, Medicine and Surgery Directorates, Nurses and other registered nurses, Medical directorate and Surgical directorate, staff aged 16 to 30, part time staff.	Continuation of appraisal compliance through directorate performance reviews. 90% achieved, 100% stretch target.	Directorate Management Teams	Regular 3:3 meetings	
		Provide appraisal training workshops for senior medical staff to increase the number of appraisals.	Lead Medical Appraiser	June 2014	
KF8	41% of appraisals were well structured (agreed clear	Focus groups to be run during May to ask staff how they can get the most out of	Head of Learning Development	Feedback to OMB and	

Finding No Eg KF21	Finding Description	Action	Who Responsible	By When	Progress
	objectives, were helpful in improving how they do their job, left appraisee feeling valued by the organisation) compared to 36% in 2012. The national average in 2013 was 38% , trust results were better than average for acute Trusts Scores particularly low in .the following groups: Medical staff, Admin and Clerical, Surgical directorate , staff aged over 51 and between 31 and 40 and white staff	their appraisal. Participants to be sought via Broadcast. Feedback to the OMB/DMTs once completed. To run additional training sessions for appraisee's on "How to get the most out of your appraisal". Issue objective writing materials onto the Intranet (SMART, golden thread) and communicate information to staff/managers via Broadcast, cascade brief, HR Newsletter. Design and issue a crib sheet to enable the Appraiser and Appraisee to prepare for their appraisal. This is to be made available on the intranet and SpIda. Issue information on the intranet to support and enable the appraiser and appraise get the most out of the appraisal discussion. Documents include leaflets on 10 top tips for performance discussion, what is a performance appraisal discussion, steps on how to undertake a performance appraisal discussion. Follow up with communications via broadcast, cascade brief, HR Newsletter. Design a short quality questionnaire that will automatically "pop up" once the performance appraisal has been completed on SpIda. Development and implementation will be dependent upon IT resources.	 Start early June and run 1 per month until March 15 Directorate HR Manager, CSFS Directorate HR Manager, CSFS Directorate HR Manager, CSFS	DMTs by July. April 2014 May 2014 Ready for the next phase of SpIda (poss. Oct 2014)	**Action completed** **Action completed**

Finding No Eg KF21	Finding Description	Action	Who Responsible	By When	Progress
		Provide "How to get the most out of your appraisal" training for medical staff to improve the quality of appraisals.	Lead Medical Appraiser	October 2014	

TRUST QUALITY INDICATORS REPORT – April 2014

PURPOSE:

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

MAIN ISSUES:

- 5 cases of C Difficile.
- 3 MSSA line related bacteraemias.
- 3 new serious incident inquiries.
- A slight increase in grade 2 pressure ulcers. Two grade 3 pressure ulcers. No clusters identified.
- Safety Thermometer – 90% 'harm free care'. A significant decrease in new hospital acquired pressure ulcers.
- HSMR has declined again to 104 in February 14 and is as expected. Anticipate up to an 11 point rise in September/October 14 when figures are rebased.
- Fractured hip patients. Slightly below 90% target. Dedicated orthopaedic trauma lists at weekends have stopped due to under utilisation. Patient flow work underway.
- Patients arriving on the stroke unit within 4 hours dipped to 85%. Patients spending 90% of their time on the stroke unit is sustained as is the number of patients having a CT scan within 12 hours. A reduction to 60% of TIA referrals seen within 24 hours - an in-depth analysis of the last six months is in progress to ascertain the key improvement actions needed.
- There were 4 non-clinical same sex accommodation breaches. Escalation bed c apacity decreased and ward moves remain low.
- 1 fall resulting in 2 fractures.
- Dementia screening reached 90% within 120 hours of admission. All wards are now capturing the data electronically and this will enable the GP referral to be pulled through to the electronic discharge summary.
- Real time feedback showed patients felt cared for and rated the quality of care as good. The Friends and Family test response rates were sustained in inpatients and ED but dipped in the Maternity Services. Positive comments included staff attitude, help, support and cleanliness.

ACTION REQUIRED BY THE BOARD:

1. To note the report.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Trust quality indicator report – April 2014

Author: **Dr Christine Blanshard**
Title: **Medical Director**
Date: **May 2014**

Salisbury NHS
NHS Foundation Trust

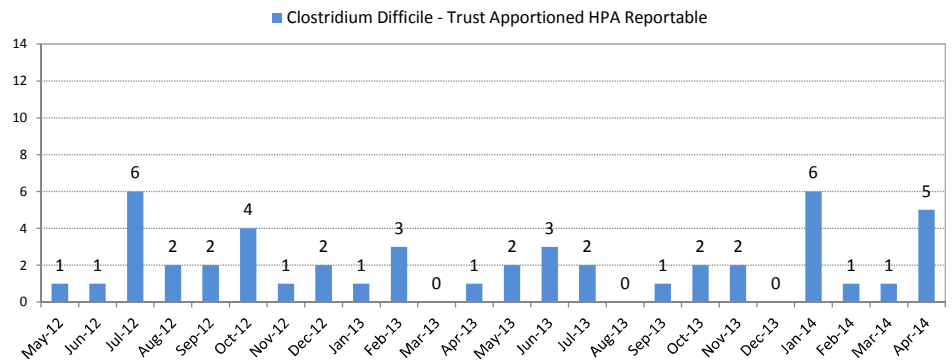
Trust Quality Indicators - April 2014

Quality Measures

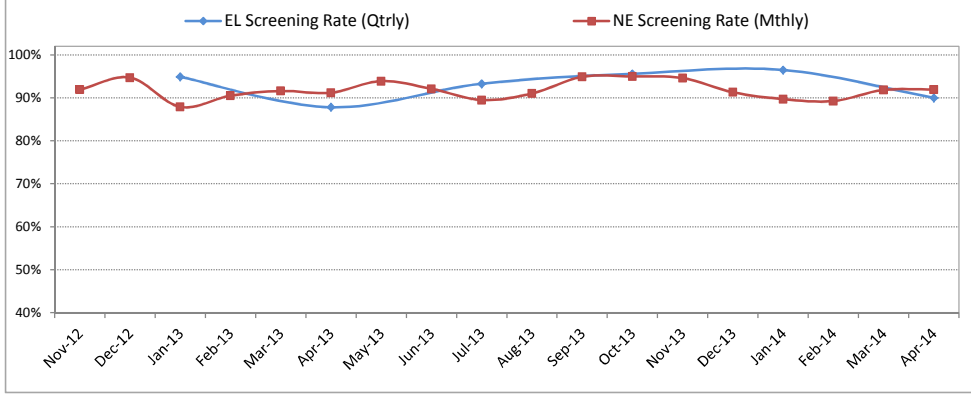
Infection Control	2012-13 Total	2013-14 YTD	2014-15 YTD
MRSA (Trust Apportioned)	3	0 (+2)	0
MSSA (Trust Apportioned)	6	13	3

Trust Incidents	2012-13 Total	2013-14 YTD	2014-15 YTD
Never Events	2	0	0
Serious Incidents Requiring Investigation	13	17	3

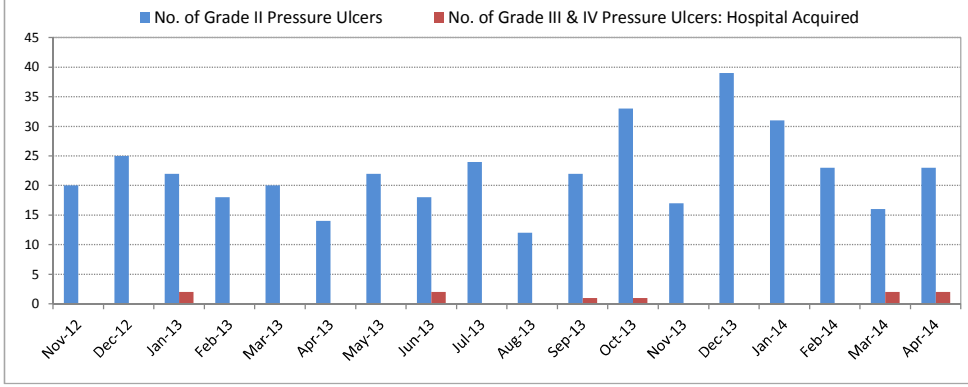
Clostridium Difficile - Trust Apportioned



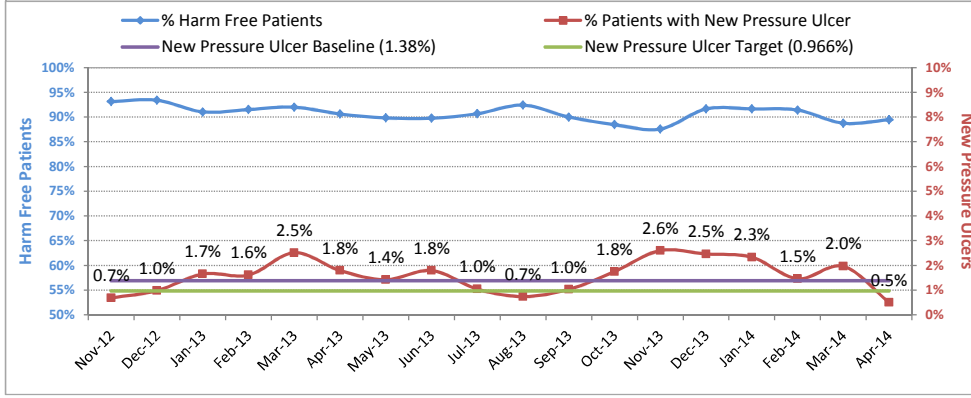
MRSA Screening



Pressure Ulcers - Total Number per Month



Safety Thermometer - One Day Snapshot per Month

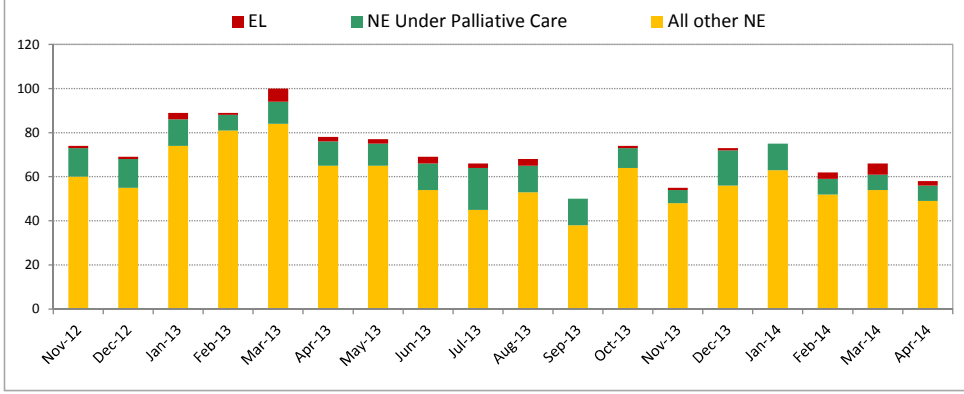


Salisbury NHS
NHS Foundation Trust

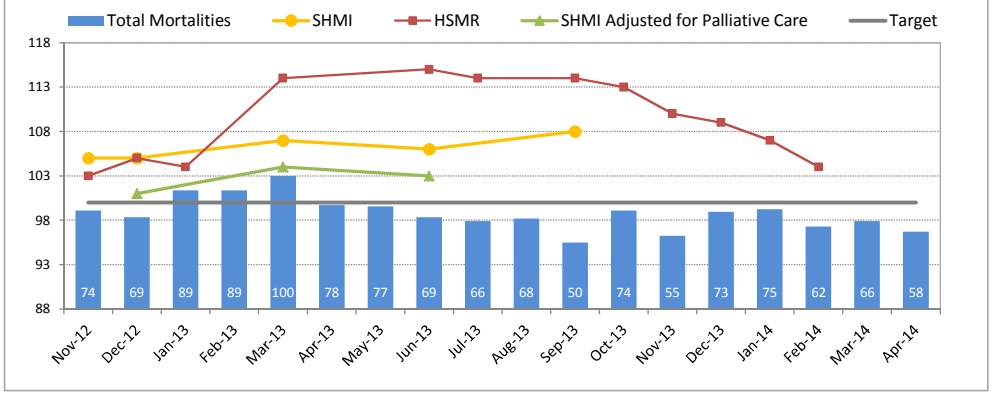
Trust Quality Indicators - April 2014

Quality Measures

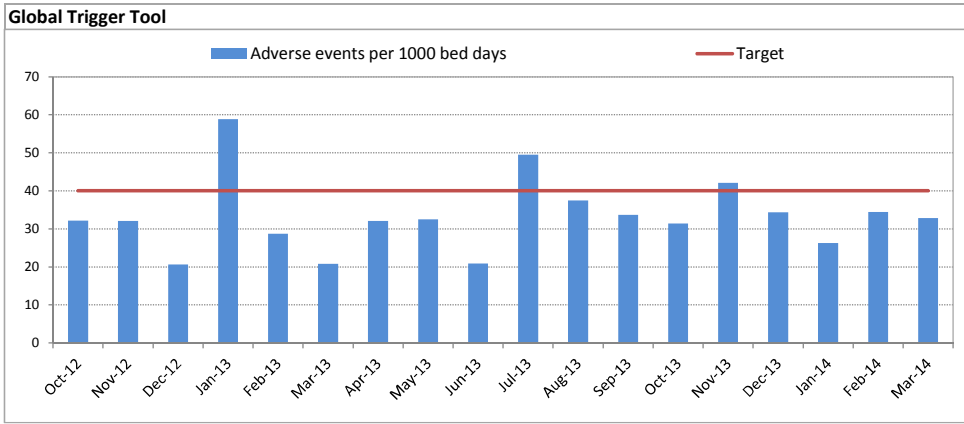
Hospital Mortalities



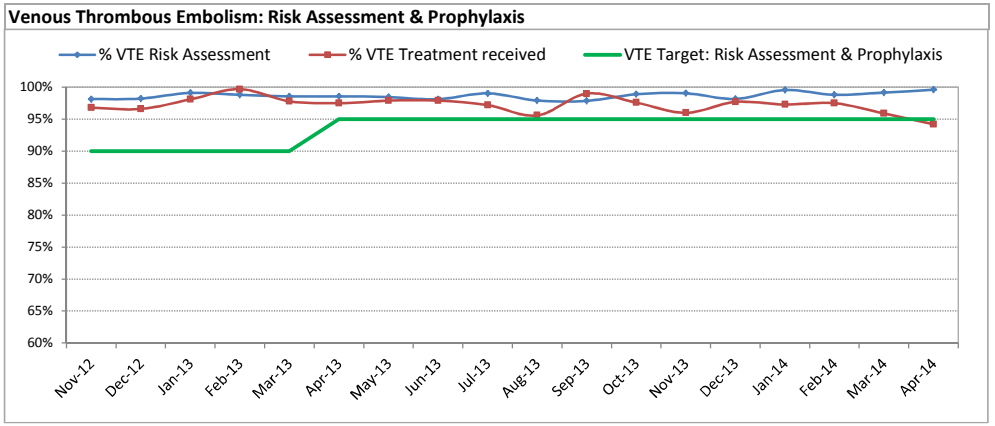
HSMR and SHMI



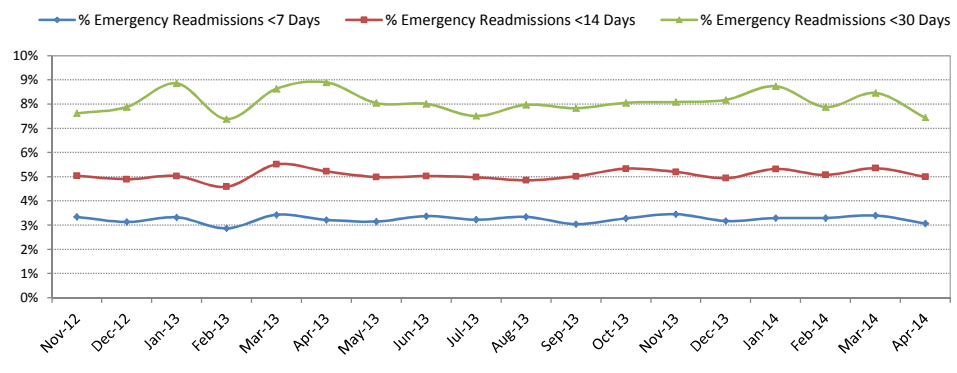
Global Trigger Tool



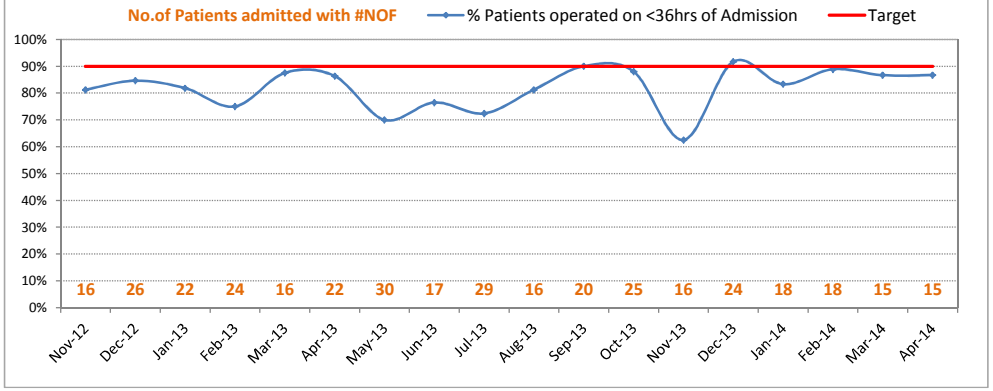
Venous Thrombous Embolism: Risk Assessment & Prophylaxis



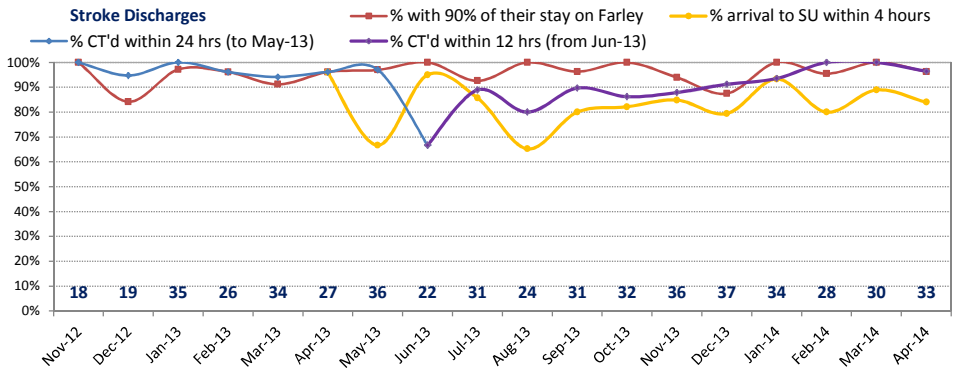
Emergency Readmissions within 7, 14 & 30 days of Discharge



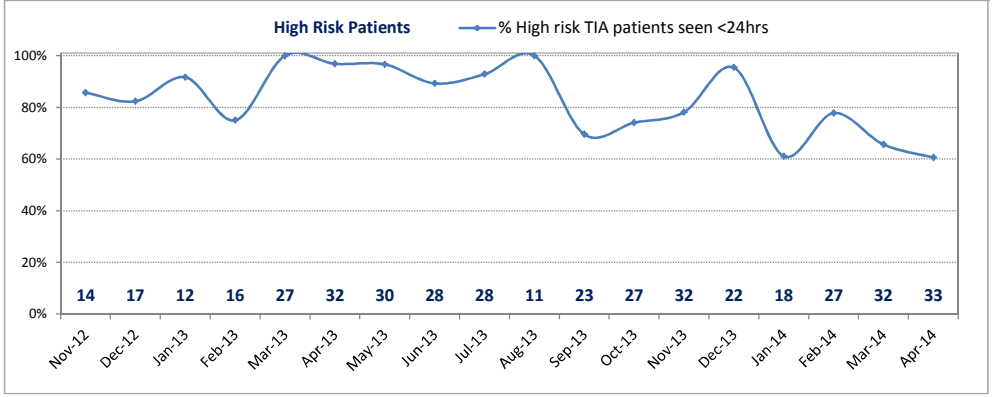
Fracture Neck of Femur operated on within 36 hours



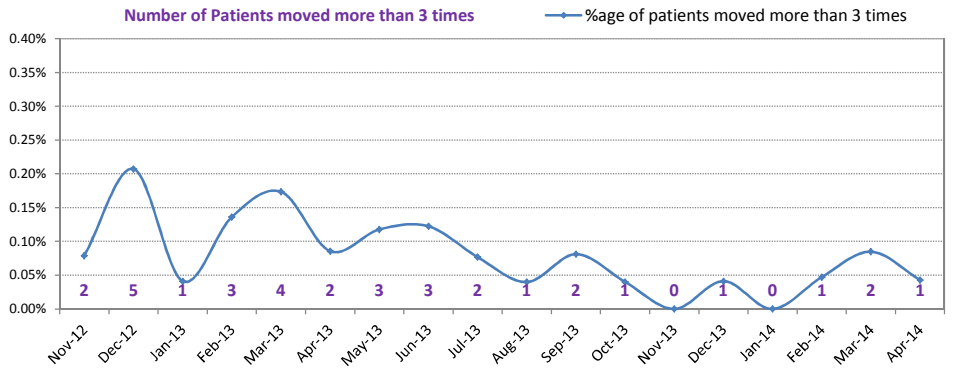
Stroke Care



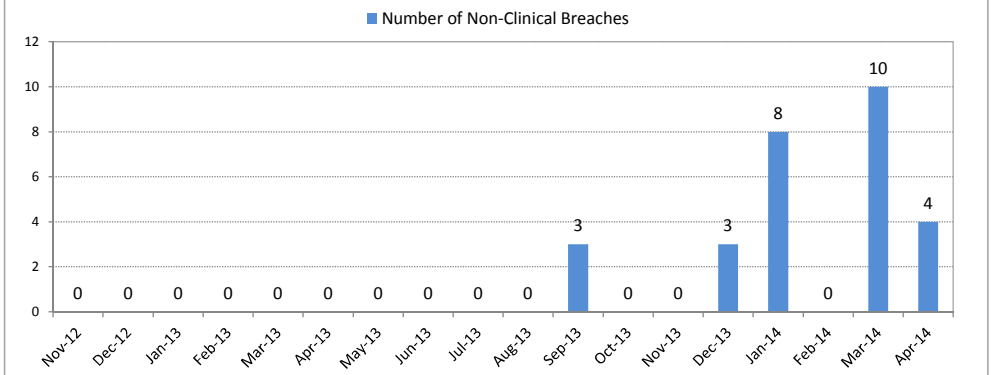
TIA Referrals



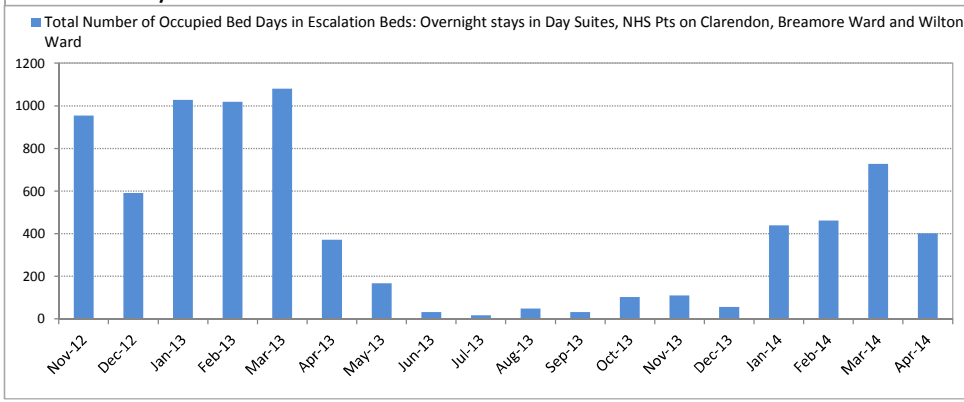
Patients moving more than 3 times during their Inpatient Stay



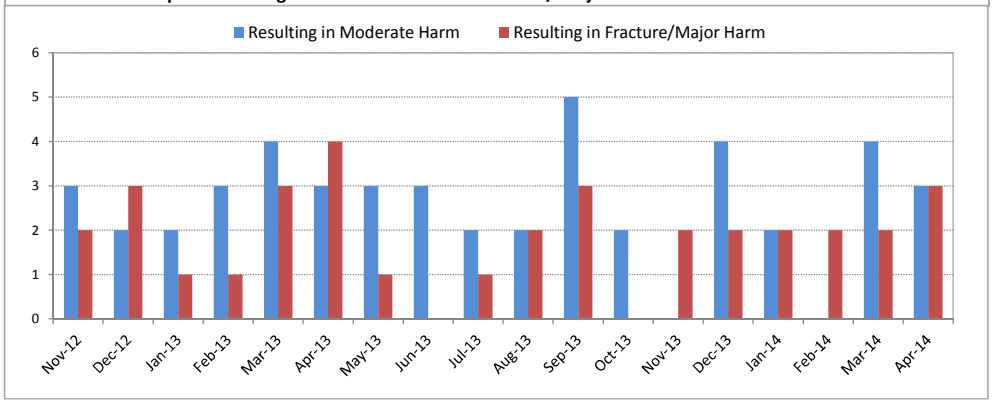
Delivering Same Sex Accommodation



Escalation Bed Days

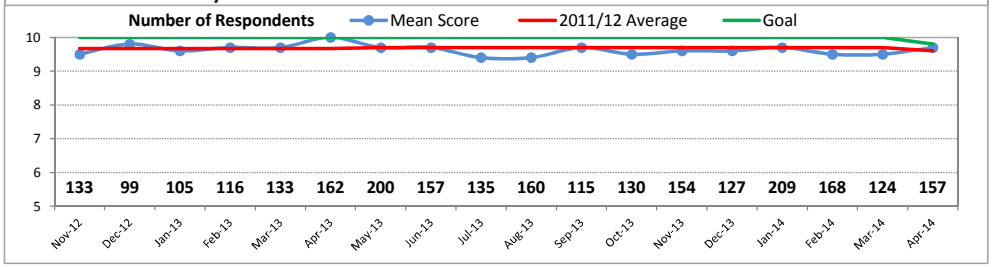


Patient Falls in Hospital Resulting in Moderate Harm or Fracture / Major Harm

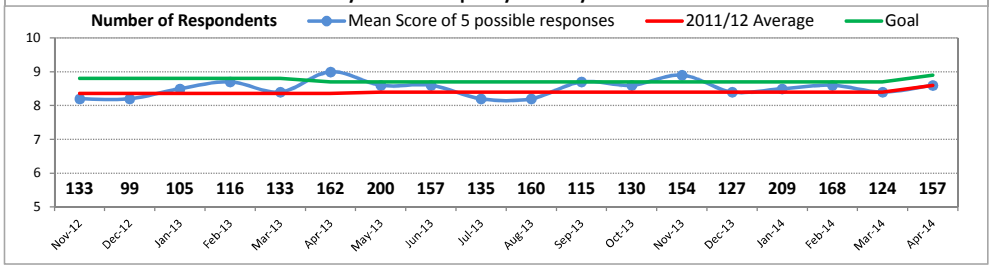


Please note, Durrington Ward (22 beds) was an escalation ward from Nov-11 to Mar-13 and has been counted within these figures for these months. The additional 10 beds above the Standard 30 beds on Winterslow Ward were escalation beds until Mar-13 and Breamore Ward has been included as an escalation ward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

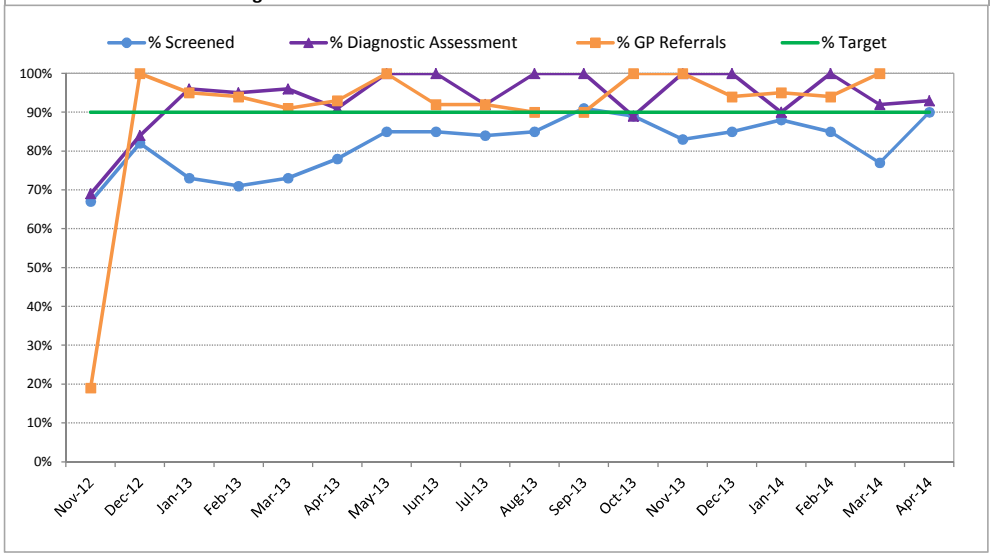
Real Time Feedback: Do you feel cared for?



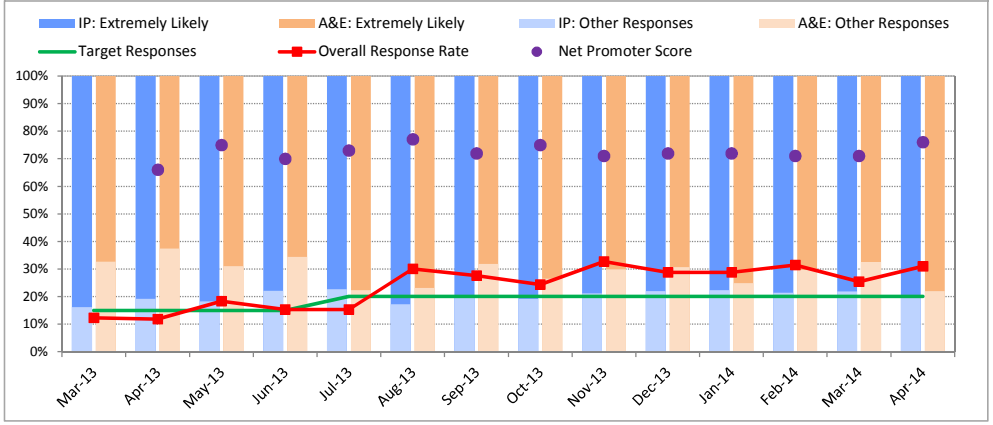
Real Time Feedback: Overall how would you rate the quality of care you received?



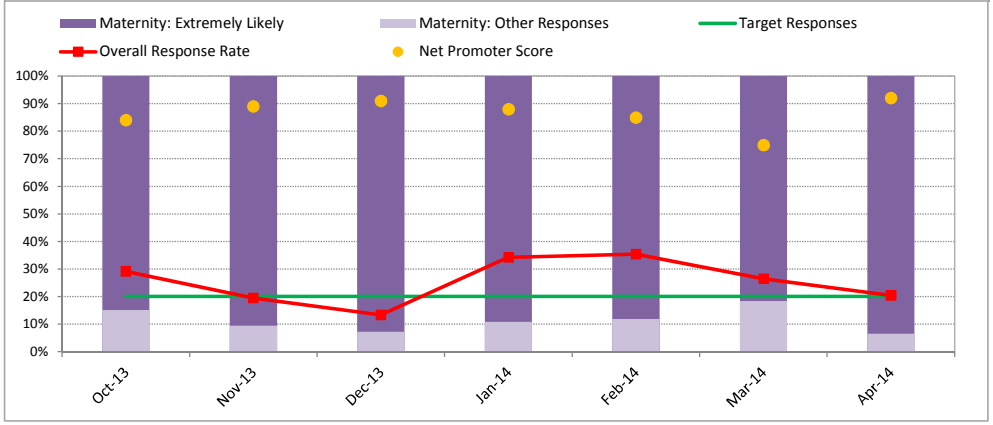
Dementia Audit of Patients Aged 75+



Friends & Family Test: Inpatients and A&E (% Responses)



Friends & Family Test: Maternity (% Responses)



Customer Care Report - Quarter 4
1 January – 31 March 2014

PURPOSE OF PAPER:

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

MAIN ISSUES:

The main issues from complaints are:

- Clinical treatment although the sub-themes show no particular themes.
- Appointment procedures mainly relating to the partial booking process.
- Staff attitude although no themes have been identified in complaints, however a high number of comments were received in praise of staff through Real Time Feedback and the Friends and Family Test.

ACTION REQUIRED BY THE BOARD: to note the report

76 complaints were received in quarter 4. This compares to 74 complaints in quarter 3 this year and 80 complaints for the same period in the previous year. A breakdown of numbers and themes according to Datix is below.

	Clin Supp & Family Services	Facilities	Medicine	Musculo-Skeletal	Surgery	Total 2013-14	Total 2012-13
Admission	0	0	1	0	0	1	1
Appointments	2	0	2	2	6	12	3
Attitude of staff	0	0	5	3	2	10	15
Car Parking	0	0	0	0	0	0	1
Clinical Treatment	3	0	12	7	4	26	38
Communication	0	0	1	2	4	7	11
Delay	0	0	0	0	1	1	0
Dementia	0	0	1	0	0	1	1
Discharge arrangements	0	0	4	0	0	4	4
Equipment, aids and appliances	0	0	0	0	0	0	1
Facilities on site	0	2	0	0	0	2	0
Falls	0	0	0	1	0	1	0
Food	1	0	0	0	0	1	0
Infection Control	0	0	1	0	0	1	1
Information	0	0	0	0	1	1	0
Invoicing	1	0	0	0	0	1	0
Nursing Care	0	0	0	0	0	0	1
Operation	0	0	0	1	1	2	1
Privacy and Dignity	0	0	0	0	1	1	1
Hospital procedures	0	0	1	0	0	1	0
Waiting time	0	0	1	1	1	3	1
Totals:	7	2	29	17	21	**76**	**80**
Patient Activity	10943	0	27743	17506	14723		

In Quarter 4, the Trust treated 15,248 people as inpatients, day cases and r egular day attendees. Another 10,260 were seen in the Emergency Department and 45,325 as outpatients. 76 complaints were received overall which is 0.1% of the number of patients treated. 83 compliments were received across the Trust in Q4, which represents 0.1% 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.

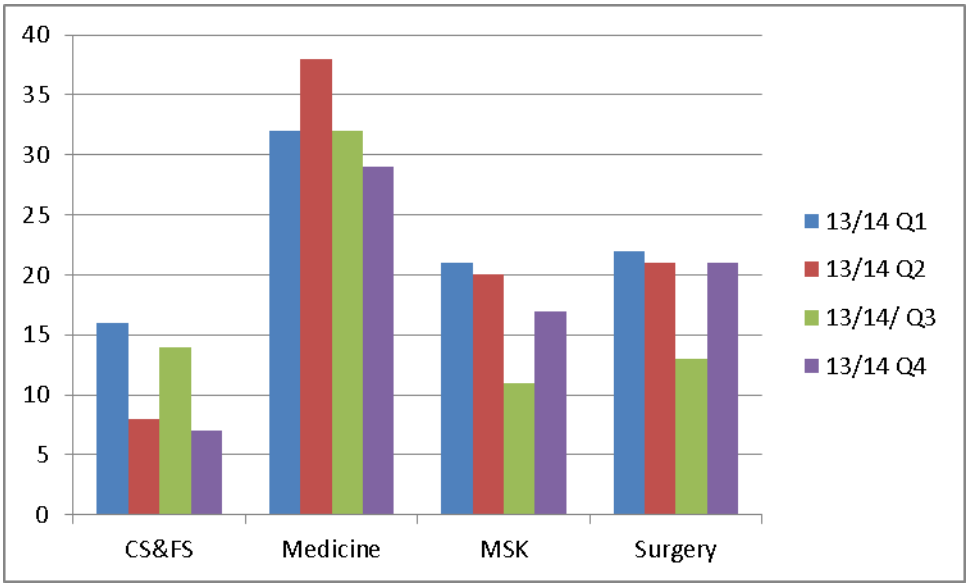
94.5% of complaints were acknowledged within three days. Delays were seen throughout this period due to the unexpected illness of key team members and improvements should be seen in Q1.

The overall number of enquiries, comments, concerns and complaints response times:

0-10 working days		10-25 working days		25+ working days	
123	46%	59	22%	84	32%

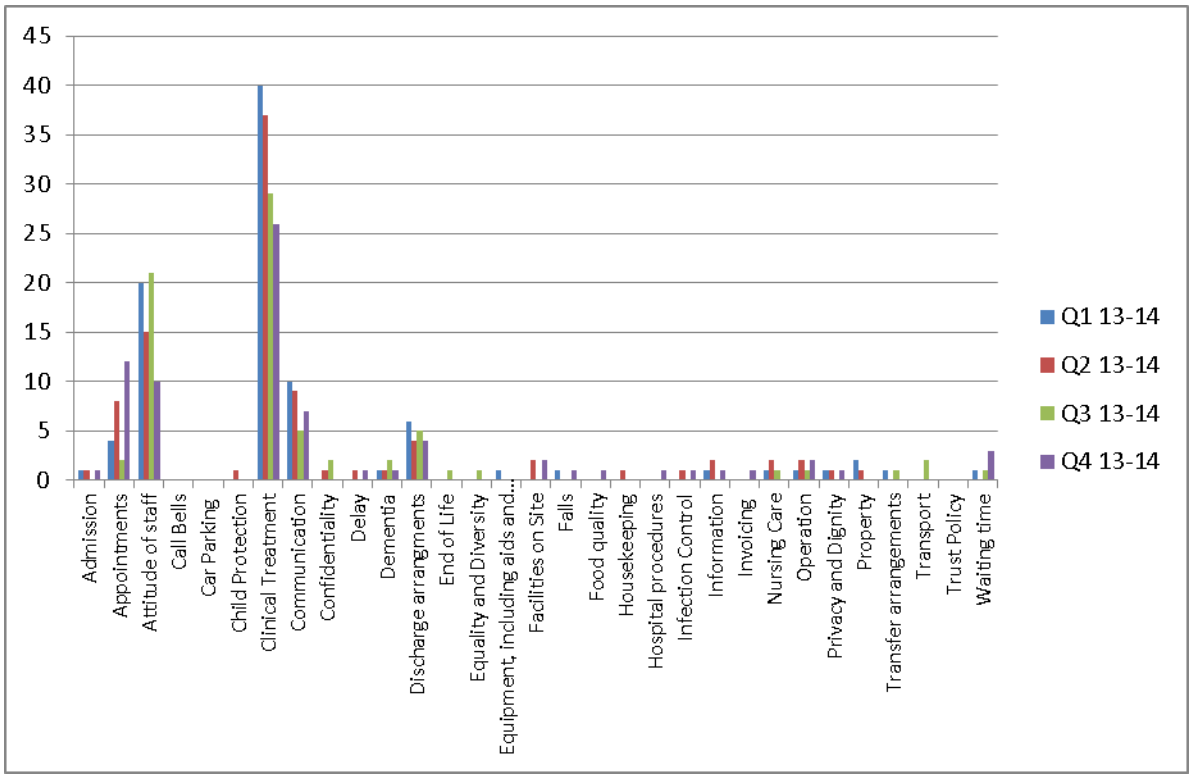
COMPLAINTS BY DIRECTORATE 2013-14

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



COMPLAINTS BY SUBJECT 2013-14

The following graph shows the trend in complaints by subject over the last four quarters. Appointments and waiting times show an increase in complaints in Q4 compared to the previous quarters. Although clinical treatment continues to be the highest theme, there has been a steady reduction since Q1.



Each quarter a Non Executive member carries out a dip sampling of complaints. Four complaints reported to the Trust between 1 January and 31 March 2014 were examined. The criteria used on this occasion, was to examine those instances where complaints made concerned the treatment of patients on a number of wards in the hospital.

Of the complaints viewed, the investigation of two was not complete. In one instance the time during which a response is promised (25 working days) had been exceeded but no further correspondence had been made to the complainant. The Head of Customer Care followed this up with the Patient Experience Advisor who explained that the response had been chased internally but nothing had been communicated to the patient. The Head of Customer Care reminded the Team to ensure all complainants are given a reason for delays in response, that a new timescale is communicated to them and this is documented on the case file.

In three of the four complaints, concern was expressed by the complainant that they were seen by nursing staff whose first language was not English and as a consequence this led to communication problems and poor service. Each of these complaints should have been flagged as having a diversity factor but subsequent enquiry revealed that only one had been. As a result, the staff responsible for recording complaints have been advised by the Head of Customer Care.

One of the complaints referred to what was perceived as poor quality care by a member of bank staff.

CLINICAL SUPPORT AND FAMILY SERVICES

There was a reduction from 14 complaints in Q3 to 8 complaints in Q4. There were no particular themes from complaints in Q4. One theme has emerged from concerns raised in Maternity about mothers perceiving that their parenting skills are being questioned.

Actions from previous quarters

- Alison Montgomery continues to drive actions to improve booking and reception areas in Radiology. No complaints or concerns reported during Q4.
- Track and trace system for managing responses is working in the Directorate.
- Face-to-face meetings offered on receipt of complex complaints.
- Map themes and ask for local actions.
- Devise system for tracking actions from the response.

Moving forward

- The Directorate Management Team (DMT) will work with Emma Rayfield, Patient Experience Advisor to track themes across complaints, concerns, Real Time Feedback and Friends and Family feedback. Monthly review meeting set up between Emma Rayfield and Colette Martindale.
- The DMT continue to work to improve the individual response times and keep track of complaints before the due date. It is recognised that some of the processes are reactive rather than proactive and the DMT are working hard to address this.

Themes and actions by area

Department/Ward	Topic	Actions
Maternity concern	Attitude towards parenting perceived by three individuals as questioning.	• Each concern dealt with at the time with the individuals concerned. • Head of Midwifery and Neo-natal services to address the issues raised with the wider team so all staff can understand the impact of how communication can be perceived especially with new mothers.

MEDICINE DIRECTORATE

- Complaints have decreased from 35 in Q3 to 29 in Q4.

General actions

- Working closely with Patient Experience Advisor in order to respond promptly by telephone and offer face-to-face meetings with families.

- Keep complainants updated by telephone when complaint responses are dependent on clinical reviews/Safeguarding to be completed.
- Developing ward leads and their staff to be more actively involved in complaint responses.

Themes and actions by area

Department/Ward	Topic	Actions
All areas	**Attitude of staff**	• Establishing nurse led appointments for families with ward lead across areas. • Information cards for families with ward lead contact details. Looking at other opportunities for contact outside 9am – 5pm.
General wards	**Discharge plans**	• Working with ward teams to develop safe practice when planning patient discharge from hospital. • Associate DSN to review complaints related to discharge, identify any common themes, share with Directorate • Implement learning outcomes from SUI and Local Review investigations.
All clinical areas/teams	**Clinical care**	• Completion of RCA's. • Share Prevention of Falls information with families and involve them in care planning for patients. • DSN and Associate DSN working with wards to support intentional rounding and appropriate use of enhanced nursing tool.

MUSCULOSKELETAL DIRECTORATE

- The numbers of complaints have significantly changed in Q4 with 22 complaints (11 complaints in Q3). Concerns have slightly decreased with 9 in Q4 (11 concerns in Q3).
- Three of the complaints are re-opened and 2 are joint with other departments (1 with Surgery and 1 with Medicine).
- Orthopaedics and Plastics continue with the highest numbers. Orthopaedics received 8 complaints and 5 concerns, Plastics received 8 complaints and 4 concerns. The re-opened complaints are also within these departments.
- Five complaints are subject to completion.

Directorate challenges

- The learning from complaints and defined actions with follow up is a priority for the Directorate. Currently learning such as communication failures are shared with the teams but measurable outcomes from these need to be defined. One clearer example has been the advice to a patient regarding the use of an external provider of an emergency call out (Lifeline). The family misunderstood the role of this provider and believed that they could use this to assist the patient with toileting at night. This is not the role of this particular organisation. The Therapist involved felt that she had fully explained this at the time but recognised that in future the way in which she recommended this community support would be very explicit. This particular complainant's family met with the DSN and Therapist and we subsequently had further understanding of their confusion regarding those services that were 'owned' by the Trust and community delivered services. This has been shared with the Therapy team to clarify with patients the difference in the various services that they may receive on discharge.
- These are discussed at the department DMT meetings and sharing of the complaints with staff is becoming more evident but continued improvement in this area is required.

General actions

- The Directorate Patient Experience Advisor is taking an active role in contacting the complainant to clarify expected outcomes and to clarify elements of the complaint. One patient after initially agreeing to a meeting with the team then cancelled the meeting. Following discussion with the Patient Experience Advisor he felt that the written response provided him with clarity of the investigation and he did not believe that meeting with the team would be helpful. In a second

example the patient discussed the elements of the response letter that he was satisfied with and clarified some further outcomes he would like addressed which related to patient centred care.

- The Directorate Patient Experience Advisor has also conducted a focus group with Spinal Patients. Key issues identified:
    - Staff understanding/empathy with patients' disabilities.
    - Levels of staff stress.
    - Patient experiences of other patients who are more demanding on the staff and are seen to receive priority from staff.

  These issues were discussed at the Heads of Department meeting on 19th May 2014 and are being led by one of the senior therapists with the Patient Experience Advisor.
- With the Directorate Patient Experience Advisor, review complaints themes in comparison with RTF, patient surveys and PPI projects.
- One meeting has taken place with a complainant who expressed that their complaint had been addressed. Two complainants declined the offer to meet with the clinical teams and one of these has decided to proceed with referral to the Ombudsman.
- Complaint topics need to be considered within any transformation projects (patient experience). There is no specific example of when this has been used in this quarter but complaints and concerns regarding communication when booking appointments or delays in clinics would be useful within the outpatient centralisation work.

Themes, topics and actions by area

Themes within the quarter include delays/length of time for appointments, attitudes of staff and outcomes of treatment or standards of care. In 3 complaints these 3 elements are apparent in the entire complaint.

There has been a delay for patients in obtaining an appointment as a result of changes in the Consultant staffing and referral to and from other hospitals. The issue with attitude is then apparent as a result of the complainant attempting to investigate why there has been a delay or wait for a particular treatment or to see a Consultant.

For each patient these issues have been resolved or have been expedited where possible. The Directorate will be utilising the updated Trust values and behaviours to challenge the departments regarding the communication and attitude elements of complaints. An analysis of the complaints and concerns for the year will be completed to identify if this is specific to individuals with 1:1 discussion and objectives to improve behaviour.

The following issues were raised in the remaining complaints:

Department/Ward	Topic	Actions
Orthopaedic Inpatients	Fall and attempted claim for negligence Communication regarding discharge arrangements Concern regarding staffing levels and staff not taking adequate breaks	• Appropriate and timely falls risk assessment completed • Therapy have reviewed the information given regarding non-Trust services • Skill mix review to address staffing ratios. Staff breaks addressed by ward sister
Spinal	Unprofessional remarks during consultation Unhappy with internal referral processes	• Reviewed by Medical Director. Specific objectives for individual • Review and monitoring in place
Plastics Inpatients	Hygiene practice, staff noise, confidentiality	• Shared with ward staff and POAU
Oral	Request for compensation regarding private treatment	• Not supported and awaiting clinician and patient meeting

Compliments
A total of 9 compliments were received in Q4 across the directorate.

Plastics	4
Rheumatology	1
Orthopaedics	2
Wessex Rehab	2

SURGICAL DIRECTORATE

- The Surgical Directorate received 21 complaints and 13 concerns in Q4.
- Two complaints were re-opened. One asked for further clinical explanations and another contested facts as stated from clinical documentation.

Directorate challenges

- Response rate within 25 days was at 90% in Q4.
- Patients continue to express concerns regarding partial booking process for ENT and Ophthalmology.

General actions

- Complaints relating to partial booking process and reception experience are continuing to be discussed with the Outpatient Transformation Project Lead for inclusion in Outpatient Transformation Project.

Department/Ward	Topic	Actions
Central Booking	Partial booking issues	• All complaints are being raised with Outpatient Transformation Project Lead/Central Booking Manager for inclusion in Outpatient Transformation Project, which is due to commence shortly.
ENT/Audiology	Dissatisfaction with newly amalgamated ENT/MSOPD reception	• Issues raised with Reception Co-ordinator and Outpatient Department Manager in order to continue to refine the processes of this newly amalgamated reception.

Themes and actions by area
No themes were identified this quarter.

TRUSTWIDE THEMES
From the chart on page 1 it can be seen that clinical treatment is the most frequently occurring trustwide theme across 21 different areas. This theme is very broad and any complaint with an aspect of clinical care will be recorded against this theme on Datix. Analysis of the sub-themes does not show any particular themes.

The second highest theme is appointments (12) of which 8 relate to appointment procedures, 2 appointment delays, 1 cancelled and 1 postponed. These complaints were raised in 10 different areas. The complaints about appointment procedures mainly relate to the partial booking process where an appointment is allocated six weeks in advance. We write to the patient asking them to contact us to accept the offered appointment, or reschedule to a more convenient date or time. This approach has not only improved attendance rates, but has given much more flexibility in offering more convenient appointments to our patients.

The third highest theme is staff attitude (10) of which as 5 relate to medical staff, 4 nursing staff and 1 administrative member of staff. Complaints against a member of staff are dealt with by a face-to-face discussion and individual action is taken as appropriate. If several complaints are received about the same person then the line manager will develop a plan with the individual through the appraisal process or possible disciplinary or capability procedures. All doctors must discuss complaints in which they have been

named at their annual appraisal. All complaints about a doctor's attitude are shared with the Medical Director.

A total of 256 comments in praise of the staff were received from Real Time Feedback.

"Absolutely wonderful treatment. It could not be better. Excellent care."

"The staff are all dedicated, caring and kind. 10 out of 10!"

"Everyone has been so caring. Salisbury must be the best of hospitals. The nurses have been wonderful, the care and are extremely hard working."

The Trust has received a huge volume of comments from the Friends and Family Test. For Q4 a total of 1,800 comments were received in praise of the staff.

"I have never been to A&E before. The receptionist was charming, the nurse very professional and I was treated quickly and calmly by the doctor. I am extremely grateful. All first class."

"Had great care from all midwives and doctors."

"The treatment I have had, and all the staff have been wonderful."

The three categories with the highest number of concerns received from Real Time Feedback have been food (102 negative against 100 positive comments); noise (38 negative; 8 positive) and communication (66 negative; 27 positive).

The negative food comments mainly relate to hot food not being up to temperature. It is anticipated the introduction of new food trolleys in May 2014 will help to improve this situation.

Issues regarding communication were also highlighted in the results of the National Inpatient survey 2013. As a result, wards across the Trust have developed action plans to try to address these concerns.

Very few negative comments are received from the Friends and Family Test but of those that were received, the three main categories were communication (12 comments); waiting time in ED (10 comments) and noise (4 comments).

FEEDBACK FROM COMPLAINANTS

Questionnaires for feedback from complainants about the complaints handling process have been sent out at the end of April for all closed complaints for 2013-14. Reminder letters are not sent out for this survey. A report of the feedback received will go to Clinical Governance Committee in September 2014.

Another questionnaire will be developed to send to people who have raised concerns.

Two complainants wrote back after receiving their response in Q4:

- Thank you for taking the trouble to undertake a thorough investigation.
- Thank you for investigating and resolving the issues raised.

PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

In Q4 there were four new requests for independent review (2 for Musculo Skeletal, Clinical Support and Family Services, and Surgery). One complaint that was closed was partially upheld and the Trust had to pay £1000 in recognition of the failings. The Patient's Property Policy was updated as result of this complaint clarifying that the Trust cannot accept liability in respect of any loss or damage to a patient's property unless it has been handed over to a member of Trust staff for safekeeping and for which the Trust has issued a receipt.

NHS CHOICES WEBSITE

In Q4 there were 14 positive comments posted on the NHS Choices website relating to nine different areas. One patient said “It was an extremely difficult time for me throughout, however the quality of the treatment and care I received at Salisbury made the experience infinitely more tolerable. The surgeon and her colleagues are overwhelmingly competent yet manage to combine this with friendly, factual and honest advice from beginning to end”.

AUTHOR: Hazel Hardyman
TITLE: Head of Customer Care
DATE: May 2014

PAPER: SFT 3536

INFECTION PREVENTION AND CONTROL REPORT

PURPOSE: 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 2013/14 Annual Action Plan to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

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

HCAI management
During quarters 1 and 2 of 2013/14, the Trust had **no** declared outbreaks.
During quarters 3 and 4 of 2013/14, the Trust declared an outbreak on Influenza A from the 5th to 13th March 2014 for a ward within the medical directorate. In total, 7 cases of Influenza A (H3N2) were identified with 1 patient also being Respiratory Syncytial Virus (RSV) positive. During the ward closure, 3 staff members were reported to be off work with cold/flu symptoms, although no formal diagnosis of Influenza was made. In accordance with national guidance, this outbreak of Influenza was reported as a Serious Incident Requiring Investigation (SIRI), and a report will be written during quarter 1 (2014/15).

- **Clostridium difficile** – during the winter period, there is always an expectation of higher numbers of positive results, with the increase in the number of patients experiencing symptoms of diarrhoea and/or vomiting within the Trust. However, the Trust did not exceed the challenging target set for 2013/14 of no more than 21 Trust apportioned reportable cases.

- **Vancomycin Resistant Enterococcus (VRE)** – during 2013/14, there has been an increase in the number of cases of VRE identified from inpatient samples. This was initially reported for patients being nursed within the surgical directorate, however cases have also been identified for inpatients in other directorates across the Trust. This increase in the incidence of VRE has reflected the trend that has been reported nationally. It is not known what percentage of the population may be colonised with VRE, and there is currently no national guidance regarding patient screening for VRE. It has been recognised that the increase in the incidence of inpatients identified to be VRE positive, and who will require isolation nursing, will 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.

Mandatory surveillance update
- **MRSA bacteraemia cases –** there have been 2 MRSA bacteraemia cases identified during 2013/14 and following investigations it was concluded that the cases were not linked with any other cases, and classed as contaminants.
- **MSSA bacteraemia cases –** during 2013/14, a total of 13 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 7 of the cases. As a result, the central venous catheter (CVC) ongoing care bundle has been reintroduced and an implementation plan has been agreed, which involves education and audit work with the clinical directorates. The peripheral vascular cannula (PVC) insertion stickers were revised again and rolled out across the clinical areas, with compliance

continuing to be reassessed. Further work with the wider involvement of Trust staff is planned.

- **Surgical Site Infection Surveillance (SSIS) –** during 2013/14, the Trust undertook the required mandatory SSIS for orthopaedic surgical procedures. The category of hip replacement surgery recorded 98 procedures. Of these, 2 surgical site infections (SSI) were recorded according to PHE definitions. One was identified as superficial and one organ/space infection requiring further intervention. The category of knee replacement surgery recorded 72 procedures. Of these, 4 superficial SSIs were identified, 2 for inpatients, 1 for a patient readmitted to the Trust and 1 when a patient developed the infection following discharge. The identification of 4 SSIs gives an infection rate of 5.55%. From further investigations, there was no evidence to indicate that these infections could have been prevented, or that they could be linked in anyway.

Audit

Sustained and improved audit compliance against key infection control policies for the use of the Isolation Risk Assessment Tool, Bare Below the Elbow (BBE) and Uniform and Workwear guidance, use of 2% Chlorhexidine Gluconate in 70% alcohol and the Revised MRSA Monitoring, Prescription and Treatment Pathway.

- **Antimicrobial stewardship audits** – during 2013/14, all scheduled antibiotic audits have been completed. During quarters 1 and 2, none of the wards scored less than 80% compliance, and 2 wards scored less than 80% compliance during quarters 3 and 4. This compares favourably with the previous year, where results for 6 wards fell below the 80% compliance threshold.

Hand hygiene – for 2013/14, the overall mean Trust compliance was 90.35% and further analysis of the data has identified several factors which have influenced the compliance scores. The Trust hand hygiene audit tool was reviewed and it is acknowledged that the audit process enables the practices of a broader range of personnel to be observed. The revised audit tool captures all of the '5 moments for hand hygiene'. This is in contrast to the previous audit tool which audited only 2 of the '5 moments for hand hygiene'. These factors may therefore affect the overall compliance scores achieved, and has allowed for targeted education with specific staff groups. As a result of lower compliance and user feedback, the placement of alcohol hand rub gel at the patients' bedsides has been trialled on both surgical wards. Compliance with hand decontamination has improved. This work will be extended across the inpatient clinical areas, and will complement the existing wall mounted gel dispensers sited at the point of care.

Cleaning services

- The Housekeeping Department has implemented a new approach to how clinical areas are deep cleaned. The Rapid Response Team has been utilised to support the clinical areas daily requirements for cleaning, as well as concentrating cleaning efforts and supporting infection control requirements e.g. enhanced cleaning.
- Cleaning hours have also been increased across 7 clinical areas following review by the Facilities Matron.
- The annual Trust PLACE was completed on the 25th April 2013, with the national results being published on the 18th September 2013 by the Health & Social Care Information Centre. The Trust score for cleanliness was 87.3%, with the national average score being 96%. However, 90% of hospital sites scored more than 80%.

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

ACTION REQUIRED BY THE BOARD:

The Board is asked to:

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

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

ATTACHMENT AVAILABLE TO VIEW ON WEBSITE:

The DIPC Annual Report for 2013/14.

AUTHOR: Fiona Hyett

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

Salisbury NHS
NHS Foundation Trust

Director of Infection Prevention & Control (DIPC)

Annual Report for 2013/14

Fiona Hyett
Interim DIPC

May 2014
Final version 3

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1. Introduction

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

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

The purpose of the DIPC Report is to inform the Trust Board of the progress made against the 2013/14 Annual Action Plan (Appendix 1), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

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

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

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

All NHS organisations must be able to demonstrate that they are complying with the Code of Practice. The Trust continues to be registered with the CQC, for Outcome 8 (Regulation 12) Cleanliness and infection control. The CQC completed a Trust site unannounced inspection during February 2013 and no concerns were noted for cleanliness and infection control.

2. Overview and Action Plan

The work towards achieving the objectives of the Annual Action Plan 2013/14 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 outbreaks.

The IP&CT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) Infection Control Nurses (ICNs) and secretary (0.61 wte) in post from the end of quarter 4 (Appendix 2). In addition, there are 2 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

4. DIPC Reports to the Board

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

- Agree an annual infection control programme and monitor its implementation.
- Oversee the implementation of infection control policies and procedures.
- Monitor and review the incidence of HCAI.
- Develop and review information regarding infection prevention and control.
- Monitor the activities of the IP&CT.
- Monitor the Trust's delivery of control of infection standards in various accreditation systems, in National Health Service Litigation Agency (NHSLA) Risk Management Standards and 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 P seudomonas water management, via the Water Safety Committee.
- Receive regular reports from the Decontamination Committee.

The membership and terms of reference of the IPCC were reviewed and approved during 2012/13. 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 2013/14 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.

During 2013/14, an outbreak of Influenza A was formally declared on 5th March 2014 for a ward within the medical directorate. There has been a change to the external reporting requirements, where the Trust is required to report HCAI outbreaks as serious incidents requiring investigation (SIRI). When a HCAI outbreak is declared, the Trust is required to initially report 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 report within 45 working days. The Trust is also required to record the these incidents on the strategic executive information system (STEIS). This process is in line with information and guidance produced by the NHS Commissioning Board Serious Incident Framework (2013), and the Health Protection Agency HCAI

Operational Guidance & Standards for Health Protection Units (2012, Health Protection Agency now Public Health England (PHE) from 1st April 2013).

During 2013/14, the Trust had no declared outbreaks of viral gastroenteritis (Norovirus); Staphylococcus aureus, including Methicillin Resistant Staphylococcus aureus (MRSA) and Methicillin Sensitive Staphylococcus aureus (MSSA); Clostridium difficile; invasive Group A Streptococcus (iGAS); Acinetobacter baumannii; Chickenpox (Varicella zoster); Extended Spectrum Beta Lactamase (ESBL) producers; Respiratory Syncytial Virus (RSV); 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 2013/14. However, testing of inpatient samples identified 39 confirmed cases of Norovirus. These 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 and developed symptoms during their admission.

During quarters 1 and 2, it was necessary to close bays across 4 wards in the medical directorate at different times, to ensure the safe management of patients and continued service provision. In addition, bays on a fifth ward in the medical directorate were closed due to patients with symptoms of diarrhoea and/or vomiting. When patients became symptomatic in the remaining bay and staff members reported symptoms, Durrington Ward was closed from 18th to 25th April 2013. During this time, 1 empty bed was closed for a 5 day period following the discharge of a patient to their own home.

For quarter 3 there were no inpatient cases of Norovirus identified from testing, and all patients presenting with symptoms on admission were appropriately isolated in sideroom facilities. Where patients developed symptoms after admission, the appropriate infection control measures were implemented, and environmental cleaning completed. There was no requirement to close beds or bays as a direct result of diarrhoea and vomiting.

During quarter 4, there was a significant increase in the number of patients experiencing symptoms of diarrhoea and/or vomiting, with a total of 27 cases of Norovirus identified from inpatient samples. Across the medical and surgical directorates there were single bay closures on 5 wards (Downton, Britford, Pitton, Farley and Redlynch Wards). The extent of patient symptoms led to the closure of more than one bay and subsequent ward closures:

- **Durrington Ward** – closed to admissions from 27th January to 5th February 2014.
- **Wilton Ward** – closed to admissions from 31st January to 3rd February 2014 due to the layout of the ward, which is only 12 beds and equivalent to a large bay area plus one sideroom.
- **Tisbury CCU** – bays affected at different times during February and March 2014. On 28th February 2014 when 3 bays were affected, the management of the ward was reviewed by the Directorate Management Team (DMT), clinicians and the ICNs. The ward remained open with the 3 affected bays closed under isolation precautions. To maintain an effective and safe cardiology service, a sideroom was made available on the ward for acute cardiology admission(s), and new patient admissions with chest pains were managed on Whiteparish Acute Medical Unit (AMU).
- **Winterslow Suite** – closed to admissions from 27th February to 7th March 2014.
- **Breamore Ward** – closed to admissions from 24th March, and on going into quarter 1 of 2014/15.

For all of these areas, additional daily enhanced cleaning by Housekeeping was instigated when bays 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.

Where bays were closed due to patients with diarrhoea and/or vomiting symptoms, the management was reviewed by the ICNs in conjunction with the ward staff, the outcome of clinician reviews and the relevant 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. 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.

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. There were however delays in the discharges of some patients to their own homes. This was due to required assessments not being completed with social workers declining to visit patients in closed bays/wards, and where care agencies declined to commence packages of care for patients in closed bays/wards. This issue is being addressed by the medical DMT.

Clostridium difficile (C.difficile)
Following the identification of 2 patients with C.difficile who had been nursed in the same bay on Redlynch Ward within the medical directorate, the bay was closed from 27th June to 1st July 2013. Immediate actions implemented by the IP&CT included enhanced environmental cleaning and additional monitoring and audit of practices by ward staff. A review meeting was held with attendance by key personnel. The group also considered 3 further inpatient cases of C.difficile, where 2 patients had been nursed on the ward during their hospital stay, and the third patient had been an identified contact on a different ward (Tisbury CCU).

Following individual case reviews, the available stool samples were sent to the external Reference Laboratory for ribotyping. The ribotyping results identified 2 patients to have the same ribotype (013), and these patients had been nursed in the bay at the same time. The remaining results identified 1 sample as ribotype 002, and 1 sample as a 'sporadic' type. This episode was classed as a period of increased incidence (PII) of C.difficile and further measures identified for implementation included antibiotic audit and reviews, daily enhanced environmental cleaning for an extended period, equipment cleaning, and the continued implementation of C.difficile High Impact Intervention (HII) measures monitored through audits.

During January 2014, there were 6 Trust apportioned reportable C.difficile cases, that had been identified across 2 clinical directorates (medicine and musculoskeletal). A meeting was held to review each case using the information obtained from the incident investigations completed by the ICNs. Discussions were held by the group and additional information provided by the directorate representatives, in relation to ward team practices. C.difficile HII audits had been completed by the ward teams to monitor compliance of infection control practices and provide additional assurance for the safe management of these patients. At the meeting it was agreed that identified stool samples from this month, plus a positive sample result for a case identified on the intensive care unit would be sent for ribotyping. From the results received, there was a genetic epidemiological link with 2 patients being typed as 014/020, and a further 2 patients being typed as 078. However these patients were not geographically linked for their admission period.

Further meetings, actions and ongoing peer support were implemented for the medical directorate where 2 cases of C.difficile were identified on the same ward during January 2014. This work included continued focus on the environment and equipment cleanliness, specific infection control practices relating to the assessment and management of inpatients with symptoms of diarrhoea, adherence to Trust policies and robust communication processes within the ward teams and staff groups. Extra environmental audit work in the form of a Patient Led Assessment of the Care

Environment (PLACE) was completed with outcomes formally reported via the Matrons Monitoring Group (MMG).

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 Occupational Health (OH) Department and PHE will also be involved if there is a requirement for the follow up of any identified patient or staff contacts.

During 2013/14, there were 7 inpatients identified to have suspected pulmonary TB. These were unrelated cases, and the patients were all isolated under respiratory precautions in sideroom facilities. There was no indication for the follow up of other patients or staff members.

Vancomycin Resistant Enterococcus (VRE)
During 2013/14, there has been an increase in the number of cases of VRE identified from inpatient samples. This was initially reported for patients being nursed within the surgical directorate, however cases have also been identified for inpatients in other directorates across the Trust. The increase in the incidence of VRE has reflected the trend that has been reported nationally. It is recognised that there is currently no national guidance regarding patient screening for VRE, either prior to or on admission to hospital. In addition, it is not known what percentage of the population may be colonised with 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.

Review meetings were held during quarters 1 and 2 (2013/14), with attendance of key personnel to discuss the cases at length. Discussions also included any patients identified to be VRE positive, and who could be linked to the surgical directorate since January 2013. These were managed as PII of VRE and ongoing actions were agreed. These included enhanced environmental and equipment cleaning by Housekeeping, additional screening of identified patient contacts and the continuation of antibiotic stewardship audits (deep cleaning of the whole Downton Ward environment was also undertaken). Samples from identified patients were sent to the external Reference Laboratory for ribotyping.

The PII of VRE has revealed the increased likelihood of VRE in high risk surgical patients. The patients identified with VRE could have been colonised either in the community or from previous hospital admissions, but it would not be possible to verify this conclusively. These episodes have been managed as an ongoing PII of VRE, and the DIPC has commissioned a full formal report to be written, for completion by the end of quarter 1 (2014/15).

During quarters 3 and 4 (2013/14), cases of VRE have been identified from inpatient samples, for patients nursed within the surgical, musculoskeletal and medical directorates. In addition, cases of VRE have been identified from samples sent in from the community. Where inpatient cases were identified, discussion with the Consultant Microbiologists occurred and the required actions agreed. These included enhanced environmental and equipment cleaning by Housekeeping, additional screening of identified patient contacts and the continuation of antibiotic stewardship.

Continuing for the surgical directorate, samples from identified positive patients were sent to the external Reference Laboratory for ribotyping and 3 distinct ribotypes were identified: Salipec – 1, 2

and 4. Multidisciplinary review meetings continued to be held for discussion of individual patients and the significance of these results. In addition, written information was provided for the General Practitioners (GPs) of discharged patients who had been identified for follow up.

Extensive environmental and patient equipment swabbing was undertaken by a Consultant Microbiologist across both surgical wards to establish the potential of environmental bioburden. This included high touch contact points such as door handles, patient tables, chairs and grab rails as well as for specific pieces of patient equipment. Six positive results were identified out of 180 swabs, which was less than 4% of the total number sent for testing. Two distinct ribotypes were identified from the positive samples identified: Salipec – 1 and 4, and although the movement of furniture and fixtures within the clinical areas could make the data difficult to interpret, contamination of the environment was acknowledged by the review group.

A programme of daily enhanced environmental and equipment cleaning had been undertaken, with additional daily cleaning completed for all siderooms where VRE positive patients were being isolation nursed. In addition, a programme of deep cleaning for all patient areas including the dirty utility rooms on both surgical wards was undertaken, which included the use of the GLOSAIR 400 room decontamination system.

It has also been recognised that the increase in the incidence of inpatients identified to be VRE positive, and who will require isolation nursing, will 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 possibility of cohorting VRE positive patients has also been considered, and this practice may be indicated in the future if numbers of cases continue to rise. As a result of these incidents, actions were identified for key personnel. This included the development of a specific Trust wide policy for the management of VRE positive patients and the environment. This work is ongoing, and the IP&CT continue to support ward teams with all aspects of patient management.

Influenza

During quarter 4 (2013/14), the Trust experienced an increase in the number of patients who were admitted with 'flu-like' symptoms, or later developed symptoms during their admission. The Trust declared an outbreak of Influenza on 5th March 2014 following the closure of a medical ward to admissions the previous day (Durrington Ward). Daily visits were undertaken by the ICNs to review patient symptoms and treatment, and to provide support and guidance to all staff groups within the ward team, including the wearing of PPE and respiratory protection.

A situation report was provided at the daily bed meeting each morning, and included an update on patient symptoms, treatment and management. Separate outbreak management meetings were held with the involvement of key personnel, and the local PHE were also informed of the outbreak. 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. During the ward closure 3 staff members were reported to be off work with cold/flu symptoms, although no formal diagnosis of Influenza was made. OH provided staff guidance relating to health management to the ward team.

In addition to the instigation of daily enhanced cleaning by Housekeeping, a planned programme of terminal environmental and equipment cleaning was agreed in preparation for the ward reopening, with deep cleaning and the GLOSAIR 400 room decontamination system utilised for the bays and siderooms. Following completion of this, Durrington Ward reopened on 13th March 2014 and the outbreak was declared over. In total, 7 cases of Influenza A (H3N2) were identified with 1 patient also being Respiratory Syncytial Virus (RSV) positive. In accordance with national guidance, this outbreak of Influenza was reported as a SIRI, and a report will be written during quarter 1 (2014/15), for submission within the required timeframe.

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 2013/14, there were 5 unrelated cases of iGAS identified from samples taken for patients nursed in the medical, surgical, musculoskeletal and clinical support and family services directorates. For each of the cases, treatment was advised by a Microbiologist and the patients were managed according to the Trust Isolation policy. The local PHE was also informed, to enable the required follow up of any identified household contacts in the community.

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 2013/14 are as follows:

- Hip replacement surgery was completed in quarter 1 (2013/14).
- During quarter 2 (2013/14), 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, and of the 98 hip replacement procedures recorded, one superficial surgical site infection was identified, and one organ/space infection requiring further intervention was identified, according to the criteria set by PHE. The identification of two surgical site infections for this cohort of 98 patients gives an infection rate of 2.04%.
- Knee replacement surgery was completed in quarter 3 (2013/14).
- During quarter 4 (2013/14), the ICNs completed data collection and follow up for patients who had undergone knee replacement surgery during the previous quarter. The data was submitted to PHE within the required time frame, and of the 72 knee replacement procedures recorded, 4 superficial surgical site infections were identified (2 for inpatients, 1 when a patient was readmitted to the Trust, and 1 for a patient who developed the infection following discharge). The identification of 4 surgical site infections for this cohort of 72 patients gives an infection rate of 5.55%.
    - From the initial investigations completed there was no evidence to indicate that these infections could have been prevented, or that they could be linked in any way, as the causative organisms were not similar. The relevant consultants were also contacted and no cause for concern has been highlighted. The consultants do not feel that the infection was significant. Patients have been reviewed in the outpatients clinic post discharge, and the surgical wounds have been assessed as healing well, with no indication of ongoing or deep seated infection.
    - Further investigation has been implemented and a formal report summarising actions taken and outcomes will be produced and formally reported via the IPCC.

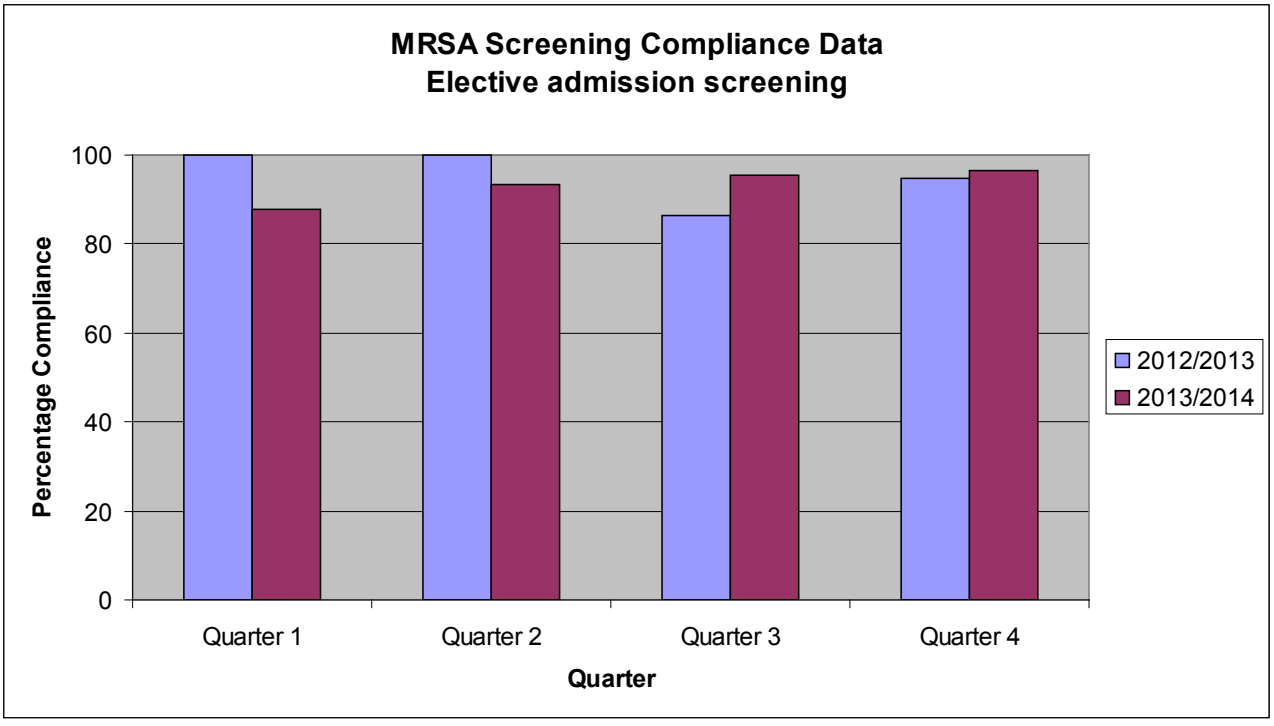
The ICNs produce a formal report outlining progress with SSIS each quarter, which is presented at the IPCC and disseminated to relevant Trust personnel. The publication of national data for mandatory SSIS by PHE for 2012/13 was produced in December 2013.

6.2.2 Methicillin Resistant Staphylococcus aureus (MRSA)

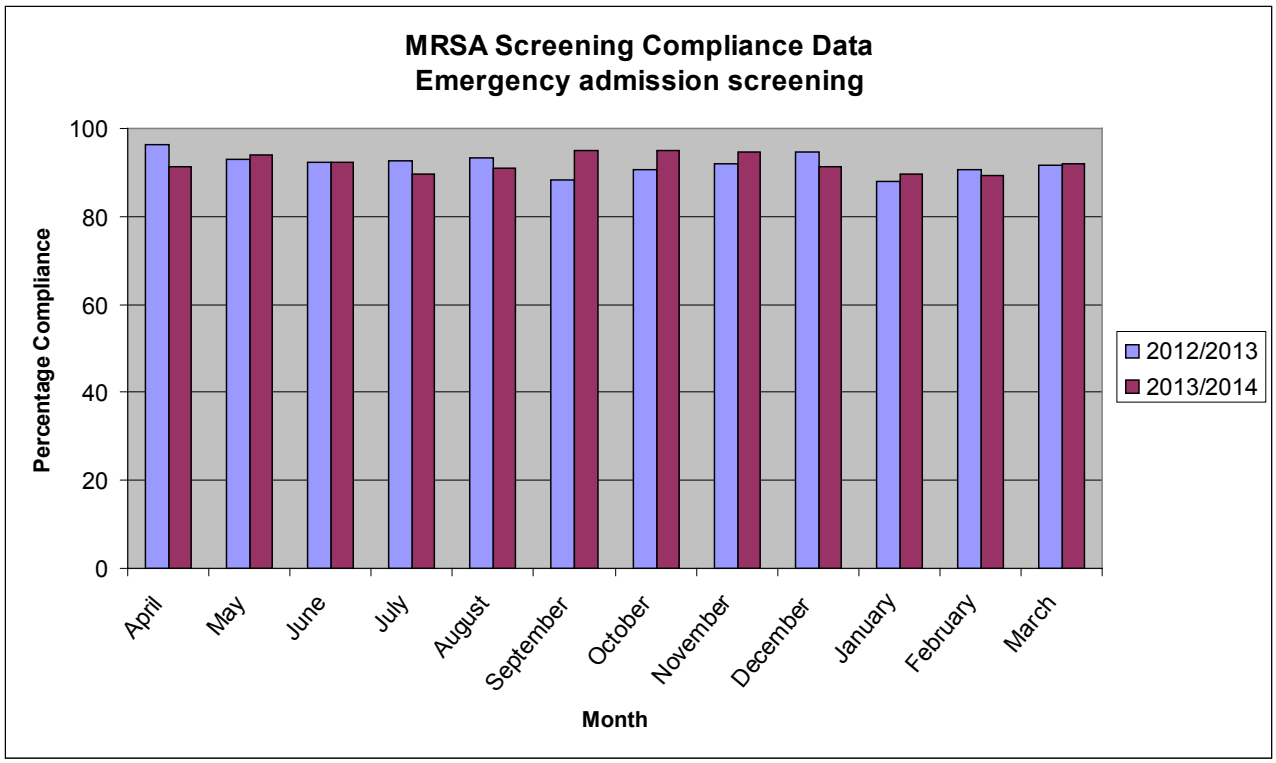
The Department of Health (DH) Mandatory MRSA Bacteraemia Surveillance scheme has been used to measure the effectiveness of infection prevention & control practices in all NHS Trusts. The rationale behind this scheme is that it is sometimes difficult to distinguish between colonisation and true infection 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 MMG.

Tables 1 and 2 relate to the overall compliance for both elective admission and emergency admission screening audit figures, for April 2013 to March 2014, and from April 2012 to March 2013 for comparison.



(Table 1)



(Table 2)

The Trust continues to report as per the requirements of PHE, with a weekly reporting format for mandatory surveillance onto the national HCAI Data Capture System. The Trust adheres to the classification of cases in accordance with the set definitions. This is applicable to MRSA bacteraemia cases and C .difficile cases, and i s 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 2013 – March 2014.
The figures in brackets show the number of cases recorded April 2012 – March 2013.

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

(Table 3)

*The MRSA bacteraemia cases identified from blood cultures during September and November 2013 were both classed as a contaminant.

The Trust's MRSA target for 2013/14 is zero Trust apportioned cases. A Post Infection Review (PIR) investigation process was performed for each of the cases identified during September and November 2013. 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 had been introduced nationally from 1st April 2013, and replaced the previous root cause analysis (RCA) tool used to investigate MRSA bacteraemia cases.

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.

Findings and key learning from the PIR investigations:

September 2013 – (Pitton Ward, Medical Directorate)

- The case was not linked with any other cases.
- In light of the patient's past medical condition and the failure to identify MRSA from the repeat blood cultures, this case was classed as a contaminant. This decision was made following discussions between the DIPC and ICD, and formally agreed with the CCG representatives.
- In addition to the PIR toolkit, a Trust action plan was generated and learning outcomes agreed by the relevant personnel/DMTs:
    - For a full MRSA screen to be completed for all emergency admissions to the Trust, and ensure that all required sites are included and documentation reflects the actions taken.
    - Ensure all staff aware of Trust policy regarding intravenous peripheral cannula and the requirement to record care including visual inspection phlebitis (VIP) scores.
    - Ensure all staff aware of Trust policy regarding the requirement to commence topical decolonisation therapy.
    - For full documentation within the patient healthcare records when blood cultures are taken, in accordance with the Trust policy.
    - Cross checking of infection control practices to include external auditing of hand hygiene behaviours.
- Completion of actions is being monitored by the directorate with reporting via the appropriate forums e.g. directorate specialty meetings and MMG.

November 2013 – (Radnor Ward, Surgical Directorate)

- The case was not linked with any other cases.
- The identification of MRSA from the blood culture was representative of colonisation of the line, and thus a contaminant. This decision was made following discussions between the DIPC and ICD, and formally agreed with the CCG representatives.
- In addition to the PIR toolkit, a Trust action plan was generated and learning outcomes agreed by the relevant personnel/DMTs:
    - For a full MRSA screen to be completed for all emergency admissions to the unit, at the earliest opportunity dependent upon their physical condition.
    - Ensure all staff aware of Trust policy regarding central and peripheral lines.
    - Ensure all staff aware of Trust policy regarding the requirement to commence topical decolonisation therapy.
    - For full documentation within the patient healthcare records when blood cultures are taken, in accordance with the Trust policy.
- Completion of actions is being monitored by the directorate with reporting via the appropriate forums e.g. directorate specialty meetings and MMG.
- As part of the PIR process, the review group discussed contamination rates, and investigative work was initiated by the Consultant Microbiologists.

Update regarding the MRSA bacteraemia case identified in quarter 3 of 2012/13 for the Neonatal Unit, Clinical Support & Family Services Directorate
During quarter 1 of 2013/14, a final follow up meeting was held with the relevant personnel. The clinical support & family services directorate was tasked to ensure that the remaining outstanding actions related to policy approval and implementation were completed, and reported through their management teams.

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.

It must be recognised that the infection control management of inpatients identified as C.difficile positive remains unchanged. This will include stool samples from those patients identified to be C.difficile positive but test toxin negative.

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 2013 – March 2014.
The figures in brackets show the number of reportable cases recorded April 2012 – March 2013.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**1 (3)**	**2 (3)**	**3 (1)**	**4 (8)**	**1 (3)**	**3 (3)**	**3 (4)**	**2 (4)**	**1 (2)**	**7 (4)**	**1 (3)**	**2 (1)**	**30 (39)**
Non Trust apportioned cases	0 (1)	0 (2)	0 (0)	2 (2)	1 (1)	2 (1)	1 (0)	0 (3)	1 (0)	1 (3)	0 (0)	1 (1)	9 (14)
Trust apportioned cases	1 (2)	2 (1)	3 (1)	2 (6)	0 (2)	1 (2)	2 (4)	2 (1)	0 (2)	6 (1)	1 (3)	1 (0)	21 (25)

(Table 4)

Breakdown of total number of reportable Trust C.difficile cases recorded April 2013 – March 2014. The figures in brackets show the number of reportable cases recorded April 2012 – March 2013.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**1 (3)**	**2 (3)**	**3 (1)**	**4 (8)**	**1 (3)**	**3 (3)**	**3 (4)**	**2 (4)**	**1 (2)**	**7 (4)**	**1 (3)**	**2 (1)**	**30 (39)**
Community Hospitals	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 (0)
General Practitioners (GPs)	2 (3)	0 (1)	1 (3)	1 (3)	1 (1)	1 (1)	1 (2)	0 (0)	0 (3)	1 (1)	1 (4)	1 (1)	10 (23)
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)	1 (0)	1 (0)	0 (0)	1 (0)	0 (0)	0 (0)	2 (0)	1 (0)	0 (0)	0 (0)	0 (0)	6 (0)
Total	**3 (6)**	**3 (4)**	**5 (4)**	**5 (11)**	**3 (4)**	**4 (4)**	**4 (6)**	**5 (4)**	**2 (5)**	**8 (5)**	**2 (7)**	**3 (2)**	**47 (62)**

(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 2013/14 was no more than 21 Trust apportioned reportable cases. For each inpatient episode, an infection control incident investigation is performed by the ICNs in conjunction with staff from the clinical area concerned, and input from the area Pharmacist. The findings are reported via e-mail and include an action plan for implementation within the relevant area. This includes patient education and the ongoing monitoring of infection control practices using the HII C.difficile audit tool, whilst the patient remain an inpatient. This audit tool aids the ward teams to ensure the safe management of these patients and provides evidence of compliance with the Trust policy. The audit criteria covers antibiotic stewardship, hand hygiene, environmental cleaning (includes equipment cleanliness), the wearing of PPE and isolation nursing.

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 day, time (length) and format of these rounds has been reviewed during quarter 4 (2013/14), with the involvement of the IPCWG members to ensure the optimum patient outcome is achieved with these reviews.

6.2.4 Methicillin Sensitive Staphylococcus aureus (MSSA)

The Trust continues to report MSSA bacteraemia cases via the HCAI Data Capture System. Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Commissioners are working with the Trust to develop a baseline for target setting.

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

MSSA Bacteraemias figures recorded for blood cultures from inpatients, and blood cultures taken in outpatient areas and the Emergency Department, from April 2013 – March 2014. The figures in brackets show the number of cases recorded from April 2012 – March 2013.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**1* (2)**	**1 (1)**	**3 (4)**	**5 (1)**	**3 (1)**	**6* (0)**	**1 (1)**	**4* (2)**	**4 (1)**	**4 (2)**	**1* (3**)**	**3 (3)**	**36 (21)**
Non Trust apportioned cases	1 (2)	1 (1)	2 (2)	3 (1)	1 (1)	4 (0)	0 (1)	3 (0)	3 (1)	2 (2)	1 (2)	2 (2)	23 (15)
Trust apportioned cases	0 (0)	0 (0)	1 (2)	2 (0)	2 (0)	2 (0)	1 (0)	1 (2)	1 (0)	2 (0)	0 (1)	1 (1)	13 (6)

(Table 6)

*During April and September 2013, additional MSSA bacteraemia cases were identified from blood cultures taken from attendees at the Salisbury Dialysis Unit.
*During November 2013, an additional MSSA bacteraemia case was identified from blood cultures taken from a patient attending the Emergency Department only, and not admitted to the Trust.
*During February 2014, an additional MSSA bacteraemia case was identified from blood cultures taken from a patient attending as outpatient only, and not admitted to the Trust.
(**During February 2013, an additional MSSA bacteraemia case was identified from blood cultures taken from an attendee at the Salisbury Dialysis Unit).

During 2013/14, there were 13 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. Support of best practice is being achieved with the introduction of the vascular access device line care bundles.

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 7 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. Five patients presented with complex clinical histories or chronic skin conditions, and there was documented evidence of difficult venous access for 2 of the patients. Overall there was documented evidence relating to the insertion of devices, however practice concerns were identified relating to inconsistent ongoing care documentation.

As a result of these findings, the CVC ongoing care bundle has been reintroduced. An implementation plan has been devised and agreed by the General Ward Workstream Group and involves education and audit work with the clinical directorates. During quarter 2 (2013/14), the PVC insertion stickers were revised again by the ICNs to ensure all aspects of the care bundle are fully completed and recorded. The revised insertion sticker was supplied initially in the Emergency Department and Whiteparish AMU, and then rolled out to all areas during quarter 3. Compliance with each aspect of the PVC insertion bundle continues to be assessed and the requirement for further work with the wider involvement of Trust staff is planned.

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 2013 – March 2014. The figures in brackets show the total number of cases recorded from April 2012 – March 2013.

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**2 (7)**	**9 (11**)**	**4 (11)**	**7 (6)**	**3 (5)**	**4 (8)**	**4 (8)**	**7* (10)**	**5 (3)**	**9 (2)**	**4 (4)**	**6 (10)**	**64 (85)**
Non Trust apportioned cases	2 (2)	8 (10)	4 (8)	5 (3)	2 (4)	3 (5)	3 (7)	7 (9)	3 (2)	9 (2)	3 (3)	5 (6)	54 (61)
Trust apportioned cases	0 (5)	1 (1)	0 (3)	2 (3)	1 (1)	1 (3)	1 (1)	0 (1)	2 (1)	0 (0)	1 (1)	1 (4)	10 (24)

(Table 7)

*During November 2013, an additional E.coli bacteraemia case was identified from blood cultures taken from a patient attending the Emergency Department only, and not admitted to the Trust.
(**During May 2012, an additional E.coli bacteraemia case was identified from blood cultures taken in the mortuary. This sample was taken from a person who had died in the community, and was 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 10 Trust apportioned inpatient cases identified during 2013/14, 5 were determined as likely HCAI related, 3 cases as possibly HCAI related, for 1 case it was unknown if it was HCAI related, and the final case was determined as not HCAI related. The classification of whether the bacteraemias are HCAI related is completed by the Microbiologist, based on the information obtained from the relevant clinicians. This data is entered onto the HCAI Data Capture site by the ICNs.

6.2.6 Carbapenemase producing enterobacteriaceae

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 are currently reviewing this toolkit, and a 'task and finish' group will be implemented to ensure this work is completed.

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%. This target is reflected in the clinical leaders and Directorate Senior Nurses (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 remains 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.

For 2013/14, the overall mean Trust compliance was 90.35%, compared to the overall mean compliance of 96.33% reported for 2012/13 (These figures are taken from the directorate mean running compliance percentages).

Appendix 4 shows a breakdown of the clinical directorates hand hygiene monthly compliance scores. On further analysis of the data over quarters 1 and 2 (2013/14), several factors were identified as having influenced the compliance scores:

- Delegation by the area leads of the audit process to an inexperienced staff member
- Capability of staff to undertake the audit
- Non returning of completed audit forms by the deadline
- Exclusion of certain groups from the audit process.

The Trust hand hygiene audit tool was reviewed during quarters 1 and 2 (2013/14). As part of this work, the ICNs facilitated the completion of hand hygiene audits across selected clinical areas by an external auditor, the Healthcare Manager for GOJO Industries. The external auditor utilised the World Health Organisation (WHO) hand hygiene audit tool, and assessed the hand hygiene practices of all staff groups against the '5 moments for hand hygiene'. The outcome of the external audits at a range of 56% to 74% compliance were presented and discussed at the MMG and ICLP forums. The identified non compliance was predominantly missed opportunity number 5, which related to contact with patient surroundings. This was addressed during the trial process with additional education and support provided for staff groups.

The WHO hand hygiene audit tool was initially trialled by selected Clinical Leaders across different clinical areas. The resulting feedback was used to generate an audit tool which captured all of the required information and audited against the '5 moments for hand hygiene', but was more 'user friendly'. The revision process was discussed monthly at the MMG and ICLP meetings and additional education sessions for hand hygiene audit training using the revised audit tool were held during August 2013. The revised hand hygiene audit tool was implemented across the Trust from 1st September 2013.

Further external audits were completed during quarters 3 and 4 (2013/14), with an overall compliance of 62%, and this involvement of the external auditor will continue. It is acknowledged that the audit process enables the practices of a broader range of personnel to be observed, and that the revised audit tool captures all of the '5 moments for hand hygiene'. This is in contrast to the previous audit tool which audited only 2 of the '5 moments for hand hygiene'. These factors may therefore affect the overall compliance scores achieved, and has allowed for targeted

education with specific staff groups. As a result of lower compliance and user feedback, the placement of alcohol hand rub gel at the patients' bedsides has been trialled on both surgical wards during quarter 4. Compliance with hand decontamination has improved. This work will be extended across the inpatient clinical areas, and will complement the existing wall mounted alcohol hand rub gel dispensers sited at the point of care.

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 2013/14, 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. An OH Advisor has also attended the sessions when available, to undertake visual skin checks and provide advice regarding skin care practices. The total number of hand hygiene assessments completed during 2013/14 is 2769 assessments, compared to 1962 for 2012/13 (Appendix 5).

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). Additional signage was utilised to promote 'essential visiting' when areas were affected with patients experiencing symptoms of influenza and diarrhoea and vomiting. The dissemination of the '5 moments for hand hygiene at the point of care' initiative remains a key focus for education. Following patient and relative feedback, the display of infection control information for visitors and the public alcohol hand rub gel stations has been reviewed with the involvement of the Trust ArtCare Department. The potential use of 'pop up' banners for information displays were considered. A new display cabinet/notice board has been installed along the main Level 4 corridor, and the refurbishment of the alcohol hand rub gel stations sited outside the inpatient and outpatient clinical areas by the ArtCare Department has commenced and will continue into quarter 1 (2014/15).

During quarter 1 of 2013/14, an improved skin cleansing product with associated wall mounted dispensers were successfully installed as planned Trust wide. This was the culmination of work first commenced during quarter 4 of 2011/12 to standardise hand wash stations and ensure the continued safe provision of approved products.

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.

During 2013/14, the IP&CT have undertaken Trust wide audits against the following key infection control policies, with the following outcomes:

- Isolation policy
    - The reaudit report for 2012/13 was presented to the IPCC in July 2013. Compliance for use of the Isolation Risk Assessment Tool (IRAT) was identified at 61.41%, where 147 patients fulfilled the criteria for a IRAT to be completed, and a IRAT was present for 78 of the patients. However all patients were being isolated appropriately and no patients were found to be in isolation unnecessarily. Actions across all clinical areas were identified within the report.
    - At the IPCC in July 2013, the DIPC requested the ICNs to complete a further mini-reaudit of identified areas, with results fedback at the next IPCWG and MMG. Compliance was 47.6%, where 42 patients fulfilled the criteria for a IRAT to be completed, and a IRAT was present for 20 of the patients. Again all patients were being isolated appropriately and no patients were found to be in isolation unnecessarily. The directorates were tasked with improving compliance.

    - Further Trust wide reaudit was completed during quarters 2 and 3 (2013/14), and data collection was also undertaken at the same time for the MRSA Pathway reaudit. Compliance for use of the IRAT was identified at 80.81%, where 99 patients fulfilled the criteria for a IRAT to be completed, and a IRAT was present for 80 of the patients. All patients were being isolated appropriately and no patients were found to be in isolation unnecessarily. This was a significant improvement, and demonstrated the highest compliance rate achieved since the tool was first introduced in 2009. The combined reaudit report for the Isolation policy and MRSA Pathway has been presented to the IPCWG and IPCC members.
- BBE policy and Uniform and Workwear guidance – reaudit completed.
    - Reaudit was undertaken by the ICNs across the clinical inpatient and outpatient areas, and resulted in the auditing of 287 staff members wearing the scrub style (smart suit) uniform as part of their role.
    - Achieved 100% compliance for staff in a scrub style (smart suit) uniform with no sleeve or garment being worn below the elbow.
    - Achieved 99.65% compliance for staff in a scrub style (smart suit) uniform with no wristwatch or wrist jewellery being worn (1 staff member out of 287 was non compliant).
    - This reaudit provides a baseline for future comparison prior to the introduction of the new style of uniform for key staff groups from March 2014. The report has been presented to the IPCWG and IPCC members.
- Use of 2% Chlorhexidine Gluconate in 70% alcohol – reaudit completed.
    - Reaudit of the use of these wipes was undertaken across the clinical inpatient and outpatient areas.
    - Reaudit confirmed that this product is consistently used for skin preparation, prior to insertion of a peripheral vascular device and prior to the taking of blood cultures, in the areas where these aspects of care are undertaken.
    - A report was completed during quarter 2 and was presented to the IPCWG, followed by distribution to the IPCC members.
- Revised MRSA Monitoring, Prescription and Treatment Pathway (MRSA Pathway)
    - The reaudit report for 2012/13 was presented to the IPCC in July 2013. Compliance for use of a MRSA Pathway was identified at 84.61%, with a MRSA Pathway being commenced for 22 of the 26 patients fulfilling the audit criteria. Actions across all clinical areas were identified within the report.
    - At the IPCC in July 2013, the DIPC requested the ICNs to complete a further mini-reaudit of identified areas, with results fedback at the next IPCWG and MMG. The small sample size of 4 patients was acknowledged, however compliance was for use of the MRSA Pathway was 100%.
    - Further Trust wide reaudit was completed during quarters 2 and 3 (2013/14), and data collection was also undertaken at the same time for the Isolation policy reaudit. Compliance for use of a MRSA Pathway was identified at 100%, with a MRSA Pathway commenced for all of the 29 patients fulfilling the audit criteria. In relation to topical decolonisation treatment which was appropriate for 28 of the patients audited, an unacceptable delay in the commencement of topical decolonisation treatment was identified for 4 patients. This included the 2 patients identified as MRSA positive in blood (unrelated cases), and was addressed at the time and escalated through the formal PIR process. The combined reaudit report for the Isolation policy and MRSA Pathway has been presented to the IPCWG and IPCC members.
- Commode Cleanliness – update on completed reaudit.
    - Commode cleanliness audits continue to be facilitated by the DSNs with results fedback via the Infection Control Update meetings and reported formally within the monthly directorate reports to the MMG until end of quarter 3. The format of both forums have been reviewed with alternative reporting structures identified. The directorates are now reporting findings and outcomes via their existing forums/meetings.
- Handling and Disposal of Linen in the Clinical Areas

- The report for the reaudit completed during 2012/13 was presented to the IPCC in July 2013. The reaudit included the inpatient areas and all outpatient areas where patient linen was in use, and identified similar themes compared to the findings from the initial audit, including the clean linen store being clean and free from dust; the clean linen store being free from inappropriate items; used linen placed in linen bags less than two thirds full; linen skips with the appropriate linen bags being taken to the bedside/bay. An additional finding was that staff did not always wear disposable plastic aprons when handling clean linen and did not always undertake hand decontamination after the removal of PPE. Actions across all clinical areas were identified within the formal audit report.
- Further reaudit was commenced during quarter 4 of 2013/14, with the report planned for completion at the beginning of quarter 1 (2014/15) with presentation to the IPCWG, and the IPCC.

The monthly audit programme for the safe use of mattresses continues and is led by the Medical Devices Management Centre (MDMC), with six monthly reporting to the MMG.

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

8.1 Innovations

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

The Trust successfully trialled a room decontamination system during quarter 4 of 2012/13, and a business plan was generated and presented to the Executive Board of Directors at the beginning of quarter 1 (2013/14). Following the completion of further discussion and comparisons between alternative decontamination systems, funding was agreed. Two machines were purchased and the company representative provided training for the relevant personnel at the beginning of quarter 3 (2013/14). The Housekeeping Department are continuing to leading on the use of GLOSAIR 400 room decontamination system within the clinical areas and reporting via the IPCWG and Decontamination Committee by the Facilities Matron.

The potential for utilising the virtual nurse concept, previously presented to the Executive Board of Directors during quarter 4 (2012/13) remains ongoing work by the Decontamination Lead. The IPCWG continue to strive to ensure that the Trust implements only those technologies and innovations that have been peer reviewed and appropriately approved.

9. Antibiotic Prescribing *(information for this section has been provided by Simon Howe, interim Lead Antimicrobial Pharmacist)*

Overview

The ARG is a sub group of the Drugs and Therapeutics Committee (DTC) which meets monthly and provides a focus for all work linked with antibiotics, advising and promoting good practice and optimal antibiotic prescribing across the Trust. The work of the ARG is aimed at delivering the DH agenda to minimise the development of antimicrobial resistance and to reduce HCAIs as set out in the 'Winning Ways' document. Continued support for this work is documented in the 2007 Saving Lives Document: Antimicrobial Prescribing: A Summary of best practice, and the 2012 'Start Smart then Focus' publication. Membership of the ARG has been expanded (in 2012) to include a Consultant Surgeon, and nursing representation from the Nurse Consultant in Critical Care. This membership review has enabled the formation of new ideas to improve awareness of antibiotic stewardship challenges across the Trust.

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

Key work areas 2013/14 include:

9.1 Guideline development/review

The following guidance has recently been reviewed:

- Adult respiratory guidelines
- Antibiotic quick reference guidance
- Clostridium difficile algorithm
- Fosfomycin policy – access and prescribing
- General adult surgical guidelines.

The ARG continues to provide input into the design of the new prescription chart which now has a specific page for the prescribing of antimicrobials, with prompts to document indication, stop dates, and to review after 48 hours (part of the start smart then focus campaign). The design of the antimicrobial chart section aims to promote efficient prescribing practice, encouraging timely review and the documentation of indication and course length. Further revisions to the design of the antimicrobial chart section have recently been suggested, in particular the removal of pre-set times for administration.

Work is underway on the following:

- Update of the Burns and Plastics antimicrobial guidelines
- Paediatric antibiotic policy
- Orthopaedic guidance
- Endocarditis adult treatment .

9.2 Audit

Regular Antimicrobial Stewardship Audits

The rolling programme of antibiotic stewardship audit, commenced in 2009, continues and has been rolled out until March 2015. The aim is to audit one ward every fortnight, to provide a snapshot of antimicrobial prescribing practice within the Trust.

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

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

Audits are carried out by the Lead Antimicrobial Pharmacist and Consultant Microbiologist/ICD, and therefore this allows for a multidisciplinary review of antimicrobial prescribing to be carried out, with interventions made as necessary. The information is entered onto a spreadsheet designed by one of the Consultant Microbiologists, and yields a percentage performance score for the ward in question. Feedback has previously been provided by the ward pharmacists. It is hoped in the future the auditing pharmacist can provide feedback to the ward leader as soon as the data has been entered into the spreadsheet. The Consultant Microbiologists also aim to feedback to the medical/surgical clinicians at the time of the audit and through pharmacy department.

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

If results show that an area is not meeting the expected standard of antimicrobial stewardship, i.e. scores less than 80%, an action plan is formulated which 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 quarters 1 and 2 (2013/14), all scheduled antibiotic audits were completed, and none of the wards scored less than 80%. This compares favourably with the previous year, where results for 6 wards fell below the 80% threshold. In the last 6 months (quarter 3 and 4 2013/2014), all scheduled antibiotic audits have been completed, though two of the wards have scored less than 80%. This compares favourably with the previous year, where results for 6 wards fell below the 80% threshold.

Point prevalence audit
The regional Annual Antibiotic Point Prevalence Audit was conducted in February 2014, This data provides a snapshot of antibiotic usage and prescribing practices within the Trust, and allows for a comparison with other Trusts in the southwest region and past results.

The results published in April 2014 will capture the improvements attained following the action taken following last years point prevalence audit. The introduction of the new chart has led to the indication being documented in 97.9% of prescriptions. Course length/review date however had not improved 69.2% (versus 71.9% previous year). The chart has since been modified in this regard.

One particular criteria that had significantly fallen was 'did the prescription fall within Trust guidelines'. Therefore results were analysed further, and from the data provided it was identified that 9 of the 22 prescriptions that fell outside of this criteria were from the Spinal Unit. The Spinal Unit is a tertiary unit that continues therapy commenced in other hospitals whose Trust guidelines and Consultant Microbiologist involvement have steered current long term antibiotic treatment regimes. We therefore acknowledge that a clinical decision has been taken to continue this treatment, however there is a need for clear documentation that this is the case. It is expected that in future point prevalence audits, these prescriptions will now fall within the standard.

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

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

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

9.3 Additional information

C.difficile
Inclusion of Fidaxomicin within Trust treatment guidelines: In line with the PHE document 'Updated guidance on the management and treatment of C.difficile infection', the Trust algorithm has been amended to include Fidaxomicin. The use of this treatment is under the direction of a Consultant Microbiologist.

Antibiotic Treatment Review Sheet: The documentation used has been updated to improve the information collected and the time taken. The 'pharmacist comment' has been replaced by a medicines management section covering four specific areas: past antibiotics, Proton Pump Inhibitor (PPI)/H2 antagonist, antimotility medicine, and antibiotic allergy. It is hoped that this will efficiently collect the information both in time taken by the ward pharmacist and the IP&CT to

analyse. The antibiotic therapy received by the patient is reviewed by a pharmacist and links with community teams as necessary. A designated Senior Pharmacist attends the multidisciplinary ward rounds on a weekly basis. This is undertaken by a Consultant Microbiologist/ICD together with an ICN. This provides an opportunity to review the treatment and management of inpatient C.difficile cases, and also use the forum to discuss any concerns. In addition, the group will liaise with the appropriate clinician/nursing staff for the patient if required, and an entry is made within the healthcare records.

An additional workstream undertaken in early 2013 has been the analysis of the relationship between PPI prescribing and the incidence of C.difficile. This has involved close working with the General Practitioners and community teams in an attempt to raise the profile of the increased risk of C.difficile for patients on long term PPIs.

9.4 Consultant Microbiologist ward round

Commenced in August 2013, this ward round has been implemented with a Senior Pharmacist and a Consultant Microbiologist leading the initiative to review those prescriptions that fall outside certain parameters including age of patient, fall outside of guidance, antibiotic used and course length. This has been found to be a very useful initiative but is reliant on the Consultant Microbiologist and recent attendance has been sporadic. It is anticipated that microbiologist cover may be fully available for this service. It is hoped that other team members will also participate to maintain a weekly ward round.

9.5 Future planning

Planned work for 2014/15 includes:

- Medicine safety poster with specific focus on antibiotic issues
- Missed/delayed dose audit with regard to antibiotics used (potential focus on first dose- integrate with Sepsis 6 initiative). It is hoped to introduce this as an integral part of the Antibiotic Stewardship Schedule and roll out across the year
- Audit of intravenous to oral antibiotic switching for patients with community acquired pneumonia.

10. Education and Training Activities

It is widely recognised that ongoing education activity in infection control is required in order to improve health care worker compliance with infection prevention and control practices. The ICNs undertake a number of induction and educational updates to a wide range of key staff within the Trust. The ICNs keep attendance data from these sessions and supports the Trust in its delivery of mandatory education for all staff. Appendix 7 identifies the figures for the IP&C Computer Based Learning (CBL) modules completed via the intranet site for 2013/14.

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

- Education Department (new starters, medical students and foundation course nursing assistants)
- Spinal Unit
- Volunteer Co-ordinators
- Redlynch Ward (staff development day)
- Hospice (clinical governance session)
- Chaplaincy Team
- Surgical directorate business meetings (to discuss the management of VRE and reinforce the ‘5 moments for hand hygiene’ and correct hand hygiene practices).

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, reinforcing hand hygiene practices with specific teams, and facilitating training for undertaking hand hygiene audits and using the revised hand hygiene audit tool.

Drop-in workshop style sessions have 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 diarrhoea symptoms. The format of the sessions was revised for quarter 4, with each one concentrating on a specific infection control aspect of patient management and care.

Opportunities continue to be provided for staff to shadow the ICNs, by both new starters to the Trust and established staff members. This aids improved understanding of infection control within an individual clinical area, in addition to 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.

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

This section summarises the water safety management precautions that the Trust has taken. 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).

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.

The Trust formed the Water Safety Group (WSG) during 2013 in response to the ongoing challenges facing the hospital water system. The WSG has continued to be active into 2014, being formed of technical and non-technical staff who can recommend, change and enforce issues relating to water safety across the Trust. The WSG includes representatives from all of the high risk areas identified in the policy.

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

Legionella Monitoring

The annual sampling was carried out between 17th July and 13th September 2013. 224 points which had been previously identified as “sentinel outlets” were sampled, of these 19 returned a positive count greater than 20 cfu/litre. Four of the positive outlets were removed as little used or unwanted points and the remainder have been cleaned, flushed and resampled as required by the policy. The results were reviewed for any specific pattern but non was found. All returned results of less than 20 cfu/litre and are now clear. The points are shown in the table below.

Description	Room No	Asset	Outcome
Spinal X-ray Blk 05	Belfast sink	Sink Hot tap	Removed
Blk 79 Belfast sink	WHB Far	Hot tap	Removed
Nunton Kitchen (Staff)	2.1.30	Mixed WHB	Cleared
Farley staff Kitchen	2.2.24	Sink Hot tap	Cleared
SDU air lock	2.3.07a	WHB Mixed left	Cleared
SDU air lock	2.3.07a	WHB Mixed right	Cleared
Microbiology	4.15.16	WHB mixed	Cleared
Path Lab staff WC	3.16.29	WHB mixed	Cleared
Cath Lab Scrub Trough	4.0.10	WHB mixed	Cleared
Outpatients treatment rm (eye clinic)	3.4.26	WHB mixed	Cleared
Nunton WC	2.1.29	WHB mixed	Cleared
Farley Re-hab Kitchen	2.2.28	Cold tap	Cleared
Nunton ladies changing	2.1.12	WHB mixed	Cleared
Mortuary Boiler Hs	Plant room	Plate heater	Cleared
Day Surgery left mixed	Theatre F	Sensor mixed	Removed
Farley sideroom	2.2.25	WHB Hot tap	Cleared
Med Outpatients far end	3.3.43	WHB mixed	Cleared
Day surgery Th F see GJ 220	Trough	Right Mixed	Removed
Cath lab 1	4.0.10	WHB hot tap	Cleared

Follow up tests and actions continued into quarters 3 and 4 (2013/14), and six outlets returned a positive count greater than 20 cfu/litre in Medical Surgical Outpatients and Radiology Department staff room in December 2013. A review of the system in outpatients resulted in the removal of unused taps and the replacement of the old style “swan neck” taps. The system was cleaned, flushed and re-sampled as required by the policy. The results were reviewed for any specific pattern but none was found. All returned results of less than 20 cfu/litre on the 6th February and are now clear having had 4 clear follow up results. The points are shown in the table below.

Description	Room No	Asset	Outcome
Med out patients sluice	3.3.37	Hot tap	Cleared
Med out patients	3.3.37	sink hot tap	Cleared
Med out patients	3.3.37	sink cold tap	Cleared
Med out patients	3.3.34	WHB hot tap	Cleared
Med out patients	3.3.22	WHB cold tap	Cleared
Med out patients	2.3.07a	WHB Mixed right	Cleared
Radiology staff room	3.2.15	Hot tap	Cleared

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 employed dedicated staff to carry out and record routine flushing of all outlets in the clinical and patient areas of the hospital. The office and support areas are required to self manage the flushing regime and report to ETS. Flushing of the systems is recorded centrally by ETS staff.

Several emergency review meetings have taken place in the Trust as a result of the sample results. The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of emails as events occur, and as regular reports to the IPCC.

Pseudomonas

On 31st March 2014, guidance was issued by DH giving advice on the monitoring and control of Pseudomonas in water systems in augmented care units (high risk areas).

The Trust has carried out two sample sets in the last 12 months. The first between 24th October 2012 and 28th February 2013. 171 points were sampled and 13 were reported as positive. All were reviewed with the department leads, infection control and the cleaning staff. The outlets were cleaned, replaced as required and retested. All points gave clear results following the remedial action. A summary of the points is given in the table below.

Reference	Location	Room	Outlet
GJ20	NICU	77.2 staff kitchen	sink
GJ24	NICU	77.21 staff toilet	whb
GJ25	NICU	77.18 dirty utility	sink
GJ30	NICU	77.4 milk kitchen	whb
GJ36	NICU	77.8 special care 1	whb
GJ37	NICU	77.14 special care 2	whb
GJ36	Radnor ward	4.2.17 sideroom	whb
GJ37	Radnor ward	4.2.20 main ward	whb3
GJ38	Radnor ward	4.2.20 main ward	whb4
MC26	Pembroke suite	2.10.35	shower
MC27	Pembroke suite	2.10.33	whb
GJ106	Pembroke ward	sideroom 6 2.10.13	whb hot
GJ34	Burns unit	4.11.54	

The second set of samples was carried out between 2nd September and the 30th October 2013. 146 points were sampled following a review of the previous set these focused on the clinical areas in the high risk departments. 15 results showed a positive count of which 13 have been reviewed and cleared. Two of the results remained under review, in the Burns unit rooms 4.11.26 & 4.11.29 neither point was positive during the previous test cycle. A summary table of the results is given below.

Description	Sample ref	Room No	Asset
Radnor ward	GJ 509	4.2.20	WHB 5 cold
Radnor ward	GJ 510	4.2.16	WHB 6 cold
NICU shower rm	GJ 533	77.17	Shower
NICU WC	GJ 534	77.21	WHB cold tap
Sarum Rm 3 en-suite	GJ 541	4.6.08	WHB mixed
Sarum Rm 4 en-suite	GJ 544	4.4.09	Shower
Sarum room 9 ensuite	GJ 576	4.5.03	Shower
Sarum	GJ 586	4.6.40	Shower
Sarum Parents shower room	GJ 593	4.5.11	WHB mixed
Britford Acute male	GJ 608	4.13.48	WHB hot
Britford Acute male	GJ 609	4.13.48	WHB cold
Britford Acute Sluice	GJ 613	4.13.49	Cold tap
Britford Acute bay 5	GJ 620	4.13.02	Shower
Burns Bay A ensuite	GJ 630	4.11.26	WHB
Burns rm 3 en suite	GJ 637	4.11.29	Shower

The Trust commenced with the routine sampling of outlets in November 2013. 220 points were sampled and 5 outlets were identified as positive. All were reviewed with the department leads, infection control and the cleaning staff. The outlets were cleaned, replaced as required and retested. All points gave clear results following the remedial action. A summary of the points is given in the table below.

Description	Sample ref	Room No	Asset
Sarum Room 3 en-suite	GJ 541	4.6.08	WHB mixed
Britford Acute Sluice	GJ 613	4.13.49	Cold tap

Britford Acute bay 5	GJ 620	4.13.02	Shower
Pembroke treatment room	GJ 713	2.10.97	Sink Hot tap
Pembroke treatment room	GJ 714	2.10.97	Sink Cold tap

Events

- The main distribution system in the central part of the hospital and the plate heat exchangers have been replaced. This work involved the disconnection of a large amount of the 70 year old pipes from the system.
- The schematic system drawings have been updated together with a reassessment of any affected sentinel outlets.

Independent advice

Rentokil Specialist Hygiene have been retained as the Trust independent advisor and a revised water risk assessment has been provided together with a list of action points and recommended remedial work which will be prioritised against the allocated capital budget.

12. Decontamination *(information for this section has been provided by Peter Wells, Decontamination Lead)*

The Trust Decontamination Committee has met regularly throughout the year and the Chair of the Group continues to give formal feedback to the IPCC. The Chairperson also attends and briefs the IPCWG, the MMG, the Theatre Risk Group and the Endoscopy Clinical Group.

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 for outstanding areas of non compliance. The Single Use Risk Assessment has recently been reviewed and the level of risk reduced. The Chairperson also attends the monthly Theatre Risk Group. Progress against these objectives is as follows:

12.1 Ensure fully compliant decontamination practice Trust-wide

The Trust Decontamination Lead continues to pursue, with representatives from MDMC, Procurement Department, Main Theatres and Day Surgery Unit (DSU), other single use alternatives which could be standardised and more economical. Single use Items have been discussed at the MMG, Theatre Team Leader Meetings and the Theatre Risk Group.

Tray tracking via the Sentinel System has been delayed due to information technology (IT) issues. The virtualisation of the server is now delayed until the Sterilisation and Disinfection Unit (SDU) has its system upgraded which is planned for Summer 2014. An alternative handheld has been identified and the previous MC35's returned to the company and the latest replacement is awaiting arrival, free of charge, in the Trust for trial. The company has again apologised for the delays with upgrades, and is also providing a free endoscope tracking system.

The Bedpan Washer and Dirty Utility Room upgrade project for inpatient areas is complete, and a pulp macerator was installed in Block 79 as a temporary measure. The Spinal Unit dirty utility refurbishments have been finished with new bedpan washers installed and the dirty utility rooms refitted, including a change in the layout to promote best practice. Monitoring with compliance with the use of dishwashers across the Trust is fedback at the MMG via the catering department. The Facilities Manager will be leading on examining disinfection temperatures and cycle times with ETS.

The Decontamination Lead and the Infection Control Senior Nurse continue to work with the MDMC regarding the reprocessing of pressure relieving mattresses and equipment. The cleaning of mattresses by MDMC continues to go well. MDMC have had concerns regarding the cleaning method on wards, products being used and issues with the cleaning and checking of "static" and pressure relieving mattresses by ward areas. The correct decontamination of mattresses, and use

of decontamination certificates when returning pressure relieving mattresses to the MDMC, has been reinforced at the MMG meetings. Cleaning solutions and how they should be used to clean static and pressure mattresses are still being discussed in relation to relevant DH guidance, and MDMC is providing regular feedback to MMG on mattress audits.

The IP&CT and the Decontamination Committee contains to work with the clinical areas and departments on how medical devices can be labelled or identified as clean and safe to use, including between patients. It has been again confirmed through the MMG and the Decontamination Committee, that the Cleaning Schedules (for clinical areas/departments) will be adjusted to include various pieces of medical equipment. These will then be checked on a daily basis by the nurse in charge. The Medical Device Decontamination Policy is being updated to accommodate these.

12.2 Ensure all endoscope decontamination takes place in fully compliant washers according to best practice/national guidance

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 2013 and early 2014 there have been issues of delays in processing flexi scopes due to additional demand, automatic endoscope reprocessing (AER) failures, SDU staffing levels and lifts not working.

12.3 Continue to maintain a fully compliant SDU

The SDU continues to maintain its compliance and accreditation to the latest European Standards in Sterile Services. The review and audit of the SDU quality system, by the external auditor (notified body) was undertaken successfully in August 2013 and February 2014. A low number of non conformities were found and an action plan devised to resolve these within the correct timescale. The Trust is funding two new washer disinfectors to meet SDU work expansion and processing needs. The new air handling unit for the clean room, which is now installed, has had to have various repairs but is now fully operational and maintaining a high level of air quality.

12.4 Marketing the SDU services to increase the external customer base

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

- The SDU continues with the Ministry of Defence (MOD) Army, Royal Marines and Navy contracts until May 2015.
- The Wiltshire Community Health Services contract for its South Wiltshire Podiatry Tray Service continues to progress but is under review.
- The SDU continues to expand its decontamination contract with an external independent healthcare provider BMI. This contract is progressing well with good feedback from their Theatres and users. The next BMI hospital is expected to come on line in September 2014.

12.5 Additional work of the Decontamination Committee

The sections listed below detail standard agenda items:

- **Decontamination equipment within the Trust** – This is to continue to examine and raise 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. The Laundry decontamination processes are now being reclarified with the new contract arrangements of the laundry, regarding Choice Framework for local Policy and Procedures (CFPP) 01-04 DH guidance on the Decontamination of Linen. These have been added to the Decontamination Committee reporting structures.
- **All data and test results from decontamination equipment used within the Trust** – Including test results and planned preventative maintenance (PPM) schedules for Trust decontamination are discussed and minuted within the meetings.
- **Identifying medical devices that have been decontaminated within the Trust** – Reviewing how existing and new medical devices can be labelled or identified as clean and safe to use. The IP&CT and the Decontamination Committee continues to work with the

clinical areas on the use of labels and indicator tape to identify that equipment and/or medical devices has been cleaned between patient use, and this has also been discussed at the MMG meetings.

- **Reviewing national directives/documentation** – Making recommendations on CFPP 01-01 Management and Decontamination of Surgical Instruments used in acute care, and CFPP 01-06 Reprocessing of Flexible Endoscopes: management and decontamination. Guidance at national level is being read and interpreted.

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

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

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

PLACE

The new national PLACE programme was piloted in 2012/13, with the key purpose of ensuring patients were at the centre of all inspections of hospital environments. In September 2012, the Trust was one of 68 acute hospital Trusts who participated in the PLACE process pilots.

The National PLACE programme was launched in January 2013, with a series of training events. These were designed to help prepare Trusts and Patient Assessors for the more in depth and robust, self-assessed PLACE programme, launched in April 2013.

The PLACE Assessments have at least a 50% patient and public membership. The PLACE assessment is wide ranging (more so than its predecessor Patient Environment Action Team) and covers cleanliness, food, privacy and dignity, wellbeing and condition, appearance and maintenance. The PLACE Assessment teams were required to score wards and internal and external areas against 150 standards.

The PLACE assessment was conducted here on the 25th April 2013, and the National results were published on the 18th September 2013, by the Health and Social Care Information Centre. For cleanliness of wards which included bathrooms, furniture, fixtures and fittings, the results were:

- National Average score was 96%
- 90% of hospital sites scored more than 80% (144 sites scored 100%)
- Our score for cleanliness was 87.30%.

An action plan was developed based on the key themes emerging from the PLACE assessment. The detailed results and action plan was taken to the Trust Board and Board of Governors. The action plan is included within Appendix 9, and has been updated to reflect progress made during quarters 3 & 4 (2013/14).

Patient Environment Action Team (PEAT) and PLACE

Between April and September 2013, 16 in-house PEAT/PLACE audits have been undertaken. These continue to receive good support from Governors and Volunteers.

Date	Areas Visited
April 2013	Avon Ward, Tamar Ward
May 2013	Whiteparish AMU, Downton Ward, Chilmark Suite, Radnor Ward
June 2013	Pembroke Ward, Pembroke Suite
July 2013	Laverstock Ward, Redlynch Ward, Tisbury Ward
August 2013	Farley Ward, Sarum Ward

September 2013	Spinal Therapy, Winterslow Suite, Britford Ward

Between October 2013 and March 2014, 4 in-house PEAT and 4 in-house PLACE audits have been undertaken. These continue to receive good support from Governors and volunteers and our local Healthwatch representatives. An action plan is produced and progress reported and monitored through the monthly MMG meeting. 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 bid and decorating programmes.

Date	Areas Visited
16th October 2013	Coronary Care, Emergency Dept, Short Stay (PEAT)
5th November 2013	Day Surgery Unit (PEAT)
20th November 2013	Tamar Ward, Post Natal (PEAT)
10th December 2013	Chilmark Suite, Amesbury Suite (PEAT)
4th February 2014	Sarum Ward, Childrens OPD (PLACE)
24th February 2014	Britford Ward, Downton Ward (PLACE)
4th March 2014	Amesbury Suite (PLACE)
28th March 2014	Coronary Care, Tisbury Ward, Cardiac Cath Lab (PLACE)

National PLACE Audit

Facilities staff attended the national training update to ensure the changes made to this years programme were reflected in the training we have provided to our patient assessors this year in preparation for our National PLACE audit. The Facilities Matron has been invited to be the independent assessor at Bournemouth and Bristol Hospitals PLACE audit.

Cleaning data

Area of Focus	KPI	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Departmental Data	Post Infection cleans	270	234	260	319	243	223
	Enhanced cleaning hrs	181	166.5	73	127.5	134	85
Cleaning	Total audits	-	-	70	98	108	95
	Passes	97%	98%	13	21	31	21
	Qualified Passes	-	-	51	72	73	70
	Fails	-	-	6	5	4	4

Area of Focus	KPI	Oct - 13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Departmental Data	Post Infection cleans	254	235	228	275	407	440
	Enhanced cleaning hrs	136	128	81	173	167	137
Cleaning	Total audits	112	97	111	95	95	94
	Passes	32	29	41	29	38	36
	Qualified Passes	79	66	70	66	57	57
	Fails	1	2	1	0	0	1

Terminal and Enhanced Cleaning

The tables below illustrate the additional cleaning undertaken in clinical areas between April 2013 and March 2014, with figures for comparison provided for the previous year (2012/13).

Month/Year	2012 Number of terminal cleans	2012 Enhanced cleaning hours	2013 Number of terminal cleans	2013 Enhanced cleaning hours
April	355	436.25	270	181

May	226	177.5	234	166.5
June	170	146.75	260	73
July	236	66	319	127.5
August	231	166	243	134.25
September	196	48.5	223	85.25
Year to date Total	**1414**	**1041 hrs**	**1549**	**767.5**

Month/Year	**2012/13 Number of terminal cleans**	**2012/13 Enhanced cleaning hours**	**2013/14 Number of terminal cleans**	**2013/14 Enhanced cleaning hours**
October	213	48	254	135.5
November	276	128.25	235	128.25
December	318	137.25	228	81.25
January	212	104.75	275	172.50
February	355	246.5	407	167
March	268	131.5	440	136.5
Year to date Total	**1642**	**796.25 hrs**	**1839**	**821 hrs**

Adenosine Triphosphate (ATP) Monitoring
ATP monitoring has been used as part of the deep clean programme, to support the measurement of 'environmental cleanliness'. The monitoring system is now in use to support effective training of housekeeping staff. This year we have focused on monitoring areas touched by patients i.e. beds, chairs, toilets and over bed tables. A capital bid has been made for new bed tables as a result of the monitoring.

Deep Clean Programme/Rapid Response Team
We adopted a different approach to how we used the Deep Clean Team in 2013/14, concentrating on key areas, toilets, bathrooms and dirty utility rooms in particular and working closely with the IP&CT to respond to need.

The cleaning hours have been increased the cleaning hours in the following ward areas – Farley Ward, Pitton Ward, Redlynch Ward, Downton Ward, Whiteparish AMU, Britford Ward and the Neonatal Unit.

The introduction and use of the GLOSAIR 400 room decontamination system in October 2013 has been a major change in practice. Two machines have been purchased and have been used to clean all rooms as requested by the IP&CT. Details of areas cleaned are detailed below.

Q1 & Q2 2013/14	**AREAS DEEP CLEANED**	**ENHANCED CLEANING HOURS**	**POST INFECTION CLEANS**	**PLACE FAILURES CLEANING**	**SEWAGE LEAK CLEANING**
APRIL	Post-Natal Sarum Bay B, Finance, IT and Sight Centre, PTS ambulances, DSU (builders), Breamore, Leisure Centre	181	270	Not started	Not recorded

MAY	HR, IT, Informatics, Block 24, Trust HQ, ETS and Staff Club, Facilities, Ophthalmology, Hedgerows (builders), O/H chairs, L3 toilets	166.5	234	Not started	Not recorded
JUNE	Pembroke and Winterslow dirty utilities and toilets/bathrooms. Labour, Benson Suite, Burns theatre ceiling, Main theatres (builders)	73	260	1	33 areas
JULY	Winterslow Bay 1 & 2, Staff Gym/Leisure Centre, Downton, Psychology and Urology, Cardiac curtains, Theatre 6, Spinal OT, Avon and Tamar sluice	127.5	319	0	30 areas
AUGUST	Labour, Downton, Britford, Hospice Carpets, ENT, Spinal sluice, Trust carpets, Endoscopy, Medical records.	243	134	1	34 areas
SEPTEMBER	Durrington, Farley, Pitton, Redlynch (pre build), Catering, Med Sur OPD, Tamar Dirty Utility, Breamore, Finance extension, Medical Records archives.	85.25	223	0	41 areas

Q3 & Q4 2013/14	AREAS DEEP CLEANED	ENHANCED CLEANING HOURS	POST INFECTION CLEANS	PLACE FAILURES CLEANING	SEWAGE LEAK CLEANING	GLOSAIR
OCTOBER	Amesbury, Chilmark, Cardiac Suite, Tisbury, Urology,	135.5	135.5	0	54 areas	7
NOVEMBER	Burns, Laverstock, Whiteparish, SSEU, Britford, Medical & Surgical OPD.	128.25	235	0	61 areas	23

DECEMBER	Endoscopy, Radiology, ward bin stores	81.25	228	0	64 areas	18
JANUARY	Avon, Tamar, Main theatres, Catering, O & G Theatre	172.5	335	0	87 areas	23
FEBRUARY	Main Theatres, Durrington, Breamore, DSU, Radnor	167	407	0	tbc	34
MARCH	Main entrance, Tamar, NICU, Labour, Antenatal, Post Natal, Block 25, Medical Engineers and Radnor beds.	136.5	440	0	tbc	26

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 2013/14 in reducing HCAI rates for the Trust and the key priorities include:

- Focusing on the reduction of all reportable Trust apportioned cases and ensuring preventable infections are avoided.
- Focusing on improving 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 and antimicrobial stewardship.
- Sustaining progress with education, training and audit relating to infection control practices and policies.
- Reinforcement of the safety stream work related to vascular access devices.
- Review and implementation of technologies and innovations related to the reduction of HCAIs, with the involvement of key personnel across the Trust site.

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 2013/14

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 (Update: completed skill mix review February 2013)	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/RP/MC	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/RP/MC/ Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	IP&CT	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	GA	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/PW	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	IR	Continuous
Ensure adherence to the uniform and BBE policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings	DIPC/DSNs	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit	DSNs/IP&CT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation	JH/SC/PR	Continuous

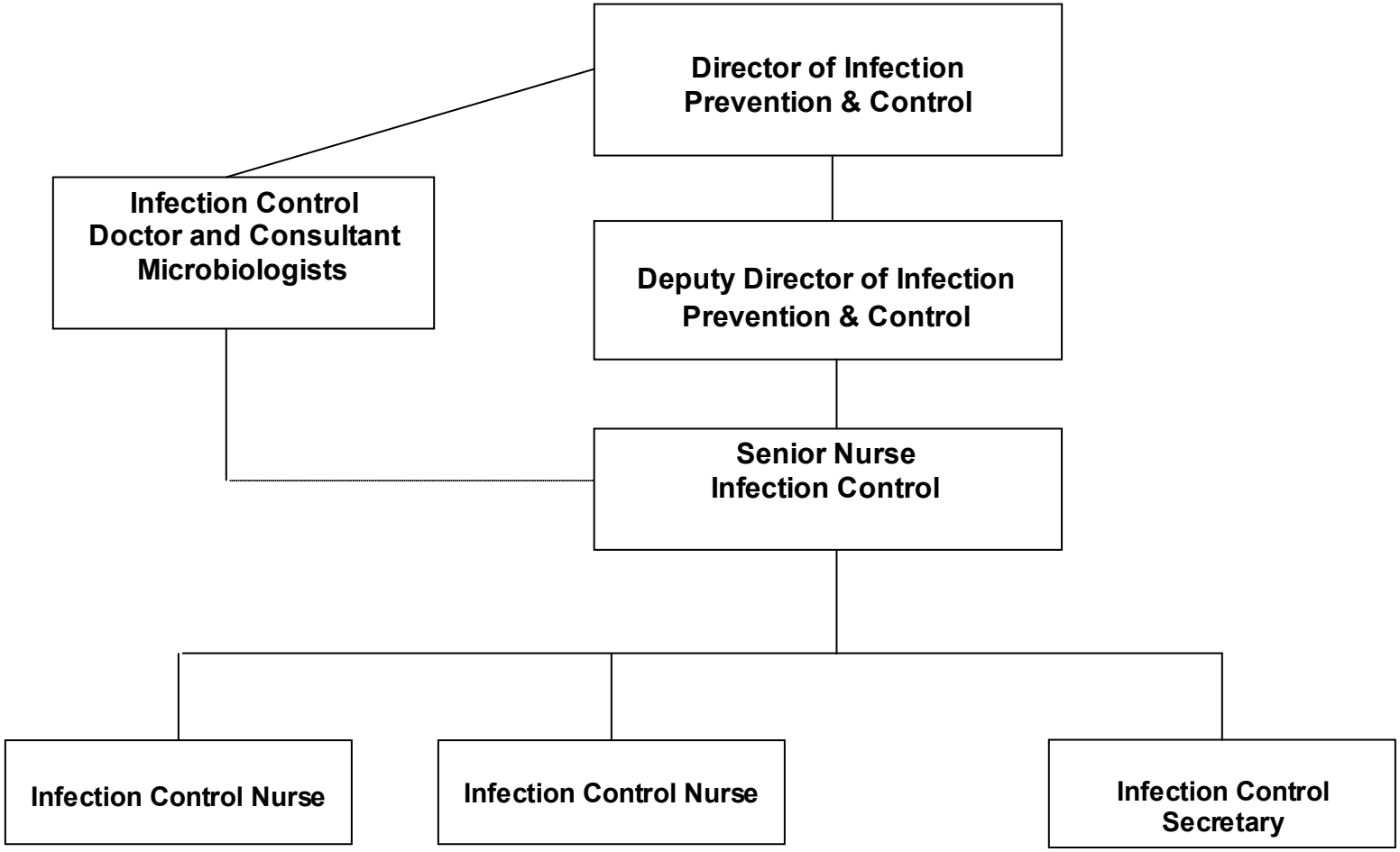
Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control*		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	IP&CT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

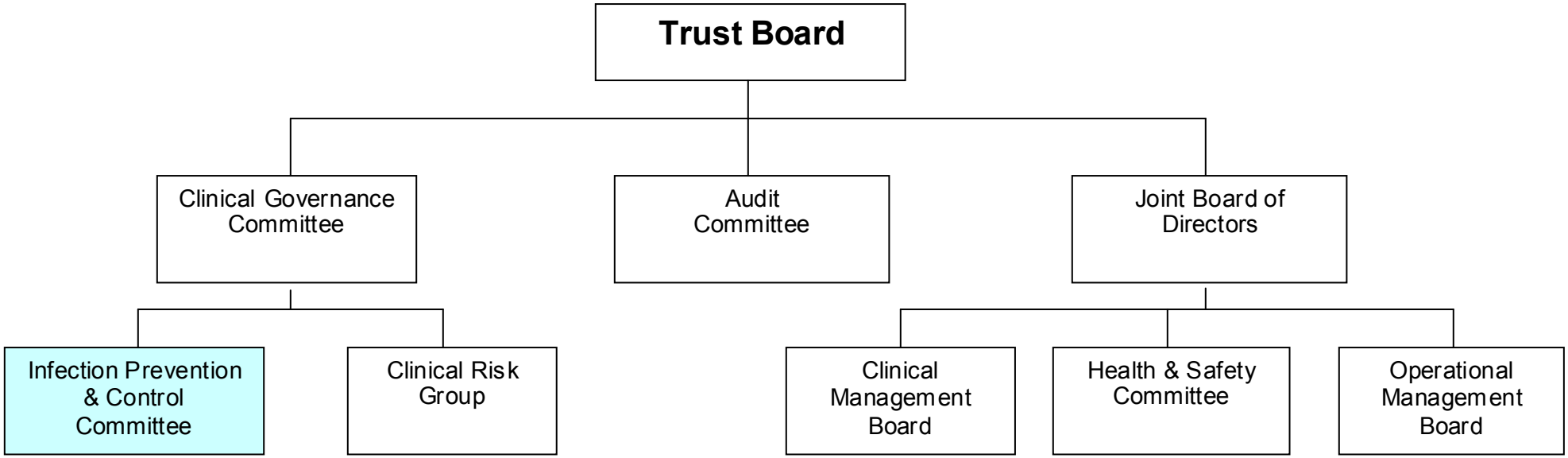
DIPC	Tracey Nutter, Director of Infection Prevention & Control (until end of March 2014)
DDIPC	Fiona Hyett, Deputy Director of Infection Prevention & Control
PW	Peter Wells, Trust Decontamination Lead and SDU Manager
JH	Julian Hemming, Consultant Microbiologist & Infection Control Doctor
SC	Stephen Cotterill,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

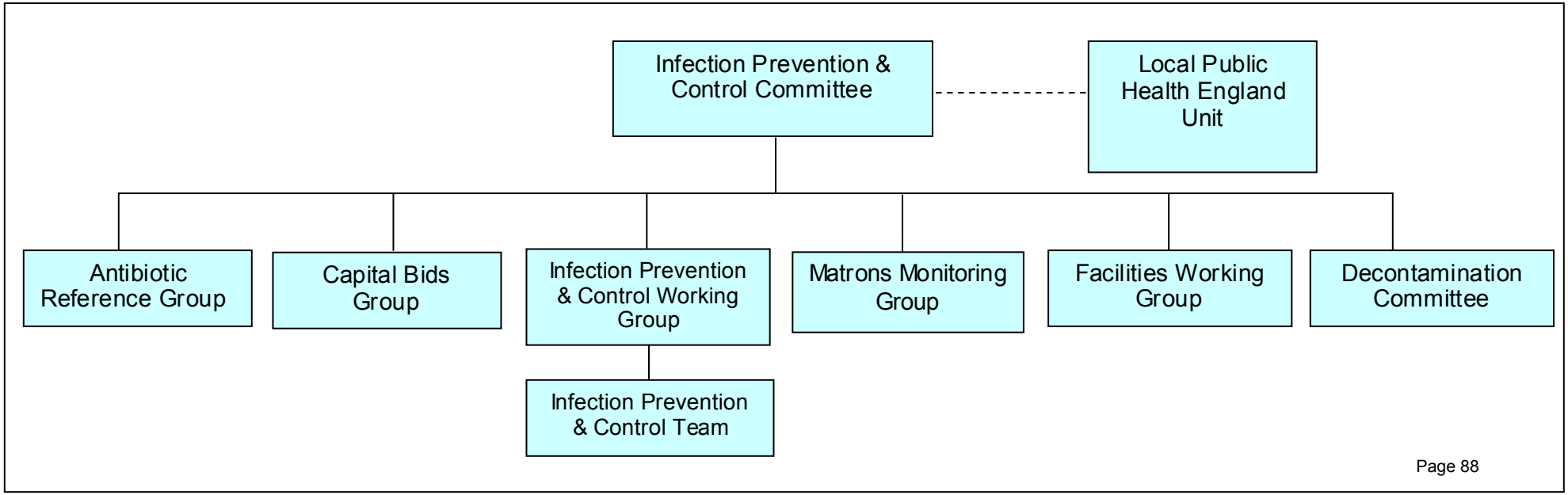
Infection Prevention & Control Team



Appendix 3

Trust Reporting Structure





Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Clinical Support & Family Services – April to September 2013

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %	**Mean Running %**
Sarum Ward	94.44%	85.71%	93.75%	100%	85%	95%	92.32%
Labour Suite	85%	92.3%	90%	0%	100%	75%	73.7%
Beatrice Post Natal	100%	100%	100%	100%	0%	100%	83.33%
Neonatal Unit (NNU)	100%	100%	100%	100%	100%	100%	100%
Gynae Clinic	100%	100%	100%	100%	100%	100%	100%
GUM Clinic	100%	95.83%	100%	100%	95%	100%	98.47%
Salisbury Fertility Centre	100%	100%	100%	100%	100%	100%	100%
Radiology Department	90%	85%	100%	100%	100%	100%	100%
Endoscopy Department	100%	100%	100%	100%	100%	100%	100%
Mean Directorate Running Compliance % (9 areas)	**96.60%**	**95.43%**	**98.19%**	**88.89%**	**86.66%**	**96.66%**	**93.74%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Clinical Support & Family Services – October 2013 to March 2014

	Mean October %	Mean November %	Mean December %	Mean January %	Mean February %	Mean March %	**Mean Running %**
Sarum Ward	0%	94.12%	0%	90.48%	85%	100%	**61.6%**
Labour Suite (inc DAU)	75%	66.66%	70%	65%	81%	86.36%	**70%**
Beatrice Post Natal	95%	100%	100%	100%	100%	100%	**99.16%**
Neonatal Unit (NNU)	100%	100%	100%	100%	100%	100%	**100%**
Gynae Clinic	100%	100%	100%	100%	100%	100%	**100%**
Sexual Health (GUM)	100%	100%	100%	100%	100%	100%	**100%**
Salisbury Fertility Centre	100%	100%	100%	0%	100%	100%	**83.33%**
Radiology Department	0%	95%	95%	100%	0%	100%	**65%**
Endoscopy Department	100%	100%	100%	100%	100%	95%	**100%**
Mean Directorate Running Compliance % (9 areas)	**74.44%**	**95.1%**	**85%**	**83.94%**	**85.11%**	**97.93%**	**88.59%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Medicine – April to September 2013

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %	**Mean Running%**
Whiteparish AMU	100%	60%	50%	88.88%	73.68%	68.18%	74.51%
Tisbury CCU	85%	80%	80%	93.18%	95%	91.66%	87.47%
Pitton Ward	97%	95%	91.66%	100%	100%	89.56%	95.53%
Redlynch Ward	92.85%	100%	100%	100%	100%	95.24%	98.01%
Farley Ward	100%	100%	100%	95%	100%	95.24%	98.37%
Winterslow Suite	100%	100%	100%	100%	100%	100%	100%
Pembroke Ward	100%	100%	100%	100%	100%	100%	100%
Pembroke Suite	100%	100%	100%	100%	100%	100%	100%
Durrington Ward	100%	100%	100%	100%	100%	94.44%	100%
Hospice	100%	100%	100%	100%	93.75%	100%	98.96%
Emergency Dept	96.66%	81.81%	100%	90.47%	96.30%	63.64%	88.15%
Dermatology Dept	90%	100%	100%	100%	100%	87.5%	96.25%
Cardiac Suite	100%	90%	100%	100%	100%	100%	98.00%
Directorate Running Compliance % (13 areas)	**97.04%**	**92.83%**	**93.97%**	**97.50%**	**96.83%**	**91.19%**	**94.89%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Medicine – October 2013 to March 2014

	Mean October %	Mean November %	Mean December %	Mean January %	Mean February %	Mean March %	**Mean Running %**
Whiteparish AMU	59.1%	78.30%	73.70%	81.18%	71.43%	100%	**77.30%**
Tisbury Ward CCU	100%	88.88%	92.86%	100%	100%	85%	**94.46%**
Pitton Ward	82.14%	95.65%	78.26%	95%	97.77%	100%	**91.47%**
Redlynch Ward	100%	100%	100%	100%	95.00%	100%	**99.16%**
Farley Ward	90%	89.50%	100%	100%	89.47%	100%	**94.83%**
Winterslow Suite	100%	90.46%	70%	95.24%	86.96%	66.67%	**84.88%**
Durrington Ward	89.5%	100%	100%	100%	90%	90%	**94.92%**
Pembroke Ward	100%	100%	85%	100%	100%	100%	**97.50%**
Pembroke Suite	92.31%	100%	100%	100%	100%	100%	**98.71%**
Hospice	100%	100%	100%	100%	100%	100%	**100.00%**
Emergency Dept	60%	52.4%	61.90%	50%	28.57%	60.90%	**52.29%**
Dermatology Dept	100%	100%	100%	100%	100%	100%	**100.00%**
Cardiac Suite	100%	95%	100%	100%	95%	100%	**98.33%**
Nunton Unit	95%	100%	95.24%	100%	95.45%	100%	**97.62%**
Wilton/Breamore Ward	**Not open at this time**			100%	84.20%	85.70%	**89.97%**
Directorate Running Compliance % (14 areas) (15 areas from Jan 2014)	**91.29%**	**92.16%**	**89.78%**	**94.80%**	**88.92%**	**92.55%**	**91.58%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Musculoskeletal – April to September 2013

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %	**Mean Running %**
Amesbury Suite	100%	100%	100%	0%	100%	67.74%	77.96%
Chilmark Suite	100%	100%	95%	100%	100%	87.5%	97.08%
Laverstock Ward	100%	100%	100%	100%	95%	0%	83%
Burns Unit	100%	100%	90%	100%	100%	95%	98%
Avon Ward	100%	100%	100%	100%	0%	100%	96.66%
Tamar Ward	100%	100%	95%	100%	85.71%	80%	96.14%
Spinal OPD	100%	100%	100%	100%	100%	87.5%	97.92%
Orthopaedic OPD	100%	100%	100%	100%	100%	90.6%	98.43%
Plastics OPD	91%	82.6%	67.65%	90%	96.30%	79.2%	84.44%
Oral Surgery OPD	100%	100%	100%	100%	100%	100%	100%
Rheumatology	100%	100%	100%	100%	100%	100%	100%
Wessex Laser Centre	100%	100%	100%	100%	100%	90.9%	98.48%
Burns & Plastics Therapy	100%	95%	100%	100%	100%	95%	98.33%
Directorate Running Compliance % (13 areas)	**99%**	**98.28%**	**95.97%**	**91.54%**	**90.54%**	**83%**	**93.06%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Musculoskeletal – October 2013 to March 2014

	Mean October %	Mean November %	Mean December %	Mean January %	Mean February %	Mean March %	**Mean Running %**
Amesbury Suite	75%	100%	79.16%	0%	68.57%	78.60%	**66.88%**
Chilmark Suite	75%	65%	61.90%	90%	85%	90%	**77.82%**
Laverstock Ward	95.45%	100%	100%	100%	100%	100%	**99.24%**
Burns Unit	82.50%	100%	100%	0%	95%	85%	**77.08%**
Avon Ward	50%	100%	100%	94.44%	90.90%	75%	**85.06%**
Tamar Ward	74.44%	89.50%	100%	100%	90%	100%	**92.32%**
Spinal OPD	93.75%	100%	0%	100%	93.75%	92.30%	**79.97%**
Orthopaedic OPD	74.20%	79.20%	75%	0%	96.87%	100%	**70.86%**
Plastics OPD	70.37%	0%	100%	80.95%	100%	100%	**75.22%**
Oral Surgery OPD	100%	100%	100%	100%	100%	100%	**100%**
Rheumatology	100%	100%	100%	100%	100%	100%	**100%**
Wessex Laser Centre	100%	100%	100%	100%	100%	100%	**100%**
Burns & Plastics Therapy	100%	87.50%	100%	0%	100%	100%	**81.25%**
Directorate Running Compliance % (13 areas)	**83.90%**	**88.25%**	**85.85%**	**66.57%**	**93.85%**	**93.91%**	**85.39%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Surgery – April to September 2013

	Mean April %	Mean May %	Mean June %	Mean July %	Mean August %	Mean September %	**Mean Running %**
Britford Ward	100%	100%	100%	100%	97.22%	95.45%	98.78%
Downton Ward	95.23%	100%	89.72%	88.88%	90%	87.50%	91.88%
Radnor Ward	95%	0%	95%	100%	100%	77.77%	78%
Vascular & Diabetic OPD	100%	100%	100%	100%	100%	0%	83.33%
Medical & Surgical OPD	100%	100%	100%	100%	95%	100%	99.17%
ENT Department	100%	100%	100%	100%	100%	80%	96.66%
Ophthalmology	100%	0%	100%	100%	0%	100%	66.66%
Main Theatres and Recovery	100%	100%	100%	100%	100%	0%	83.33%
Surgical Admissions Lounge	100%	100%	100%	100%	100%	0%	83.33%
Day Surgery Unit	100%	95%	100%	100%	96.66%	0%	81.94%
Pre-op Assessment Unit	100%	100%	100%	100%	100%	0%	83.33%
Clarendon Suite	100%	100%	100%	100%	0%	100%	83.33%
Breamore Ward	95%	80%	Closed	Closed	Closed	Closed	88%
Directorate Running Compliance % (13 areas)	**98.86%**	**82.69%**	**98.73%**	**99.07%**	**81.57%**	**53.39%**	**85.71%**

Appendix 4

Clinical Directorates Hand Hygiene Monthly Compliance Tables

Surgery – October 2013 to March 2014

	Mean October %	Mean November %	Mean December %	Mean January %	Mean February %	Mean March %	**Mean Running %**
Britford Ward	55.55%	85%	90%	100%	100%	93.33%	**87.31%**
Downton Ward	60%	96.30%	89.47%	85.71%	71.66%	100%	**83.85%**
Radnor Ward (ITU)	85%	100%	90%	90%	95.45%	85%	**90.91%**
Vascular & Diabetic OPD	100%	100%	100%	100%	100%	100%	**100%**
Medical & Surgical OPD	100%	100%	Incomplete	100%	100%	100%	**83.33%**
ENT Department	100%	100%	100%	100%	100%	88.88%	**98.15%**
Ophthalmology	100%	100%	100%	100%	100%	100%	**100%**
Main Theatres and Recovery	100%	100%	100%	0%	100%	100%	**83.33%**
Surgical Admissions Lounge	95%	90.50%	95.24%	100%	85%	0%	**77.62%**
Day Surgery Unit	100%	70%	95.24%	100%	100%	81.80%	**91.17%**
Pre-operative Assessment Unit	100%	100%	100%	100%	100%	100%	**100%**
Clarendon Suite	100%	100%	93.75%	0%	100%	96%	**81.63%**
Directorate Running Compliance % (12 areas)	**91.30%**	**95.17%**	**87.80%**	**81.31%**	**96%**	**87.08%**	**89.78%**

Appendix 5

Completed Hand Hygiene Assessments for 2013 to 2014 – figures shown in brackets are for the previous year (2012/13)

Directorate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Chief Executive	19 (25)	20 (27)	44 (7)	49 (21)	**132** (80)
Clinical Support and Family Services	102 (90)	83 (109)	193 (123)	146 (122)	**524** (444)
Consultants/Doctors/Medical students	24 (37)	58 (49)	55 (38)	48 (43)	**185** (167)
Contractors/Other	24 (3)	0 (0)	3 (4)	29 (9)	**56** (16)
Facilities	149 (71)	67 (59)	97 (67)	39 (40)	**352** (237)
Finance and Procurement	30 (11)	13 (0)	16 (5)	23 (17)	**82** (33)
Human Resources	9 (10)	24 (31)	87 (39)	26 (47)	**146** (127)
Medicine	96 (73)	62 (36)	135 (53)	72 (63)	**365** (225)
Musculo-Skeletal	74 (71)	68 (28)	92 (34)	72 (58)	**306** (191)
Quality	27 (17)	20 (26)	70 (49)	24 (47)	**141** (139)
Students/Work Experience	4 (0)	6 (9)	6 (15)	0 (3)	**16** (27)
Surgery	56 (37)	76 (73)	219 (24)	69 (97)	**420** (231)
Wiltshire Council (Previously Wiltshire Primary Care Trust)	21 (6)	10 (16)	7 (6)	6 (17)	**44** (45)
Total	**635** (451)	**507** (463)	**1024** (464)	**603** (584)	**2769** (1962)

- 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

Appendix 6

Infection Prevention & Control Annual Audit Programme

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

No	Aim	Audit	When by/How	Person(s) responsible/main author
4	High standards of hygiene in clinical practice.	Hand hygiene, including Isolation nursing and use of personal protective equipment (PPE).	• Priorities & timescales agreed with DIPC. • Plus, targeted audits.	Clinical Leaders/DSNs assisted by ICNs. IP&CT.
5	Prudent use of antibiotics.	Antibiotic prescribing & usage.	Action Plan agreed & monitored by the Antibiotic Reference Group (ARG).	Chief Pharmacist & Interim Antimicrobial Pharmacist.
6	Management & organisation – • Policy, guideline & information development & review programme (review dates according to ICID or SDH intranet site).	Pt information leaflet - Acinetobacter.	Review 2015.	ICNs.
		Microbiology Alerts.	Review 2014.	Stephen Cotterill.
		Aseptic technique.	Review 2015.	ICNs.
		Clostridium difficile.	Under Review.	ICD/ICNs.
		Pt information leaflet - C.difficile.	Review 2014.	ICNs.
		Contractors/Procurement information leaflet - Infection Control.	Review 2015.	ICNs.
		Creutzfeldt Jacob Disease (CJD).	Review 2015.	Decontamination Lead & IP&CT.
		Decontamination.	Review 2014	Decontamination Lead.
		Pt information leaflet - ESBL.	Review 2017.	ICNs.
		Glove Usage Policy & Chart.	Review 2015.	ICNs.
		Pt information leaflet - Group A Strep (GAS).	Under Review.	ICNs.
		Staff information leaflet - Hand Hygiene.	Review 2015.	ICNs.
		Infection Control Policy.	Review 2014.	IP&CT.
		Inclusion of Infection Control within Renovation & Construction.	Under Review.	George Atkinson.
		Isolation (including diarrhoeal infections & other alert organisms).	Under Review.	ICD.
		Hand Hygiene.	Review 2014.	IP&CT.
		Pt information leaflet - Invasive GAS Disease.	Under Review.	ICNs.

No	Aim	Audit	When by/How	Person(s) responsible/main author
6	**Continued**	Linen Policy.	Under Review.	IP&CT.
		Legionellosis Management.	Review 2015.	George Atkinson.
		Clinical Management of MRSA.	Review 2015.	ICD.
		Pt information leaflet - MRSA.	Under Review.	ICNs.
		Pt information leaflet - MRSA Contact Bay.	Review 2016.	ICNs.
		Pt information leaflet - MRSA Screening.	Review 2015.	ICNs.
		Outbreak Management.	Under Review.	IP&CT.
		Outbreak Management of Norovirus.	Review 2014.	IP&CT.
		Pt information leaflet – Norovirus.	Review 2015.	ICNs.
		Pt information leaflet - 'Now that I am in Isolation'.	Review 2016.	ICNs.
		Prevention of spread of Carbapenem resistant organisms.	Review 2015.	ICD.
		Inpatients with diarrhoea algorithm.	Review 2015.	ICNs.
		Management of VRE Policy.	Under development.	ICD.
		Pt information leaflet – new leaflet for VRE devised.	For final approval.	ICNs.

Appendix 7

Completed Infection Control CBL Package on the MLE for 2013 to 2014 - figures shown in brackets are for the previous year (2012/13)

Directorate	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Clinical Support and Family Services	100 (44)	90 (66)	93 (145)	**104** (67)	**387** (322)
Facilities	84 (37)	66 (50)	40 (73)	**28** (67)	**218** (227)
Medicine	94 (41)	99 (61)	61 (53)	**95** (64)	**349** (219)
Musculo-Skeletal	65 (40)	55 (20)	50 (42)	**47** (40)	**217** (142)
Quality	41 (33)	62 (53)	42 (36)	**40** (57)	**185** (179)
Surgery	89 (34)	84 (54)	85 (55)	**85** (60)	**343** (203)
Corporate	45 (12)	43 (25)	66 (32)	**55** (46)	**209** (115)
Doctors	12 (17)	48 (13)	38 (29)	**35** (25)	**133** (84)
Wiltshire Council (Previously Wiltshire Primary Care Trust)	0 (2)	0 (10)	2 (14)	**0** (0)	**2** (26)
Other Groups	12 (11)	10 (6)	15 (6)	**10** (27)	**47** (50)
Total	**542** (271)	**557** (358)	**492** (485)	**499** (453)	**2090** (1567)

- It is a mandatory requirement for Trust staff to complete the infection control CBL package on the MLE every 2 years

Appendix 8

Topics covered at the ICLP monthly meetings during quarters 1 and 2 of 2013/14 have included the following:

- Feedback and review of the total number of cases identified in the Trust for 2012/13, in relation to MRSA bacteraemia cases, and reportable Trust apportioned cases of C.difficile. The importance for all staff to remain vigilant with infection control practices was acknowledged by the ICLPs with the focus on reducing the number of healthcare associated infections during 2013/14.
- Notification and discussion of the scheduled CQC visit in June 2013, and the expected follow up visit.
- The identified PII of C.difficile in the medical directorate, and VRE in the surgical directorate. A summary of events was provided and included the measures implemented as part of the resulting investigations.
- Water safety management – covered the work being undertaken in the Trust regarding the prevention of Legionella and Pseudomonas, and the formation of the Water Safety Review Group. Discussion of the flushing of low use outlets for Legionella prevention, and reinforcing practices for responding to a sewage leak and the correct use of clinical hand wash sinks. This also covered the escalation process for reporting concerns.
- Antimicrobial resistant organisms – feedback of incidence within the Trust of multiresistant organisms and the immediate patient management in accordance with Trust policies. The importance of adhering to standard precautions for all patients was emphasised, regardless of whether patients are known to have an alert organism or not.
- Update on progress with the installation of the GOJO mild hand wash soap Trust wide and explanation of the product. Hand care health promoted through use of the GOJO hand medic professional skin conditioner.
- Hand hygiene audit work:
    - Discussion of the established and current hand hygiene audit method, the tool used and the data collection process, with a review of the monthly hand hygiene audit compliance results.
    - Presentation of the results from independent hand hygiene audit work carried out in the Trust by the GOJO Healthcare Manager during April and May 2013. This incorporated ten clinical inpatient areas and used an audit tool based upon the WHO '5 moments for hand hygiene' methodology.
    - Explanation and discussion of the '5 moments for hand hygiene', and the trial of the WHO audit tool in selected clinical areas. Discussion of the outcome from the trial, and the resulting adaption of the WHO audit tool into the final revised hand hygiene audit tool for the Trust.
    - Education and support to enable effective use of the revised hand hygiene audit tool from 1st September 2013.
    - Hand care health promoted through use of the GOJO hand medic professional skin conditioner.
- Feedback and discussion of the results from completed reaudits across the Trust:
    - Isolation Risk Assessment Tool
    - MRSA Pathway
    - Handling and Disposal of Linen.
- Information relating to the reaudit to establish compliance with the use of 2% Chlorhexidine Gluconate in 70% alcohol wipes.
- Measles – an overview of the number of cases identified nationally and the implementation of the MMR vaccination catch-up programme. This was followed by group work covering signs and symptoms, diagnosis, treatment and complications, in addition to

the management and isolation of suspected/confirmed cases and the required personal PPE. Sources for accessing further information were provided.
- Reinforcement of the Trust dirty utility room standard, and notification of the completed refurbishment of the dirty utility rooms on the Spinal Unit.
- ICLP role profile – discussion of the role and the requirement to provide evidence of work undertaken in the relevant area or department, as part of their Personal Development Review (PDR). The ICLPs were instructed to make an appointment to meet with an ICN to discuss the hand hygiene audit process and update on using the UV light box.
- ICLP achievements – an opportunity was provided for the ICLPs to share infection control related experiences.
- The journey of a sample or specimen sent for microbiological testing, including the correct completion of the investigation request cards.
- Health Protection Agency – explanation of the HPA becoming part of Public Health England from 1st April 2013, with resources provided for further information.
- Update on the scrubs/uniform consultation and a reminder to view/comment on the display of proposed uniform samples.
- Clarification of the dress code for work experience students.
- Specific clinical related issues, including the management of diarrhoea and vomiting and Norovirus activity within the Trust, and a monthly update of the Clostridium difficile inpatient cases identified. This included consideration of patient management, staff factors, targets and the impact strategically for the Trust.
- Educational resources – discussion of the infection control education provided by the ICNs in addition to the MLE computer based training package. This outlined the formal and informal teaching completed, and specialism specific sessions in response to requests from areas/departments. The 'Infection Control Update' drop-in sessions were highlighted as being relevant to all clinical staff members.
- Use of the UV light box by the ICLPs, and an explanation of the reminder emails received by staff members for their hand hygiene assessment on the MLE.

Topics covered at the ICLP monthly meetings during quarters 3 and 4 of 2013/14 have included the following:

- Feedback and discussion of the 2 unrelated MRSA bacteraemia cases identified during September and November 2013. Explanation of the required Post Infection Review process to investigate the cases. Discussion of the findings and learning identified, and the outcome of both cases being classified as skin contaminants.
- MRSA screening requirements for patients admitted as an emergency to the Trust. Discussion of results from the MRSA screening audits for elective and emergency admissions completed by the ICNs.
- Management of patients with symptoms of diarrhoea and/or vomiting:
    - Revisiting the PII of C.difficile during 2011/12, linking back to the key learning points and resulting actions.
    - Sending of faecal samples, including the electronic requesting process for testing.
    - Reinforcing the Trust flowchart for the management of inpatients with diarrhoea.
    - Department of Health best practice guidance for C.difficile.
    - Decontamination requirements for the environment and equipment.
- VRE: Discussion of the incidence within the hospital and community settings, and the impact of the cases identified in the Trust that could be linked geographically to the surgical directorate. Patient management and required risk assessment outlined to promote the optimal use of side room facilities. Emphasis was placed on the strict adherence to correct hand hygiene practices, antibiotic stewardship, equipment cleanliness and environmental cleanliness.

- Update and information regarding the introduction of the GLOSAIR 400 room decontamination system:
    - Explanation of the background and rationale for the Trust to purchase the system, and the priority use for the decontamination of vacated siderooms after C.difficile and other multiresistant organisms, e.g. VRE, in addition to part of the commissioning process following building and refurbishment works.
    - Attendance by the company representative to outline the process, with a machine available for the ICLPs to view.
    - Explanation that use across the Trust is led by the Housekeeping Department, supported by the ICNs.
    - Clarification that the system is utilised only after the area has been deep cleaned by Housekeeping staff, and that additional equipment can also be placed in the area to be decontaminated provided it has been cleaned first.
- Infection control related documentation and staff responsibilities, covering completion of the Isolation Risk Assessment Tool, MRSA Pathway and stool charts.
- Antibiotic stewardship, and the antibiotic awareness day on 18th November 2013.
- Hand hygiene audit process – Reinforcing the WHO '5 moments for hand hygiene', and providing education and support to enable effective use of the revised hand hygiene audit tool. Update on how the audit results are reported and discussed at the MMG.
- Discussion of the initial findings from audit work, and progress with the audit programme. Presentation of the final reports for the reaudit of compliance with use of the Isolation Risk Assessment Tool and MRSA Pathway, and compliance with the Bare Below the Elbow and Uniform Workwear policy. Presentation of the final report for the third reaudit of compliance with use of 2% Chlorhexidine Gluconate in 70% alcohol wipes.
- Attendance by the GOJO Healthcare Support Manager to outline their role in the provision of education and support to staff at the Trust. Explanation of the additional hand hygiene audits completed by the Healthcare Support Manager across clinical areas, and promotion of improved skin care through the correct use of products used in the Trust, e.g. the foam soap, alcohol hand rub gel and the Hand Medic professional skin conditioner.
- PLACE:
    - Introduction to PLACE, what it involves, how this is being implemented internally across the clinical areas, and discussion of the proposed timetable for auditing.
    - Review of the associated documentation, with consideration of how the process could be utilised as evidence to aid capital bids and improvement projects.
    - Feedback from 2 PLACE audits completed within the medical directorate.
    - Confirmation of how the internal PLACE audits will be reported by the directorates to the MMG, with monitoring of resulting action plans.
- Handling and disposal of linen reaudit for inpatient and outpatient areas by the ICLPs. Explanation of the requirement to reaudit practices and the audit process, with data collection for completion by the ICLPs and/or Clinical Leaders in areas where patient linen was in use.
- Specific clinical related issues, including Norovirus activity within the Trust and the surrounding community, and a monthly update of the Trust apportioned reportable inpatient cases of Clostridium difficile identified, with explanation of any additional measures implemented.
- Notification of the criteria of the testing of faecal samples for Norovirus by the Laboratory from the beginning of February 2014, and reinforcing the use of the Trust flowchart for the management of inpatients with diarrhoea.
- Patient management workshop, where information for 2 inpatient areas affected with confirmed Norovirus was provided in the form of a map of each area, detailing actual patient symptoms and bay closures. The ICLPs undertook small group work to consider how to manage the situation, devise plans for resolution, and the cleaning and staffing

implications. The exercise highlighted the importance of the risk assessment process in maintaining patient safety and ensuring the continued service provision.

- Further discussion and clarification in relation to the management of patients with symptoms of diarrhoea and/or vomiting:
    - Clarification of permitted patient movement from bays and/or wards within the Trust, when closed due to diarrhoea and vomiting and/or confirmed Norovirus.
    - Required investigations, tests or therapy to proceed with any potential risks minimised and the patient managed as for any other patient with a suspected or confirmed infection.
    - The safe management of medications.
    - Staff illness.
    - Terminal cleaning requirements prior to the reopening of a bay/ward.
- Planned trial within the surgical directorate for the placement of alcohol hand rub gel at the patient bedside, either at end of bed or on lockers.
- Reinforcing the correct method for the decontamination of mattresses, and the correct use of the universal sanitising wipes.
- Feedback of practices witnessed from visits made by the ICNs to clinical areas, and how any concerns identified are addressed. Emphasis was placed on the strict adherence to correct hand hygiene practices, including washing hands after the removal of PPE, the correct wearing of PPE, and adherence to standard precautions.
- The increase in the number of influenza cases nationally, and the incidence of suspected and confirmed inpatients cases of influenza within the Trust. Notification of a bay closure on a medical ward (at the time of the meeting in March 2014). Update on the wearing of PPE for the management of suspected and confirmed influenza, with explanation of the different respiratory face masks and the indications for use, including for other organisms.
- Implementation of the new scrubs/uniform for relevant staff groups. Discussions initiated by the ICLPs surrounding compliance with the Uniform Workwear policy by clinical staff wearing a uniform, with experiences shared by the group.
- Reminders for the ‘drop-in’ sessions facilitated by the ICNs, for the completion of hand hygiene assessments and infection control updates.
- Christmas quiz.

Appendix 9

Patient Led Assessment of the Care Environment (PLACE) Action Plan 2013/14 - Generated by Maggie Cherry, Facilities Matron

Theme	Group/Person Responsible	By when	Comments/Update
Hand bacterial rub available at bedside	IP&CT	Completed September 2013 April 2014	• Trial commences on Doctors trolleys. • Ward areas also selected for trial, Britford and Downton Wards by IP&CT.
Patients bedside lockers have no secure/lockable areas for personal belongings	Lesley Meaker & Sue Biddle	January 2014 August 2014	• Capital Bid Submitted. As areas are refurbished lockers have been updated to comply. Maternity, Pembroke and Redlynch Wards completed. • Redlynch & Pitton Wards requested staff only locks for single drug drawer due to clinical need reasons. This was discussed at the steering group project meetings, • New lockers already provided to Pitton Ward, currently on Breamore template during refurbishment process. • Pharmacy to be involved over choices for lockable drawer for medications.
Decorating issues across wards and departments, and internal and external spaces	Martin Penny, David Connolly - ETS & Geoff Walford – PFI	Commenced September 2013 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 Ward fully compliant and setting standard that will be followed as wards are refurbished.

Theme	Group/Person Responsible	By when	Comments/Update
Food trolleys not retaining heat	Ian Robinson, General Manager, Hotel Services & Paul Straughair, Catering Manager	Awaiting Outcome of Capital Bid	• Capital Bid submitted August 2013. • Bid successful £170k invested in new food trolleys, delivery expected in June 2014.
Grounds and Gardens; accessibility and condition	Maggie Cherry (MC), ETS & Alison Kingscott (AK)	Commenced November 2013 Full site survey completed by MC and AK April 2014	• Potential partnership with Wiltshire Wildlife, as part of their wellbeing programme and our Shape-up programme. • Paper completed and going to the Charitable Trustees on May 22nd 2014 for funding.

Appendix 10

Additional information relating to Trust activity with alert organisms

- **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 2013/14.

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 throughout 2013/14.

- **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 2013/14, the ICNs were not informed of any new inpatient cases of multi drug resistant Acinetobacter.

- **Carbapenem resistant organisms**

Carbapenems are a group of antibiotics predominantly used to treat multi-resistant gram-negative bacterial infections. Although still relatively rare, Carbapenem resistant organisms are more difficult to treat, as they are often resistant to most other classes of antibiotics. 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.

During 2013/14, the ICNs were not informed of any new inpatient cases of Carbapenem resistant organisms.

- **Chickenpox (Varicella Zoster)**

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

During 2013/14, the ICNs were informed of 2 unrelated cases where patients were admitted with a diagnosis of suspected chickenpox. Both patients were isolated in sideroom facilities.

- **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 2013/14.

- **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.

Additional information regarding alert organisms can be accessed from the HPA website:
http://www.hpa.org.uk/Topics/TopicsAZ

From 1st April 2013, the HPA became part of Public Health England (PHE), an executive agency of the DH, working with national and local government, industry and the NHS to protect and improve the nation's health and support healthier choices: www.gov.uk/phe

PAPER: SFT 3537

National InPatient Survey 2013
Analysis of the Care Quality Commission's 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 2013 and the actions to be taken by the Trust.

MAIN ISSUES:

1.0 Introduction

Salisbury NHS Foundation Trust participated in the eleventh national inpatient survey between October 2013 and January 2014. Questionnaires were sent to 850 randomly selected patients who had spent at least one night at Salisbury District Hospital during the month of July 2013. The Trust achieved a response rate of 65% which was 5% 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.

The CQC is continuing to use the scoring format introduced last year whereby results are scored out of 10, rather than 100, to avoid confusion with percentages.

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

Q29 Did nurses talk in front of you as if you weren't there?	9.1	7.7	9.7	519	8.8	↑

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 ten sections and Trusts are scored for their overall performance in each section. SFT scored 'about the same' as all other Trusts in each of the ten categories:-

- 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 and experiences

For the 60 individual questions,

SFT scored 'significantly better' for one question:-

- Did you get enough help from staff to eat your meals?

The remaining 59 questions scored 'about the same' as all other Trusts.

When compared with its own 2012 benchmark results, SFT significantly improved in three areas:-

- Nurses not talking in front of patients as if they were not there.
- A member of staff explaining to the patient how the operation or procedure had gone, in a way they could understand.
- Patients being asked, whilst they were in hospital, to give their views on the quality of the care they were receiving.

There were no significant declines.

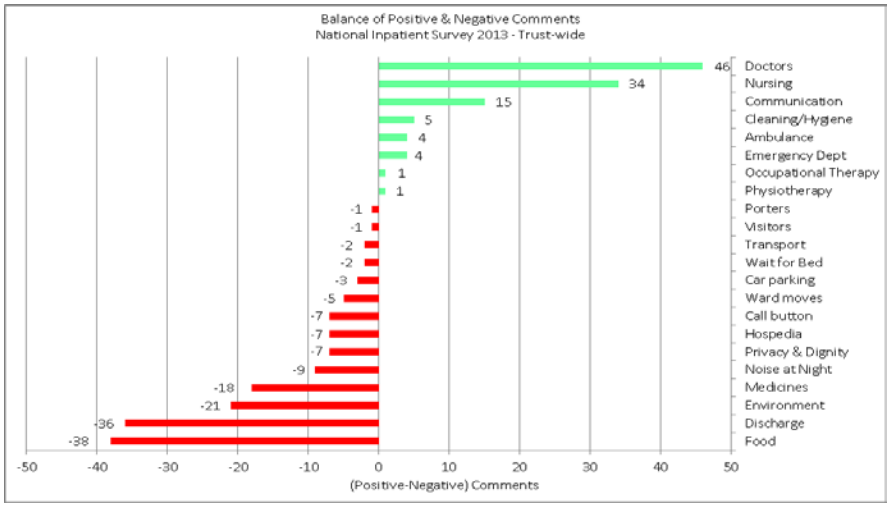
4.0 Comparisons with Demographic Characteristics

The split between male and female respondents was exactly 50/50, compared with 46% male and 54% female 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 (95% compared with 89%); responses from other ethnic groups were 5% 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 282 'good' comments were received and 252 'improve' comments. These have been categorised and analysed to show the areas where further attention is required, as indicated in the graph below:



Issues regarding the environment mainly related to the fact that the weather was hot in July and wards found it difficult to keep their areas cool.

Issues relating to discharge have been incorporated into ward action plans where appropriate.

Whilst 38 more negative than positive comments were received, the overall score for hospital food has not significantly changed from the previous year (down 0.3%); an achievement given that between July and September 2013 the catering service was provided from temporary facilities whilst the main kitchen underwent a major capital refurbishment. Following this work, the results from real-time feedback have improved. It is anticipated that following the introduction of new food trolleys in May 2014 feedback will continue to improve and it is believed that this will be reflected in the 2014 national inpatient survey results.

The Patient Experience Analysis Group met in February 2014 to look at the results in conjunction with themes arising from incidents, concerns and complaints. Action plans have been drawn up by the wards with the over-arching theme of improving communication (see Appendices 1 – 4). A progress report will be presented to the Clinical Governance Committee in November 2014.

ACTION REQUIRED BY THE BOARD:

Board members are invited to endorse this approach and note the contents of this report.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:

Appendix A	IP2013 Action Plan_Medicine
Appendix B	IP2013 Action Plan_Surgery
Appendix C	IP2013 Action Plan_Musculo-Skeletal
Appendix D	IP2013 Action Plan_Spinal Unit

AUTHOR: **Fiona Hyett**

TITLE: **Interim Director of Nursing**

Name of Ward reporting

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.	• 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.	Senior sister of each ward.	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.

APPENDIX B

Name of Ward reporting

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 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 (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 team.	Senior sister of ward	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 June 2014.

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.	• 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.	Senior sister of each ward.	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.

APPENDIX C

Name of Ward reporting

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 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 (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 team.	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 June 2014.

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.	• 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.	Senior sister of each ward.	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.

APPENDIX D

Name of Ward reporting

Issue	Action plan	Lead	Monitoring
Patients state in the national survey that they are not always given sufficient discharge information.	• Ensure all patients have a copy of the SIA Patient learning pack, and that they have read it and understand it. • Ensure the patient has a copy of their care plans and check list. • Ensure monthly review meeting of the patient's care plan with the named nurse. • Ensure that check list covers all areas of the patients needs. • Encourage use of Trust discharge check list one week prior to discharge to ensure that all needs are covered. • Liaise with discharge co-ordinator to ensure package ready for patient's discharge and ensure completion of spinal discharge check list.	Dominic Holbourne	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.

Name of Ward reporting

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.	• 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.	Senior sister of ward.	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 Nurse Staffing Report - May

Trust Board June 2014

Background

In November 2014 the National Quality Board (NQB) and the Chief Nursing Officer published guidance that set out the current guidance on safe staffing. The guidance *'How to ensure the right people, with the right skills, and in the right place at the right time'* clarifies the expectation on all NHS bodies to ensure that every ward and every shift have the right number of 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 12 expectations within the NQB guidance with three key reporting elements that each Trust is required to have in place by June 2014:

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

Update on Skill Mix Review

At the Board in April 2014 a full skill mix review was discussed and an £800k investment was agreed for ward nurse staffing levels. This money has being allocated to support the introduction of supervisory ward sisters, to provide 7-day senior cover through additional Band 6 nurses and to support wards whose nursing requirements were below 1:8 ratios where this had the potential to impact on care.

In undertaking the first review staffing levels were assessed and triangulated against quality indicator data. As the Trust continues to implement the agreed recommendations it will continue to evaluate the impact on the quality of care and staffing experience.

Further embedding of the Allocate e-rostering system will enable the use of SaferCare module which will enable nurse staffing hours to be assessed against the acuity and dependency levels of patients thus providing greater assurance on staffing levels. The system allows for flexibility in acuity tools to be used so they can be appropriate to the specific needs of an area. This module cannot be rolled out until the system is embedded into practice.

The supervisory role of ward sisters will commence with publication of rosters in July. In April a developmental session was held with the ward sisters to support their understanding of the concept of the supervisory role, and will continue to be supported through the use of action learning sets to ensure the maximum impact is gained from the introduction of this role in the delivery of safe quality care.

The Directorate Senior Nurses have worked with their teams to maximise the allocated investment into improving staffing ratios. The conversion of some Nursing Assistant (NA) posts to Registered Nurses (RN) has enabled additional areas to benefit from changes to staffing on night shifts.

The following changes in ward areas have been agreed:

Ward	Action	Impact
Chilmark	Convert NA to RN on late shift	Improved RN ratio on late shift
Laverstock	Additional RN x 3 nights per week Additional NA x 4 nights per week	Improved RN ratio on night shift and support with night shift
Amesbury	Additional NA on night shift	Improved NA support on night shift
Redlynch	Convert NA to RN on late shift Convert NA to RN on night shift	Improved RN ratios on late and night shift
Pitton	Convert NA to RN on late shift Additional RN on night shift	Improved RN ratios on late and night shift
Winterslow	Convert NA to RN on late shift	Improved RN ratio on late shift
Farley	Additional RN on long day shift and additional NA on night shift	Improved RN ratio on long day shift and increased NA support on night shift
Tamar	Additional RN on night shift	Improved RN ratio on night shift

The ward teams continue to focus on recruitment of staff to enable them to undertake the supervisory role alongside supporting the increase to staffing in some areas. Over the last couple of months a cohort of Spanish nurses have commenced in the Trust; a successful recruitment open day was held for student nurses due to qualify in September; Directorates have held their own recruitment events attracting mix of qualified and student nurses and progress continues to be made with the recruitment of nursing assistants.

Publishing of information at ward level:
Expectation 8 of the NQB guidance asks that NHS providers clearly display information about the nurses, midwives and care staff on each ward, clinical setting on each shift. Information should be made available to patients and the public that outlines which staff are present and what their role is. Information displayed should be visible, clear and accurate and should include the full range of support staff available on each ward.
Appendix 1 includes a copy of the board that will be displayed at the entrance to each ward from the beginning of June. It is our intention to further develop this to display additional information alongside to demonstrate the quality and safety of the ward. This will include the quality indicator information for each ward for the month ie infection control rates, pressure ulcer and falls data, friends and family information and complaints. This will provide overall re-assurance to patients and their families of the standard of care provided on the ward.

Monthly Reporting of Actual vs Planned Staffing Levels
The NQB guidance expectation 1 states that the Board should receive monthly updates on staffing levels. The monthly report needs to include the planned staff versus the actual staff on a shift by

shift basis and to advise of wards where staffing capacity and capability frequently falls short of what is required to provide quality care, the reasons why, the impact on quality and the action taken to address any gaps. It is anticipated that this report be completed as an exception report to avoid the need for numerous amounts of data being presented to Board and to more meaningfully describe and debate risks and mitigations. The Trust will publish this monthly exception report on the Trust website.

Due to the rollout of Allocate over the first quarter of this year the Trust has not been able to provide this detailed report, however 2 months of analysis of the data will be published at the next Board. Future utilisation of the SaferCare Module will enable much more detailed analysis of staffing levels analysed against patient need through the use of staffing tools, and supports expectation 3 of the guidance which is to use evidence-based tools to inform nursing, midwifery and care staffing capacity and capability.

On the 16th May NHS England announced their requirement for all Trusts to publish their staffing fill rates (actual vs planned) in hours for May on the NHS Choices Website in June. This data will be published on NHS Choices on the 24th June and will sit alongside a range of other safety data including CQC National Standards, Infection Control, Patients Assessed for Blood Clots, Responding to Patient Safety Alerts under the title of "How Safe is Your Hospital?". The data will be rated but the ratings/parameters have not yet been agreed by NHS England. Failure to upload the data onto UNIFY each month (first due by 10th May) will result in a Trust being given a red flag on NHS Choices indicating that no data is available, and regulatory bodies are likely to want to know the reasons for not publishing the data.

The data from May will not be available until the end of the first week of June and will be tabled at Board as part of this report for discussion.

Alongside this data being available on NHS Choices, the Trust is required to have a website page which includes the full data collection so the public can view all wards in one place for the Trust, the six monthly skill mix review containing the detail regarding capacity and capability of all wards, and the monthly Board report relating to planned versus actual staffing variances.

The Trust has experienced significant challenge in collating this data as the Allocate rostering system is not yet set up to provide the data required, the company will be providing a fix which will enable this in the future. As outlined previously improved data analysis will be available when the SaferCare module is rolled out. There is significant workload associated with the daily collection and validation of the data both at ward and Senior Nurse level as well as for the e-rostering team.
The data collated monthly also needs to include maternity and NICU staffing levels, these areas are currently not on the Allocate e-rostering system and so will require full manual data collection.

NICE Guidance
As highlighted in the skill mix review published in April the National Institute for Health and Care Excellence (NICE) have been asked to produce evidence based guidance on safe staffing and endorse tool for the setting of safe staffing levels in acute settings. The draft guidance has been published and is currently open for consultation until the 6th June. The draft indicates that there is no single nursing staff to patient ratio that can be applied across the wide range of wards to safely or adequately meet the nursing care needs of patients, and goes on to recommend that factors need to be systematically assessed at ward level when determining nursing staffing requirements, with the

nursing care needs of individual patients being the main driver. NICE are likely to endorse the Shelford Nurse acuity tool as the first endorsed tool for setting nurse staffing levels.

Action Required by the Board

As a result of this report the Board is asked to:

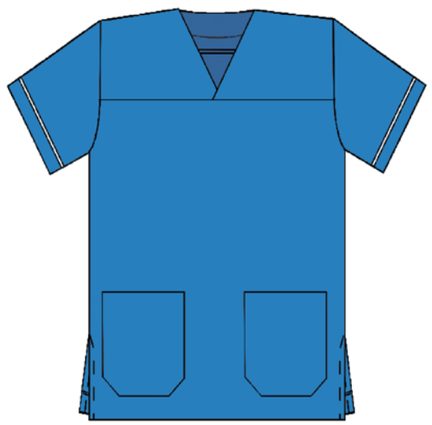
- Note the improvements which have been made to staffing levels as a result of the investment of £800k
- Agree the tabled planned vs actual staffing data which will be submitted to UNIFY on the 10th June
- Agree that there will be monthly exception reporting to Trust Board of planned versus actual staffing levels which will be published on the Trust website
- Agree the publication of this report on the Trust website to meet the requirement of publishing monthly staffing information

REDLYNCH WARD STAFF NUMBERS Today's Nurse in Charge is: .....

Date: Shift:

Today we planned to have: ..... Registered Nurses ..... Nursing Assistants

HOW MANY STAFF ARE WORKING TODAY?

Sisters / Charge Nurses		**Deputy Sisters / Charge Nurses**	
Staff Nurses / Assistant Practitioners	 **of which..... is / are agency staff**	**Nursing Assistants**	 **of which..... is / are agency staff**

This means there is 1 Registered Nurse for every ..... patients.

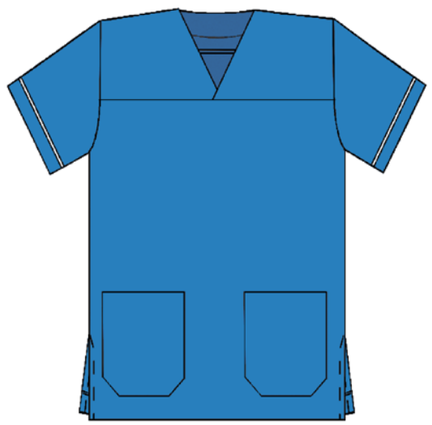
In addition to nursing staff our ward team includes Doctors, Therapists, Ward Clerk, Students and Cleaning staff.

SARUM WARD STAFF NUMBERS Today's Nurse in Charge is: .....

Date: Shift:

Today we planned to have: ..... Registered Nurses ..... Nursing Assistants

HOW MANY STAFF ARE WORKING TODAY?

Sisters / Charge Nurses		**Deputy Sisters / Charge Nurses**	
Staff Nurses / Assistant Practitioners	 **of which..... is / are agency staff**	**Nursing Assistants**	 **of which..... is / are agency staff**

In addition to nursing staff our ward team includes Doctors, Play Therapist, Therapists, Ward Clerk, Students and Cleaning staff.

PAPER - SFT 3540

MINUTES FROM THE FINANCE COMMITTEE MEETING HELD ON 22 APRIL 2014

PURPOSE

To present these approved minutes to the Board to provide assurance on the range of issues the Finance Committee has examined on the Board's behalf and to indicate the conclusions reached and direction given.

MAIN ISSUES

The committee noted the work in progress to bring down waiting times for orthopaedics. It has looked at how additional income earned in 2013/14 had affected the Trust's final position. The VAT changes described at the meeting (page 3) are now understood to have been withdrawn. The committee approved the Trust's Monitor return for quarter 4 with the associated future declarations.

ATTACHMENTS AVAILABLE TO VIEW ON WEBSITE

The approved minutes from the meeting held on 22 April 2014

ACTION REQUIRED BY THE BOARD

The Board is asked to note the minutes and the decisions taken by the Finance Committee.

Nick Marsden
Chairman

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance Committee
Held on 22 April 2014

Present:	Dr N Marsden	Chairman
	Mr A Freemantle	Non-Executive Director
	Mr P Hill	Chief Executive
	Dr L Brown	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
In Attendance:	Mrs C Gorzanski for item '4'	Head of Clinical Effectiveness
Apologies:	Mr I Downie	Non-Executive Director
	Ms K Hannam	Chief Operating Officer

1. MINUTES

The minutes of the meeting held on 24 March 2014 were agreed as a correct record.

2. MATTERS ARISING

Trauma and Orthopaedic Waiting Times

It was noted that work had been commissioned to address waiting times and this was due to report in June.

PH would report back on the review of Private Patient Procedures being conducted by OPCL which was understood to be nearing completion.

Committee members received a note from MC setting out the relationship between the Trust's income, excess activity and increased nursing costs.

3. PROGRESS WITH CQUIN OBJECTIVES

The Committee received the report giving the year end position for 2013/14 and the current status of 2014/15 CQUINs

2013/14

The Trust's high level of achievement of the 2014 CQUIN was recognised and the Trust had only missed out on two of the schemes in the standard acute contract and specialised commissioning contract relating to the safety thermometer and dementia screening.

2014/15

Standard acute contracts for 2014/15 were agreed in relation to the Friends and Family test, reduction of new pressure ulcers and dementia screening.

Four local CQUINs had been agreed with Wiltshire and Dorset including Ceiling of treatment in the end of year pathway, Sepsis 6, antibiotic prescribing and functional movement in hospital for elderly care patients.

For West Hants CCG four CQUINs had been agreed for outpatient follow ups, reducing delay transfers of care, reducing ward moves and time to arrival to initial consultant assessment. These were supported by specialist CQUINs for

2014/15 that were agreed – reducing chemotherapy wastage, improved access to breast milk in pre term infants, patient held records, quality dashboards and the three national CQUINs.

The Committee noted the CQUIN report.

4. MONITOR Q4 RETURN TARGETS AND INDICATORS AND QUALITY

The Committee received a report setting out the draft quarterly return for Monitor.

Under Quality the Trust would declare one Director resignation during the Quarter in respect of Tracey Nutter. The Monitor template required a commentary to any changes.

For targets and indicators there was no CQC activity and all targets for Quarter 4 have been met.

The Chairman and Chief Executive were required to submit to Monitor declarations that the Board anticipate it will be able maintain a continuity of service rating of at least three for the next twelve months, that plans are in place to ensure on-going compliance with all existing targets, and commitment to comply with all known targets going forward and that there were no matters requiring an exception report which had not already been reported (details of examples of exception reports were provided).

The Committee approved the Monitor Q4 submission.

5. FINANCE REPORT - TO 31 MARCH 2014

The Committee received the Finance Report to 31 March 2014 (subject to Audit). It was noted that the figures shown included Odstock Medical and Salisbury Trading but not the hospital charity or Replica 3D.

The Trust had slightly exceeded its plan but concern remained that in meeting financial targets there was over reliance on excess income. It was becoming more difficult to achieve savings and there may be a tighter financial situation later in the year with the CCGs.

The cash position had improved and the continuity of service rating was considered to be a four.

There continued to be more activity through outpatients and day cases, some of which was driven by better coding.

Spend on nursing agency was reducing but was still considered to be high similarly the expenditure on agency doctors was over budget.

Following the completion of the internal audit review of compliance with standing financial instructions MC was discussing how to act on the findings to improve compliance.

On local contracts the contract with Dorset CCG was awaiting signature, the Wiltshire contract had been progressing slowly in recent weeks and no documentation had been received so far from the specialist commissioners.

The VAT issue highlighted at the previous meeting was ongoing and amounted to a £½bn tax on the National Health Service if it went forward in its current form. The Foundation Trust Network were aware of this position.

The Trust had been unsuccessful in recruiting a Deputy Director of Finance and it was disappointing that there had been no interest arising from within the National Health Service. Hays continued their executive search to find a suitable candidate.

In relation to cost improvement programmes it was agreed that there should be a separate monthly agenda item in this regard.

The Committee noted the Finance Report.

6. GP REFERRAL/MARKETING INTELLIGENCE

Alison Herod attended for this item and the Committee received the Quarterly Market Intelligence Report.

The Committee discussed progress with tendering activities and further opportunities to support and develop provision in West Wiltshire. The Committee noted the Market Intelligence Report.

7. ASSURANCE FRAMEWORK AND RISK REGISTER

Fenella Hill attended for this item and the Committee received the Quarterly Report on the Assurance Framework and Risk Register. Gaps and positive assurances principally related to failure to secure income and specifically to deliver the required levels of savings. Positive assurances reflected the signing of 2014/15 contracts.

8. ANY OTHER BUSINESS

Avastin/Lucentis

It was suggested that the Committee would need to revisit this issue.

8. DATE OF NEXT MEETING

Tuesday 27 May 2014 at 9.30 am in the Boardroom.

SALISBURY NHS FOUNDATION TRUST BOARD

PERFORMANCE TO 30 APRIL 2014

PURPOSE:

To inform the Board of the financial and contracting position to 30 April 2014.

MAIN ISSUES

1. GENERAL

The report shows a summarised position for April due to the effect of closing the old year accounts and the on-going contract discussions.

Key indicators of performance for the period to 30 April 2014 are summarised below and detailed in Appendix 1.

	FT Plan to 30.04.14	Actual To 30.04.14	% of Plan to 30.04.14
EBITDA £m	1.231	1.229	1.00
I & E (Deficit)/Surplus £m*	-0.002	0.021	
Total spells	4,746	5,103	1.08
Outpatient attendances	18,977	19,065	1.00
A&E Attendances	3,586	3,565	0.99
RAF Rating	4	4	

*Including donated assets treated as income under new rules

I & E Summary £m	FT Plan to 30.04.14	Actual to 30.04.14
I & E (Deficit)/Surplus - Trust	-0.035	0.021
I & E Surplus – Net Donated income	0.033	0.000
Total I & E (Deficit)/Surplus	**-0.002**	**0.021**

The above figures represent just the Trust's performance and plan for April 2014. They exclude the results of the Trust's subsidiary companies, Salisbury Trading Limited and Odstock Medical Limited for the month. The consolidated figures will be included in the report for the quarter to 30 June 2014.

The April plan figures are derived from the 2-year plan submitted to Monitor in early April.

Operating income is £15.70m, which is marginally above the FT plan of £15.68m (Appendix 2). Operating expenditure within EBITDA amounted to £15.22m against a plan of £15.25m.

EBITDA is £1.229m which is in line with the plan of £1.231m.

A surplus of £0.021m has been achieved against a planned deficit of £0.002m

Net current assets amounted to £10.54m against a plan of £10.47m, with a cash balance of £16.9m against a plan of £16.8m.

Discussions with Wiltshire CCG are well advanced and the contract is being finalised. The financial value has been set at £86.24m. The contract will be cost and volume for all services covered by the national tariff.

The contract with Dorset CCG has been agreed and signed at a value of £18.36m. This contract is on a cap and collar basis with risk sharing.
Financial values have been agreed with the various Hampshire CCGs. The value of the most significant of these, West Hampshire CCG, has reduced to reflect the lower activity levels experienced in 2013-14. However, it has been agreed this contract can be varied by a maximum of £500k up or down, depending on performance.

A contract value of £27.39m has been agreed with the Specialist Commissioners, which is based on 2013-14 outturn. The value of the Military contract has also increased to reflect the overperformance last year. The Military Commissioners are not anticipating significant over performance this year as there is not expected to be any population increase in 2014-15.

2. SALES

Elective inpatient activity in April was similar to the same month last year whilst elective daycases were below the same period last year.

Non-elective activity levels were higher than in April 2013 with increases in a number of specialties.

Outpatient activity was slightly below the level experienced at this stage last year but the numbers were ahead of plan and there was one less working day in the month than in 2013.

Neonatal care was 193 'badger' days compared with 143 in April 2013, which was a fairly low month.

Critical care and Spinal activity (both paid on a bed day basis) was well ahead of the April 2013 figure. Burns activity was considerably down on the same month last year, but April was the highest month in 2014.

Performance v 2013/14 actual and 2014/15 plans	**Actual M1 2013/14**	**Actual M1 2014/15**	**FT plan M1 2014/15**	***Comm plan M1 2014/15**	**FT plan Variance M1 2014/15**	***Comm plan Variance M1 2014/15**
Elective: Inpatients	471	475	516	506	-41	-31
Elective: Daycases	2,615	2,544	2,191	2,530	353	14
Non-elective spells	1,960	2,084	2,039	2,068	45	16
Outpatient: Initial attend	5,293	5,532	5,238	5,238	294	294
Outpatient: Follow-up attendances	10,530	10,536	10,984	10,984	-448	-448
Outpatient procedures	3,528	2,997	2,755	2,755	242	242
Total Outpatient	19,351	19,065	18,977	18,977	88	88
A&E Attendances	3,800	3,565	3,586	3,586	-21	-21

***Comm = Commissioning plan (CCGs, Specialist Services and Military)**

3. COST OF SALES INCLUDING INDIRECT COSTS

All pay and non-pay costs and provisions have been fully accrued, and inflation and other reserves, including agreed cost pressures, have been added to budgets as appropriate. The total for all Directorates is an overspend position of £105k. The position is summarised below:

Directorate	**Net Budget to 30.04.14 £000**	**Net Expend to 30.04.14 £000**	**Variance to 30.04.14 £000**
			[+ over/- under]
Medicine	3,169	3,216	47
Musculo Skeletal	2,436	2,423	-13
Surgery	2,428	2,438	10
Clinical Support & Family	2,658	2,737	79
Facilities	370	365	-5
Sub-Total	**11,061**	**11,179**	**118**

Other Directorates	1,552	1,539	-13
TOTAL	**12,613**	**12,718**	**105**

The areas overspent this month are Spinal (agency junior doctor cover), Radiology (agency consultant due to vacancies), Obstetrics (agency junior doctor cover), Gynaecology (agency junior doctor cover), Elderly Care and Stroke (agency junior doctor cover), ENT (agency consultant due to vacancy) and Ophthalmology (agency consultant due to vacancy).

At the end of Month 1 nursing and healthcare assistant budgets are overspent by £40k. Nursing has been allocated £1million for budget uplift during 2014/15 and the Interim Director of Nursing and Directorate Senior Nurses are currently working through the proposals for its use. Part of this funding will be allocated to 'Specialing' (sum to be finalised). In Month 1, £72k was spent on 'Specialing' patients. In Month 1 £3, 624k was spent on nurses and healthcare assistants compared to £3,538k for the same month last year, an increase of £86k, which is concerning given the increase in 2013/14 compared with 2012/13. The use of Agency staff for nursing and healthcare assistants was £189k in April compared to 279k for the same month last year, a decrease of £90k. This is welcome but we will need to improve further throughout the financial year.

At the end of Month 1, Medical budgets are overspent by £30k. In month 1, £91k has been spent on agency consultants and £156k on agency junior doctors.

4. STATEMENT OF FINANCIAL POSITION (BALANCE SHEET)

The Trust's cash position at 30 April was £16.9m, which was marginally above plan. Interest earned was £5k.

Non-current receivables of £3.33m represent loans to the Trust's subsidiary company, Salisbury Trading Limited (STL). As previously reported, these are repayable over 5 to 10 years periods commencing in April 2015. These loans are removed when consolidated accounts are compiled.

The Capital Programme expenditure for the period to 30 April 2013 was £631k against a plan of £13.2m (Appendix 3).

5. COST IMPROVEMENT PLANS

Cost improvement savings targets for the year total £9.0m, which includes revenue generation and expenditure reduction schemes. Monitor requires revenue generation and expenditure reduction to be separately reported.

The savings achieved during April are £364k, against a phased plan for the month of £397k (91.7%), and of the achieved savings 56% are recurring. If phasing is removed the savings target would be £750k and therefore only 48.5% was achieved. It is important to consider this to avoid a situation whereby savings planned for the year end do not materialise and undermine the Trust's financial position.

6. RISKS

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

- Deliver the CIP target – this is probably the greatest financial challenge
- Meet contractual obligations and avoid penalties
- Meet CQUIN targets
- Manage budgets effectively particularly in respect of: nursing agency and 'specialing' costs, and locum doctors and additional payments to doctors
- Match capacity to demand in the most cost effective way in order to avoid losing work to local competitors

7. CONTRACT DISCUSSIONS FOR 2014/15 AND OTHER ISSUES

7.1 Contracts: Some minor contracts and the contract with Dorset CCG are signed. We are moving forward with the remainder of the contracts and it is not expected that there will be any major issues to stop us signing. The emphasis is payment under PbR tariff and we will discuss some level of risk share with Wiltshire CCG.

7.2 Transfer of Vascular Services to RBH: This transfer may cost up to £1m in lost income. Most non-elective work has transferred but a lot of elective work remains with SFT at the moment. The actual amount which transfers will depend on di scussions on-going to retain some of this activity at SDH and the ability of RBH to safely undertake all the work. Discussions are taking place with the Specialist Commissioners and RB&C FT regarding transfer of contract value.

8. CONCLUSION

The Trust has a surplus at Month 1 of £21k, which is slightly ahead of the planned position. The finance risk rating is 4.

9. RECOMMENDATION

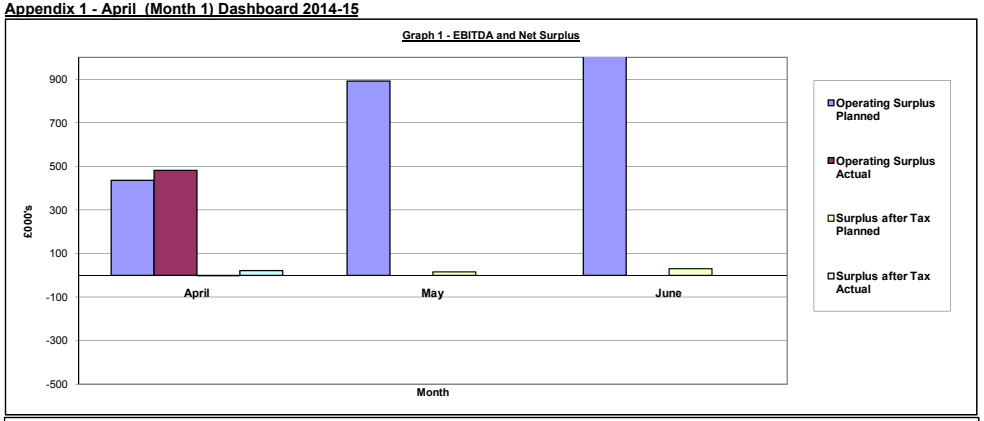
The Trust Board is asked to consider the position at 30 April 2014.

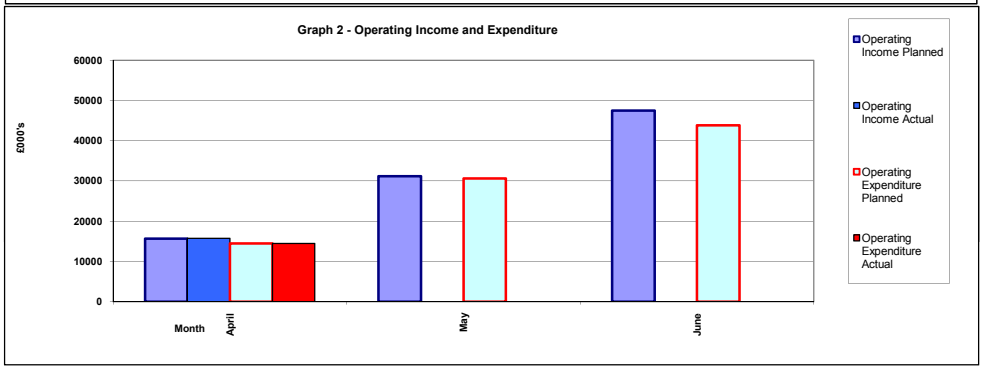
Malcolm Cassells
Director of Finance
27 May 2014

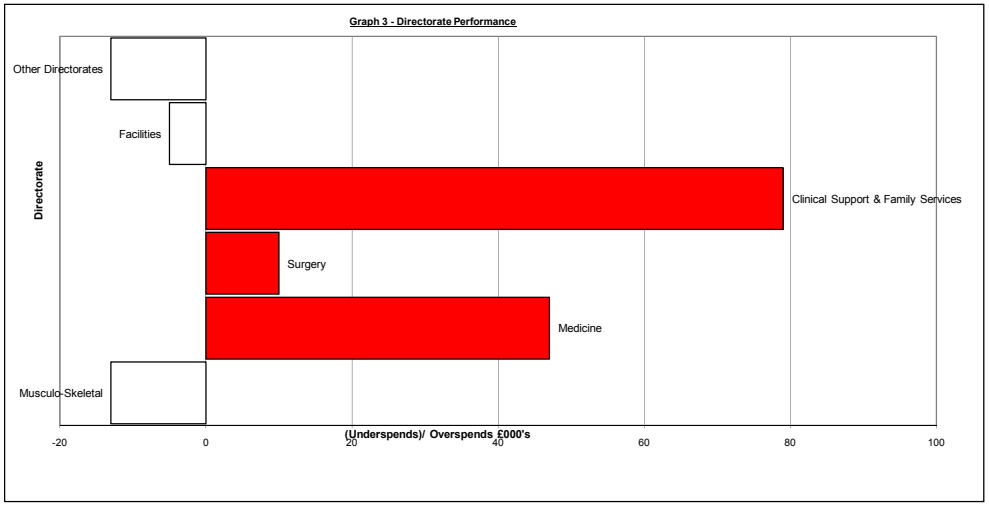
ATTACHMENTS TO VIEW ON WEBSITE

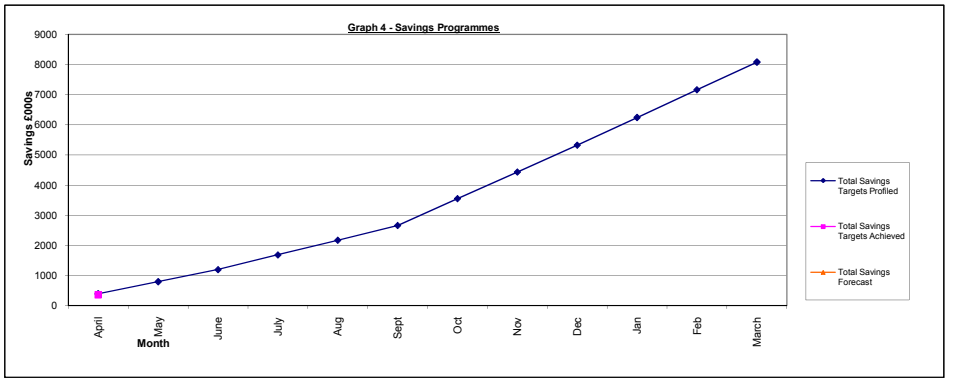
Appendix 1 – Summary Financial Activity and Budget position
Appendix 2 – Income & Expenditure
Appendix 3 – Capital Programme

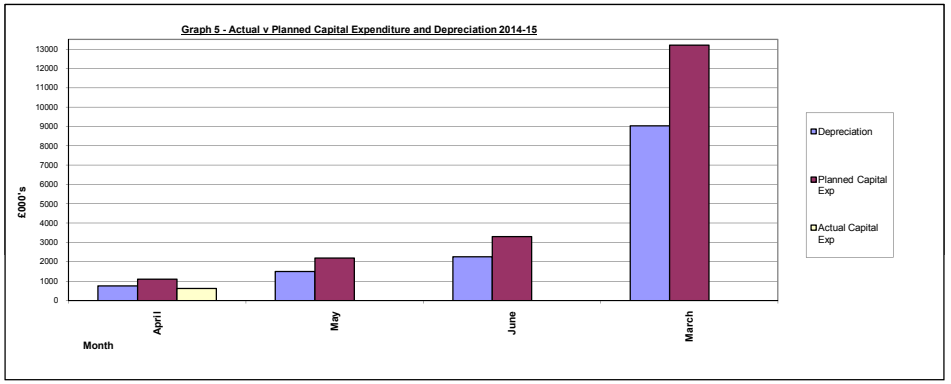
Appendix 1 - April (Month 1) Dashboard 2014-15











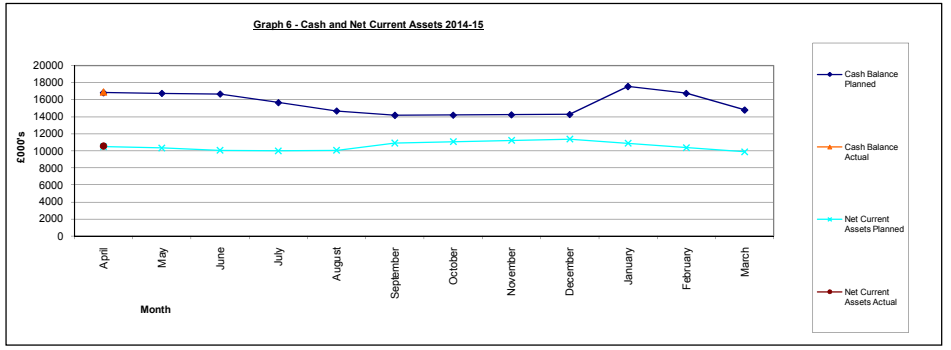


Table 2 New FRR

Ratio	Description	Planned Risk Score	Actual			Rating	Risk Ratings
Capital Service Capacity	Revenue Avaliable for Debt Service Divided by Capital Service Costs	4	769.00 465.00	=	1.65	3	50%
Liquidity	cash for liquidy puposes*360 divided by operating expenses	4	719.00 14469.00	=	17.89	4	50%
Total Weighted Score		**4.0**				**4.0**	**100%**

				Actual Year 2013/14 £M	Plan April £m	Actual April £m	Variance April £m
Operating							
NHS Clinical Revenue							
NHS Acute Activity Income							
Elective inpatients							
Tariff revenue	£m	(+ve)		18.665	1.592	1.369	-0.223
Non-Tariff revenue	£m	(+ve)		0.100	0.009	0.003	-0.006
Elective activity revenue, Total	£m			**18.765**	**1.601**	**1.372**	**-0.229**
Elective day case patients (Same day)							
Tariff revenue	£m	(+ve)		16.944	1.263	1.511	0.248
Non-Tariff revenue	£m	(+ve)		1.263	0.100	0.063	-0.037
Elective Day Case activity revenue, Total	£m			**18.207**	**1.362**	**1.574**	**0.212**
Non-Elective patients							
Tariff revenue	£m	(+ve)		46.673	3.308	3.263	-0.045
Non-Tariff revenue	£m	(+ve)		16.542	0.897	0.864	-0.033
Non-Elective activity revenue, Total	**£m**			**63.215**	**4.205**	**4.127**	**-0.078**
Outpatients							
Tariff revenue	£m	(+ve)		27.050	2.101	1.905	-0.196
Non-Tariff revenue	£m	(+ve)		2.651	0.213	0.210	-0.003
Outpatients activity revenue, Total	**£m**			**29.701**	**2.314**	**2.115**	-0.199
A&E							
Tariff revenue	£m	(+ve)		4.915	0.386	0.405	0.019
Non-Tariff revenue	£m	(+ve)		0.000	0.000	0.000	0.000
A&E activity revenue, Total	**£m**			**4.915**	**0.386**	**0.405**	**0.019**
Other NHS activity							
Direct access & Op, all services	£m	(+ve)		2.688	0.228	0.296	0.068
Unbundled chemotherapy delivery	£m	(+ve)		0.819	0.073	0.056	-0.017
Unbundled external beam radiotherapy	£m	(+ve)		0.000	0.000	0.000	0.000
Maternity Pathway tariff	£m	(+ve)		0.000	0.726	0.762	0.036
Other tariff revenue	£m	(+ve)		0.134	0.019	0.015	-0.004
Tariff revenue	£m	(+ve)		3.641	1.046	1.129	0.083
CQUIN revenue	£m	(+ve)			0.271	0.335	0.064
Diagnostic tests & Imaging revenue outside tariff	£m	(+ve)			0.318	0.276	-0.042
Critical care (outside tariff) Adult, Neonate, Paediatric	£m	(+ve)			0.508	0.492	-0.016
High cost drugs revenue from commissioners	£m	(+ve)			0.883	1.135	0.252
Other drugs revenue (all types all bands including Chemotherapy)	£m	(+ve)			0.000	0.000	0.000
Other non-tariff revenue	£m	(+ve)			1.029	0.931	-0.098
Non-Tariff revenue	£m	(+ve)		33.073	3.008	3.169	0.161
Other NHS activity revenue, Total	**£m**			**36.714**	**4.054**	**4.298**	**0.244**
Total NHS Tariff income	**£m**			**117.888**	**9.697**	**9.582**	-0.115
Total NHS Non-Tariff income	**£m**			**53.629**	**4.227**	**4.309**	0.082
NHS Acute Activity Income, Total	**£m**			**171.517**	**13.923**	**13.891**	-0.032
Sub-total NHS Clinical Revenue	**£m**			**171.517**	**13.923**	**13.891**	-0.032
CHANGE **Contract penalties or adjustments not included above**	**£m**	**(+ve)**		**0.000**	**0.000**	**0.000**	0.000
NHS Clinical Revenue, Total	**£m**			**171.517**	**13.923**	**13.891**	-0.032
Non Mandatory/Non protected revenue							
Private patient revenue	£m	(+ve)		1.865	0.059	0.145	0.086
Other Non Mandatory/Non protected clinical revenue	£m	(+ve)		5.572	0.305	0.260	-0.045
Non Mandatory/Non protected revenue, Total	**£m**			**7.437**	**0.365**	**0.405**	**0.040**
Other Operating Revenue							
Research and development revenue	£m	(+ve)		0.789	0.060	0.088	0.028
Education and training revenue	£m	(+ve)		5.260	0.421	0.466	0.045
PFI specific revenue	£m	(+ve)		0.000	0.000	0.000	0.000
Donations & Grants received of PPE & intangible assets (see comment)	£m	(+ve)		0.000	0.000	0.000	0.000
Donations & Grants received of cash to buy PPE & intangible assets	£m	(+ve)		0.648	0.033	0.000	-0.033
Donations& Grants received of PPE & intangibles	£m	(+ve)		**0.648**	**0.033**	**0.000**	**-0.033**
Parking revenue	£m	(+ve)		1.276	0.106	0.111	0.005
Catering revenue	£m	(+ve)		0.861	0.073	0.071	-0.002
Accommodation revenue	£m	(+ve)		1.296	0.106	0.107	0.001
Revenue from non-patient services to other bodies	£m	(+ve)		0.959	0.492	0.139	-0.353
Misc. other operating revenue	£m	(+ve)		4.226	0.106	0.420	0.314
Other Operating revenue, Total	**£m**			**15.315**	**0.881**	**0.848**	**-0.033**
Operating Revenue, IFRS, Total	**£m**			**194.269**	**15.683**	**15.698**	**0.015**
Operating Expenses							
Raw Materials and Consumables Used							
Drugs	£m	(-ve)		-14.704	-1.338	-1.328	0.010
Clinical supplies	£m	(-ve)		-19.221	-1.478	-1.503	-0.025
Decrease (increase) in inventories of finished goods & WIP	£m	(-ve)		0.000	0.000	0.000	0.000
Vehicle Fuel costs (ambulance trusts)	£m	(-ve)		0.000	0.000	0.000	0.000
Non-clinical supplies	£m	(-ve)		-17.890	-1.391	-1.357	0.034
Raw Materials and Consumables Used, Total	**£m**			**-51.815**	**-4.207**	**-4.188**	**0.019**
Cost of Secondary Commissioning of mandatory services	£m	(-ve)		-2.595	-0.216	-0.257	-0.041
Employee Expenses [was "Pay"]							
Employee expenses, permanent staff	£m	(-ve)		-113.833	-9.319	-9.251	0.068
Employee expenses, agency & contract staff	£m	(-ve)		-6.038	-0.556	-0.567	-0.011
Employee Expenses, Total	**£m**	**(-ve)**		**-119.871**	**-9.874**	**-9.818**	**0.056**
Research & Development expense	£m	(-ve)		-0.449	-0.033	-0.027	0.006
Education and training expense	£m	(-ve)		-0.348	-0.025	-0.014	0.011
Consultancy expense	£m	(-ve)		-0.330	-0.027	-0.020	0.007
Misc. other Operating expenses	£m	(-ve)		-1.182	-0.055	-0.038	0.017
(Increase)/decrease in Provisions, Current and Non-Current, net	£m	(+/-ve)		-0.084	0.000	0.000	0.000
(Increase)/decrease in Impairment of receivables, Current and Non-Current, net	£m	(+/-ve)		-0.105	0.066	0.000	-0.066
PFI operating expenses							
PFI unitary payment	£m	(-ve)		-0.935	-0.081	-0.107	-0.026
IFRIC12 revenue/(expense) adjustment	£m	(+/-ve)		0.000	0.000	0.000	0.000
Other PFI expenses	£m	(-ve)		0.000	0.000	0.000	0.000
PFI operating expenses, total	**£m**	**(-ve)**		**-0.935**	**-0.081**	**-0.107**	**-0.026**

Operating Expenses within EBITDA, Total	**£m**		**-177.714**	**-14.451**	**-14.469**	**-0.018**
Depreciation and Amortisation						
Depreciation and Amortisation - owned assets	£m	(-ve)	-8.282	-0.713	-0.668	0.045
Depreciation and Amortisation - donated assets	£m	(-ve)	-0.334	-0.028	-0.033	-0.005
Depreciation and Amortisation - owned assets			**-8.616**	**-0.742**	**-0.701**	**0.041**
Depreciation and Amortisation - assets held under finance leases	£m	(-ve)	-0.062	-0.005	-0.005	0.000
Depreciation and Amortisation - PFI assets	£m	(-ve)	-0.493	-0.048	-0.042	0.006
Depreciation and Amortisation, Total	**£m**		**-9.171**	**-0.795**	**-0.748**	**0.047**
Impairment (Losses) / Reversals net (on non-PFI assets)	£m	(-/+ve)	0.000	0.000	0.000	0.000
Impairment (Losses)/ Reversals net on PFI assets	£m	(-/+ve)	0.000	0.000	0.000	0.000
Restructuring Costs	£m	(-ve)	0.000	0.000	0.000	0.000
Operating Expenses excluded from EBITDA, Total	**£m**	**(-ve)**	**-9.171**	**-0.795**	**-0.748**	**0.047**
Operating Expenses IFRS, Total			**-186.885**	**-15.246**	**-15.217**	**0.117**
Surplus (Deficit) from Operations			**7.384**	**0.436**	**0.481**	**0.132**
Non Operating						
Non-Operating income						
Finance Income [for non-financial activities]						
Gain (Loss) on Financial Instruments Designated as Cash Flow Hedges	£m	(+ve)	0.000	0.000	0.000	0.000
Gain (Loss) on Derecognition of Available-for-Sale Financial Assets	£m	(+ve)	0.000	0.000	0.000	0.000
Gain (Loss) on Derecognition of Non-Current Assets Not Held for Sale, Tota	£m	(+ve)	0.000	0.000	0.000	0.000
Gain (Loss) on Investments & Inv.Property (NOT charitable funds)	£m	(+ve)	0.000	0.000	0.000	0.000
Interest Income	£m	(+ve)	0.068	0.006	0.005	-0.001
Dividend Income	£m	(+ve)	0.000	0.000	0.000	0.000
Share of profit (loss) from equity accounted Associates, Joint Ventures						
Share of Private Patient Income from equity accounted Associates, Joint Ventures	£m	(+ve)	0.000	0.000	0.000	0.000
Share of non Private Patient Income from equity accounted Associates, Joint Ventur	£m	(+ve)	0.000	0.000	0.000	0.000
Share of expenses from equity accounted Associates, Joint Ventures	£m	(-ve)	0.000	0.000	0.000	0.000
Share of profit (loss) from equity accounted Associates, Joint Ventures, Tota	£m		0.000	0.000	0.000	0.000
Finance Income [for non-financial activities], Total	**£m**		**0.068**	**0.006**	**0.005**	**-0.001**
Other Non-Operating income	£m					
Gain/(loss) on asset disposals	£m	(+/-ve)	0.000	0.000	0.000	0.000
Income of NHS Charitable funds (if consolidated)	£m	(+ve)	0.000	0.000	0.000	0.000
Gain (Loss) of NHS Charitable funds' investments (if consol.)	£m	(+ve)	0.000	0.000	0.000	0.000
Other Non-Operating income	£m	(+ve)	0.000	0.000	0.000	0.000
Other Non-Operating income, Total	**£m**		**0.000**	0.000	0.000	0.000
Non-Operating income, Total	**£m**		**0.068**	**0.006**	**0.005**	**-0.001**
Non-Operating expenses						
Finance Costs [for non-financial activities]						
Interest Expense						
Interest Expense on Overdrafts and Working Capital Facilities	£m	(-ve)	0.000	0.000	0.000	0.000
Interest Expense on Bridging loans	£m	(-ve)	0.000	0.000	0.000	0.000
Interest Expense on Non-commercial borrowings	£m	(-ve)	-0.028	-0.001	-0.001	0.000
Interest Expense on Commercial borrowings	£m	(-ve)	0.000	0.000	0.000	0.000
Interest Expense on Finance leases (non-PFI)	£m	(-ve)	-0.026	-0.002	-0.002	0.000
Interest Expense on PFI leases & liabilities	£m	(-ve)	-1.908	-0.160	-0.145	0.015
Interest Expense, Total	**£m**		**-1.962**	**-0.163**	**-0.148**	**0.015**
Other Finance Costs	£m	(-ve)	-0.010	0.000	0.000	0.000
PDC dividend expense	£m	(-ve)	-3.510	-0.281	-0.317	-0.036
Finance Costs [for non-financial activities], Total	**£m**		**-5.482**	**-0.444**	**-0.465**	**-0.021**
Other Non-Operating expenses						
Non-Operating PFI costs (eg contingent rent)	£m	(-ve)	0.000	0.000	0.000	0.000
Other Non-Operating expenses (developments)	£m	(-ve)	0.000	0.000	0.000	0.000
Misc Other Non-Operating expenses	£m	(-ve)	0.000	0.000	0.000	0.000
Non-Operating expenses, Total	**£m**		**-5.482**	**-0.444**	**-0.465**	**-0.021**
Surplus (Deficit) before Tax	£m		1.970	-0.002	0.021	0.023
Income Tax (expense)/ refund	£m	(-/+ve)	0.000	0.000	0.000	0.000
Surplus (Deficit) After Tax	**£m**		**1.970**	**-0.002**	**0.021**	**0.023**
Profit/(loss) from discontinued Operations, Net of Ta›	£m	(+/-ve)	0.000	0.000	0.000	0.000
Surplus (Deficit) After Tax from Continuing Operations	**£m**		**1.970**	**-0.002**	**0.021**	**0.023**
Elements of Comprehensive Income						
Share of comprehensive income from associates and joint ventures	£m	(+/-ve)	0.000	0.000	0.000	0.000
Revaluation gains/(losses) straight to revaluation reserve	£m	(+/-ve)	0.000	0.000	0.000	0.000
Impairments/(reversals) straight to revaluation reserve	£m	(+/-ve)	0.104	0.000	0.000	0.000
Fair Value gains/(losses) straight to reserves	£m	(+/-ve)	9.904	0.000	0.000	0.000
Additions/(reduction) in "Other reserves"	£m	(+/-ve)	0.000	0.000	0.000	0.000
Other recognised gains and losses	£m	(+/-ve)	0.000	0.000	0.000	0.000
Actuarial gains/(losses) on defined benefit pension schemes	£m	(+/-ve)	0.000	0.000	0.000	0.000
Total			**10.008**	**0.000**	**0.000**	**0.000**
Total Comprehensive Surplus/(Deficit)			**11.978**	**-0.002**	**0.021**	**0.023**
Memorandum lines						
Total Revenue	£m		194.337	15.689	15.703	0.014
Total Expenses	£m		-192.367	-15.690	-15.682	0.008
Total Operating Revenue for EBITDA	£m		194.269	15.683	15.698	0.015
Total Operating Expenses for EBITDA	£m		-177.714	-14.451	-14.469	-0.018
EBITDA (for FRR calculation)	£m		16.555	1.231	1.229	-0.002
EBITDA Margin Metric (YTD)	£m		8.52%	7.85%	7.85%	0.000
Operating Surplus (Deficit)	£m		7.283	0.436	0.481	0.045
Surplus (Deficit) After Tax (for FRR calculation)	£m		1.869	-0.002	0.021	0.023

Cost Centre	Project Name	Area	Board Approved 2014/15	Schemes B/Fwd to 2013/14	Slippage from 2013/2014	14/15 Board Approved + 13/14 final slippage - 13/14 b/fwd	Adjustments to final Plan	Brought Forward from 2015/16	Slippage to 2015/16	Revised Plan	Spend to 30th April 2014	Under/(Over) spent on Project	Outstanding Spend 2014/15
1	**Donated Assets**												
7082C0	Benson Suite - Donated	A1	0	0	16,138	16,138	0	0	0	16,138	0		16,138
7081C0	NICU / Parents Accommodation - Donated Assets	A1	0	0	15,769	15,769	0	0	0	15,769	0		15,769
1	**Donated Assets - Totals**		**0**	**0**	**31,907**	**31,907**	**0**	**0**	**0**	**31,907**	**0**	**0**	**31,907**
2	**Phase 3 Building Schemes**	BWG		0									
7230C0	CT Scanner Building and Enabling	A2	155,000	-5,530	0	149,470	0	0	0	149,470	1,346		148,124
7067C0	Helter Skelter Storage	A2	150,000	0	0	150,000	0	0	0	150,000	0		150,000
7085C0	Laundry Buildings	A2	0	0	56,636	56,636	0	0	0	56,636	0		56,636
7084C0	Maternity - DoH Grant	A2	0	0	30,367	30,367	0	0	0	30,367	56,749	-26,382	0
7073C0	Radnor Ward Development	A2	1,168,000	0	0	1,168,000	0	0	0	1,168,000	0		1,168,000
7087C0	Springs entrance development	A2	400,000	0	989,924	1,389,924	0	0	0	1,389,924	0		1,389,924
7086C0	Ward changes - Dementia Patient Care	A2	230,000	0	397,156	627,156	0	0	0	627,156	11,316		615,840
2	**Building Schemes - Totals**	**0**	**2,103,000**	**-5,530**	**1,474,083**	**3,571,553**	**0**	**0**	**0**	**3,571,553**	**69,411**	**-26,382**	**3,528,524**
3	**Building and Works**	BWG		0									
7014C0	Accommodation - Langley House Kitchen Upgrade	BWG	29,000	0	0	29,000	0	0	0	29,000	0		29,000
7009C0	Accommodation - Replacement glazing units	BWG	0	0	3,023	3,023	0	0	0	3,023	0		3,023
7035C0	Accommodation & Leisure Centre Boilers	BWG	100,000	-24,072	0	75,928	17,500	0	0	93,428	0		93,428
7040C0	Accommodation key security	BWG	0	0	7,000	7,000	0	0	0	7,000	0		7,000
7088C0	AGSS Overhaul & Med Gas Racking	BWG	0	0	15,000	15,000	0	0	0	15,000	0		15,000
7041C0	AHU replacement yr 3 (2014/15) of 7	BWG	280,000	0	140,593	420,593	0	0	0	420,593	0		420,593
7042C0	Asbestos management	BWG	0	0	22,217	22,217	0	0	0	22,217	0		22,217
7814C0	BMS upgrade 3rd year of 3 - invest to save	BWG	0	0	42,679	42,679	0	0	0	42,679	31		42,648
7043C0	Catering boiling pan replacement	BWG	0	0	3,153	3,153	0	0	0	3,153	0		3,153
7008C0	Catering Dishwasher	BWG	126,000	0	0	126,000	0	0	0	126,000	0		126,000
7044C0	Catering refrigeration upgrade	BWG	0	0	27,427	27,427	0	0	0	27,427	0		27,427
7090C0	Catering Replacement Cooking Equipment	BWG	0	0	9,175	9,175	0	0	0	9,175	0		9,175
7046C0	Catheter Suite - Rebalance of Heating System	BWG	20,000	0	0	20,000	0	0	0	20,000	0		20,000
7091C0	Childrens OPD Audiology Soundproof Room	BWG	0	0	72,043	72,043	0	0	0	72,043	34,751		37,292
7092C0	DSU Replacement Insulation to Air Handling System	BWG	0	0	8,600	8,600	0	0	0	8,600	0		8,600
7010C0	DSU Theatres - Flooring	BWG	0	0	1,882	1,882	0	0	0	1,882	0		1,882
7093C0	Ductwork & Fire Damper Cleaning Whole Site 2nd year of 2	BWG	70,000	0	119,508	189,508	0	0	0	189,508	0		189,508
7066C0	ED Data Centre Ventilation	BWG	40,000	0	0	40,000	0	0	0	40,000	0		40,000
7094C0	Education Centre Reception DDA Compliance	BWG	0	0	8,000	8,000	0	0	0	8,000	0		8,000
7828C0	Electricity at Work Regulations Compliance - Year 3 (2013/14) of 3	BWG	0	0	133,505	133,505	0	0	0	133,505	1,161		132,344
7012C0	Endoscopy Ensuite Enema Room	BWG	30,000	-30,000	30,000	30,000	0	0	0	30,000	0		30,000
7017C0	Eye clinic expansion	BWG	0	0	4,377	4,377	0	0	0	4,377	0		4,377
7065C0	Fertility Air Conditioning	BWG	12,000	0	0	12,000	5,000	0	0	17,000	0		17,000
7215C0	Finance fire alarm system upgrade	BWG	0	0	21,600	21,600	0	0	0	21,600	0		21,600
7001C0	Finance Office Refurbishment	BWG	0	0	-1,899	-1,899	1,899	0	0	0	0		0
7050C0	Fire alarms - detection & prevention equip - various	BWG	0	0	5,548	5,548	10,000	0	0	15,548	0		15,548
7062C0	Fire compartmentation SDH north - remedial works	BWG	0	0	58,013	58,013	-10,000	0	0	48,013	0		48,013
7036C0	Fire Suppression to Transformer Rooms	BWG	42,000	-372	0	41,628	0	0	0	41,628	0		41,628
7007C0	Gas mains test	BWG	0	0	7,000	7,000	0	0	0	7,000	0		7,000
7030C0	Genetics Air Conditioning	BWG	11,000	0	0	11,000	0	0	0	11,000	0		11,000
7059C0	Hedgerows - Public WC's Refurbishment	BWG	0	0	2,598	2,598	0	0	0	2,598	0		2,598
7005C0	Hedgerows extension	BWG	0	0	14,935	14,935	0	0	0	14,935	0		14,935
7201C0	Hot Water Pipes - SDH Various Areas	BWG	100,000	0	65,990	165,990	0	0	0	165,990	0		165,990
7052C0	IVF lab. Ventilation system modifications	BWG	0	0	854	854	0	0	0	854	0		854
7054C0	Legionella risks	BWG	0	0	85	85	0	0	0	85	0		85
7096C0	Level 2 Flooring	BWG	0	0	98,721	98,721	0	0	0	98,721	0		98,721
7097C0	Level 4 Bedspace Power Sockets	BWG	0	0	69,460	69,460	0	0	0	69,460	0		69,460
7056C0	Llfts overhaul - year 3 (2014/15) of 3	BWG	80,000	0	76,298	156,298	0	0	0	156,298	0		156,298
7098C0	Main Entrance L3 Upgrade	BWG	0	0	54,556	54,556	0	0	0	54,556	12,150		42,406
7070C0	Main Theatres 4th Laminar Flow System	BWG	0	0	185,000	185,000	0	0	0	185,000	0		185,000
7032C0	Maternity Obstetric Theatre Refurbishment	BWG	78,000	0	0	78,000	0	0	0	78,000	0		78,000
7029C0	Maternity Post Natal Upgrade	BWG	122,000	0	0	122,000	0	0	0	122,000	0		122,000
7033C0	Maternity Relocation - Enabling	BWG	0	0	1,622	1,622	0	0	0	1,622	0		1,622
7080C0	Mattress Laundering	BWG	0	0	2,521	2,521	0	0	0	2,521	0		2,521
7031C0	MDMC Infusion Device Analyser	BWG	8,000	0	0	8,000	0	0	0	8,000	0		8,000
7072C0	Medical Air (Dryers) SDH North	BWG	0	0	4,120	4,120	0	0	0	4,120	0		4,120
7051C0	Medical Gas Hoses 1st year of 2 (2014/15)	BWG	66,000	0	0	66,000	0	0	0	66,000	0		66,000
7852C0	Medical Gas System	BWG	0	0	3,456	3,456	0	0	0	3,456	0		3,456
7003C0	Microbiology - Category 3 Room	BWG	0	0	58,164	58,164	0	0	0	58,164	0		58,164
7013C0	Mortuary electrical installation compliance	BWG	0	0	11,673	11,673	0	0	0	11,673	0		11,673
7142C0	Mortuary Refrigeration	BWG	0	0	15,901	15,901	0	0	0	15,901	0		15,901
7492C0	Noise Reduction & Facilities Equipment	BWG	0	0	29,488	29,488	0	0	0	29,488	0		29,488
7202C0	Nurse Call System Upgrade - SDH North & Maternity - 2nd year of 2	BWG	70,000	0	103,397	173,397	0	0	0	173,397	0		173,397
7203C0	Occupational Health Replacement Boilers	BWG	0	0	1,068	1,068	0	0	0	1,068	0		1,068
7894C0	Oral Surgery - Theatre 9 (plus more dental chairs)	BWG	0	0	44,659	44,659	0	0	0	44,659	0		44,659
7204C0	Pathology & Histopathology OSNA Room (4.5.20) Air Conditioning	BWG	0	0	4,973	4,973	0	0	0	4,973	0		4,973
7057C0	Piped medical gas system safety valves replacement	BWG	0	0	3,683	3,683	0	0	0	3,683	0		3,683
7208C0	Procurement Out of Hours Bay	BWG	0	0	5,642	5,642	0	0	0	5,642	5,941	-299	0
7848C0	Productive Operating Theatres	BWG	0	0	27,415	27,415	0	0	0	27,415	0		27,415
7209C0	Public & Staff WCs L5,L4,L3	BWG	0	0	84,000	84,000	0	0	0	84,000	0		84,000
7210C0	Public Spaces Fund	BWG	0	0	18,404	18,404	0	0	0	18,404	0		18,404
7211C0	Radiology Recovery Area Improvements	BWG	0	0	60,000	60,000	0	0	0	60,000	0		60,000
7095C0	Relocation of Liquid Oxygen VIE Plant	BWG	0	0	28,148	28,148	0	0	0	28,148	0		28,148
7061C0	Rheumatology temperature control	BWG	0	0	17,079	17,079	0	0	0	17,079	0		17,079
7020C0	Roads and paving repairs	BWG	0	0	160,949	160,949	0	0	0	160,949	0		160,949
7880C0	Roof Repairs - Various	BWG	0	0	20,866	20,866	0	0	0	20,866	28,082	-7,215	0
7212C0	SDH Main Chillers Replacement	BWG	42,000	0	-15,188	26,812	0	0	0	26,812	1,633		25,179
7006C0	SDU X 2 Washers	BWG	100,000	0	0	100,000	0	0	0	100,000	0		100,000
7214C0	Security Improvements 2013/14	BWG	0	0	35,431	35,431	0	0	0	35,431	39,411		-3,980
7037C0	Server Rooms - Air Conditioning	BWG	0	0	41,522	41,522	0	0	0	41,522	0		41,522
7038C0	Shower Cubicle Drainage Improvements	BWG	30,000	0	0	30,000	0	0	0	30,000	0		30,000
7219C0	Site Signage 2013/14	BWG	0	0	3,580	3,580	0	0	0	3,580	0		3,580
7678C0	Security improvements 2010/2011	BWG	0	0	0	0	0	0	0	0	0		0
7028C0	Security improvements 2011/2012	BWG	0	0	0	0	0	0	0	0	0		0
7049C0	Spinal treatment centre refurbishment	BWG	0	0	189,935	189,935	0	0	0	189,935	10		189,926
7016C0	Spinal Unit - wheelchair cleaning and storage	BWG	0	0	3,370	3,370	0	0	0	3,370	0		3,370
7024C0	Spinal Unit Double Glazing 1st yeat of 2 (2014/15)	BWG	60,000	0	0	60,000	0	0	0	60,000	0		60,000
7026C0	Spinal Unit Fire Escape	BWG	17,000	0	0	17,000	0	0	0	17,000	0		17,000
7890C0	Spinal X-ray booking facilities and doors	BWG	0	0	28,677	28,677	0	0	0	28,677	0		28,677
7217C0	Theatres 1 - 10 Replacement Taps	BWG	0	0	4,051	4,051	0	0	0	4,051	0		4,051
7018C0	Walls - repairs to failing walls	BWG	0	0	8,000	8,000	0	0	0	8,000	0		8,000
7022C0	Wessex Rehab Windows and Cladding	BWG	0	0	11,466	11,466	0	0	0	11,466	0		11,466
7077C0	Wilton Ward Winter Pressures 13/14 (Block 79)	BWG	0	0	33,924	33,924	0	0	0	33,924	5,898		28,026
3	**Building Projects/Building and Works Totals**	BWG	**1,533,000**	**-54,444**	**2,358,938**	**3,837,494**	**24,399**	**0**	**0**	**3,861,893**	**129,067**	**-7,514**	**3,740,340**
4	**Information Technology**	IT		0									
7968C0	Abdominal Aortic Aneurysm (AAA) Project	IT	0	0	0	0	0	0	0	0	0		0
7962C0	ACS Licences	IT	12,000	0		12,000	0	0	0	12,000	0		12,000
7901C0	AD Upgrade to 2008	IT	0	0	28,827	28,827	0	0	0	28,827	0		28,827
7990C0	Allocate' Roster System	IT	0	0	39,168	39,168	0	0	0	39,168	39,000		168
7995C0	Auditbase link to iPM	IT	0	0	20,000	20,000	0	0	0	20,000	0		20,000
7930C0	Backup Tape Library Replacement	IT	52,000	0	0	52,000	0	0	0	52,000	1,561		50,439
7714C0	Blood Tracking	IT	0	0	17,491	17,491	0	0	0	17,491	0		17,491
7996C0	Blood Tracking Phases 1 - 3	IT	200,000	0	137,177	337,177	0	0	0	337,177	0		337,177
7993C0	BMS Network Upgrade	IT	0	0	31,955	31,955	0	0	0	31,955	0		31,955
7940C0	Brocade Switch Replacement	IT	0	0	7,513	7,513	0	0	0	7,513	0		7,513
7989C0	Capturestroke	IT	0	0	0	0	0	0	0	0	0		0
7980C0	Clikview Reporting System	IT	80,000	0	0	80,000	0	0	0	80,000	0		80,000
7954C0	Clinical Coding Encoder	IT	0	0	23,692	23,692	0	0	0	23,692	0		23,692
7984C0	Community Midwifery system trial	IT	0	0	35,748	35,748	0	0	0	35,748	0		35,748
7915C0	Connectivity Upgrade for Warminster & Shaftesbury	IT	42,000	0	0	42,000	0	0	0	42,000	0		42,000
7904C0	COSD - Cancer Database	IT	24,000	0	0	24,000	0	0	0	24,000	20,000		4,000
7969C0	Dell Kace Push Software	IT	96,000	-96,000	1,437	1,437	0	0	0	1,437	0		1,437

Capital Programme at 30th April 2014

Appendix 3

Cost Centre	Project Name	Area	Board Approved 2014/15	Schemes B/Fwd to 2013/14	Slippage from 2013/2014	Board Approved + 13/14 final slippage - 13/14 b/fwd	Adjustments to final Plan	Brought Forward from 2015/16	Slippage to 2015/16	Revised Plan	Spend to 30th April 2014	Under/(Over) spent on Project	Outstanding Spend 2014/15
7909C0	Desktop PC Windows 7 Upgrade	IT	0	0	12,472	12,472	0	0	0	12,472	2,354		10,118
7110C0	Diabetic Retinopathy Screening	IT	0	0	1,621	1,621	0	0	0	1,621	0		1,621
7911C0	EDCR-Changes to improve air flow and balance	IT	0	0	9,500	9,500	0	0	0	9,500	0		9,500
7920C0	Edge Security replacement	IT	0	0	0	0	0	0	0	0	0		0
7997C0	Electronic Letters	IT	0	0	24,160	24,160	0	0	0	24,160	0		24,160
7961C0	EPMA (Yr 2 (2014/15) of 7)	IT	82,000	0	70,438	152,438	0	0	0	152,438	3,287		149,151
7925C0	Estates Management Information System	IT	0	0	5,000	5,000	0	0	0	5,000	0		5,000
7926C0	Exchange 2010 Upgrade	IT	0	0	23,301	23,301	0	0	0	23,301	967		22,334
7903C0	Genetics High Spec Analysis Equipment & Software	IT	86,000	0	0	86,000	0	0	0	86,000	0		86,000
7929C0	Histopathology Hardware	IT	20,000	0	0	20,000	0	0	0	20,000	0		20,000
7912C0	Inhouse development team - applications, databases and Dashboards (subject to bus case)	IT	78,000	0	14,176	92,176	0	0	0	92,176	11,981		80,195
7927C0	iPad Security	IT	0	0	22,000	22,000	0	0	0	22,000	1,716		20,284
7913C0	Lab Medicine-Tpath to Nxt Gen	IT	0	0	0	0	0	0	0	0	0		0
7916C0	Maternity PC & Screens Replacement	IT	22,000	-22,000	22,000	22,000	0	0	0	22,000	0		22,000
7914C0	Mobile Computing	IT	50,000	0	26,332	76,332	0	0	0	76,332	1,976		74,357
7972C0	Moorefield's Eye Hospital Software	IT	0	0	27,000	27,000	0	0	0	27,000	0		27,000
7956C0	Network Load Balancers	IT	36,000	0	0	36,000	0	0	0	36,000	0		36,000
7928C0	Network Upgrade Consultancy	IT	21,000	0	70,500	91,500	0	0	0	91,500	0		91,500
7974C0	Neurophysiology Project	IT	0	0	4,446	4,446	0	0	0	4,446	0		4,446
7960C0	Nexus 5 Expansion	IT	49,000	0	0	49,000	0	0	0	49,000	0		49,000
7934C0	Open Eyes System	IT	68,000	-36,000	8,152	40,152	0	0	0	40,152	0		40,152
7942C0	Order Comms (includes System Admin Bid & Sexual Health Bid)	IT	0	0	22,889	22,889	0	0	0	22,889	14,624		8,265
7943C0	PACS Reprocurement	IT	0	0	78,940	78,940	0	0	0	78,940	0		78,940
7931C0	Palliative Care EPR	IT	0	0	4,437	4,437	35,000	0	0	39,437	0		39,437
7908C0	PAS 2016 Replacement - Consultancy Costs	IT	70,000	0	0	70,000	0	0	0	70,000	2,398		67,602
7902C0	Patient Observations Monitoring and Decision Support/Early Warning System/POET	IT	280,000	-12,617	0	267,383	0	0	0	267,383	3,270		264,113
7552C0	Patient Tracking	IT	0	0	1,253	1,253	0	0	0	1,253	10		1,243
7905C0	Radiologists 'on-call' Laptops	IT	12,000	0		12,000	0	0	0	12,000	0		12,000
7918C0	Radiology - OrderComms	IT	0	0	71,257	71,257	0	0	0	71,257	0		71,257
7923C0	Radiology Replacement PC's	IT	10,000	0	0	10,000	0	0	0	10,000	0		10,000
7906C0	Results System in GP Practices 'Review' System	IT	30,000	0	0	30,000	0	0	0	30,000	5,328		24,672
7985C0	RIS patient self check in	IT	0	0	7,848	7,848	0	0	0	7,848	0		7,848
7970C0	Scanned Health Rtecords	IT	0	0	7,418	7,418	0	0	0	7,418	0		7,418
7977C0	SLAM	IT	0	0	805	805	0	0	0	805	0		805
7952C0	Sophos Renewal	IT	36,000	-36,000	0	0	0	0	0	0	0		0
7948C0	Telecomms Voice Over IP - invest to save	IT	0	0	16,397	16,397	0	0	0	16,397	0		16,397
7987C0	Telepath enhancements	IT	0	0	46,365	46,365	0	0	0	46,365	0		46,365
7913C0	Telepath to NexGen (Phase 3 of 4 2014/15)	IT	75,000	0	0	75,000	0	0	0	75,000	0		75,000
7950C0	Theatre management system - balance	IT	0	0	1,496	1,496	0	0	0	1,496	0		1,496
7944C0	Upgrade of low spec equipment (680 machines)	IT	0	0	0	0	71,340	0	0	71,340	0		71,340
7935C0	UPS Replacement Programme	IT	24,000	0	2,036	26,036	0	0	0	26,036	0		26,036
7922C0	UPSs - Room based for Computer Rooms	IT	0	0	27,000	27,000	0	0	0	27,000	0		27,000
7979C0	VMWare Upgrade	IT	20,000	0	0	20,000	0	0	0	20,000	0		20,000
7924C0	Wireless Expansion	IT	0	0	2,710	2,710	0	0	0	2,710	0		2,710
4	**Information Technology Totals**	**IT**	**1,575,000**	**-202,617**	**974,957**	**2,347,340**	**106,340**	**0**	**0**	**2,453,680**	**108,472**	**0**	**2,345,208**
5	**Medical Devices**	**MDC**		**0**									
7106C0	Anaesthetic Machines	MDC	100,000	0	0	100,000	0	0	0	100,000	0		100,000
7122C0	B-Braun Review of Theatre Instruments	MDC	300,000	0	0	300,000	0	0	0	300,000	0		300,000
7131C0	BED replacement programme - 2nd (2014/15) yr of 4	MDC	150,000	0	43,885	193,885	0	0	0	193,885	141,388		52,496
7105C0	Birthing Beds x8	MDC	60,000	0	0	60,000	0	0	0	60,000	0		60,000
7124C0	Clinical Radiology 2 x Ultrasound	MDC	160,000	0	0	160,000	0	0	0	160,000	0		160,000
7119C0	DSU Operating Theatre Lightys	MDC	110,000	0	0	110,000	0	0	0	110,000	0		110,000
7116C0	Foetal Heart Monitors X 6	MDC	0	0	7,531	7,531	0	0	0	7,531	0		7,531
7104C0	ICSI Rig	MDC	67,000	-67,000	0	0	0	0	0	0	0		0
7118C0	Laparoscopic instrumentation	MDC	0	0	53,902	53,902	0	0	0	53,902	0		53,902
7112C0	Laser Holmium Yag Machine - Urology	MDC	50,000	0	0	50,000	0	0	0	50,000	0		50,000
7121C0	Maternity Theatre Equipment	MDC	63,000	0	0	63,000	0	0	0	63,000	0		63,000
7113C0	Medical Equipment < £50k 12/13	MDC	0	0	73,800	73,800	0	0	0	73,800	8,533		65,266
7103C0	Medical Equipment < £50k 13/14	MDC	0	0	115,234	115,234	0	0	0	115,234	0		115,234
7101C0	Medical Equipment <£50k 14/15	MDC	350,000	0	0	350,000	0	0	0	350,000	0		350,000
7127C0	Orthodontics & Oral Surgery Cone Beam CT Scanner	MDC	110,000	0	0	110,000	0	0	0	110,000	0		110,000
7134C0	Patient monitoring and stations 2nd phase of 2	MDC	52,000	0	3,392	55,392	0	0	0	55,392	0		55,392
7135C0	Patient trolleys x 14 + 1 Radiology	MDC	0	0	69,000	69,000	0	0	0	69,000	67,093		1,907
7140C0	Revenue Grouped Items	MDC	0	0	25,525	25,525	0	0	0	25,525	5,003		20,522
7123C0	Revenue Grouped Items	MDC	100,000	0	0	100,000	0	0	0	100,000	0		100,000
7136C0	Rigid hysteroscopes x 4 plus stack	MDC	0	0	39,842	39,842	0	0	0	39,842	0		39,842
7125C0	Vascular Unit Ultrasound Machine	MDC	90,000	0	0	90,000	0	0	0	90,000	0		90,000
7111C0	Ventillators Programme - 1st year of 5 (2014/15)	MDC	60,000	0	0	60,000	0	0	0	60,000	0		60,000
7114C0	Zimmer Meshers & Dermatones	MDC	75,000	-75,000	4,382	4,382	0	0	0	4,382	0		4,382
5	**Medical Equipment Totals**	**MDC**	**1,897,000**	**-142,000**	**436,493**	**2,191,493**	**0**	**0**	**0**	**2,191,493**	**222,018**	**0**	**1,969,476**
6	**Other**	**OTHER**		**0**									
7766C0	Car Park Machinery	OTHER	30,000	0	0	30,000	0	0	0	30,000	0		30,000
7716C0	Catering Trolley Replacement x20	OTHER	170,000	-170,000	4,652	4,652	0	0	0	4,652	0		4,652
7712C0	Drinking Water Stations	OTHER	0	0	700	700	0	0	0	700	0		700
7703C0	Efficiency schemes	OTHER	200,000	0	138,370	338,370	0	0	0	338,370	423		337,947
7701C0	Finance systems 2011/2012	OTHER	30,000	0	10,170	40,170	0	0	0	40,170	7,213		32,957
7709C0	Fire Safety Training Equipment	OTHER	0	0	820	820	0	0	0	820	0		820
7700C0	Forklift Truck Replacement - Procurement	OTHER	0	0	17,500	17,500	0	0	0	17,500	0		17,500
7707C0	LED Lighting	OTHER	0	0	81,675	81,675	0	0	0	81,675	2,816		78,858
7762C0	Microfibre Cleaning	OTHER	44,000	0	0	44,000	0	0	0	44,000	0		44,000
7710C0	Outpatient Kiosks	OTHER	0	0	198,000	198,000	0	0	0	198,000	0		198,000
7790C0	Phhotovoltaic's / Solarthermal PV	OTHER	0	0	49,276	49,276	0	0	0	49,276	0		49,276
7760C0	Project costs 2013/14	OTHER	10,000	0	4,715	14,715	0	0	0	14,715	3,305		11,411
7711C0	TRV's (details to be taken to CapCG Oct mtng)	OTHER	0	0	17,500	17,500	-17,500	0	0	0	0		0
7706C0	Voltage Optimization	OTHER	0	0	94,705	94,705	0	0	0	94,705	88,593		6,112
7718C0	Ward Waste Bins	OTHER	50,000	0	91,839	141,839	0	0	0	141,839	0		141,839
6	**Other Totals**		**534,000**	**-170,000**	**709,921**	**1,073,921**	**-17,500**	**0**	**0**	**1,056,421**	**102,350**	**0**	**954,071**
	TRUST TOTALS		**7,642,000**	**-574,591**	**5,986,299**	**13,053,708**	**113,239**	**0**	**0**	**13,166,947**	**631,318**	**-33,896**	**12,569,525**
7	**Outside of Trust Sourced Funding**												
7708C0	Laundry Equipment	A2	0	0	112,500	112,500	0	0	0	112,500	0		112,500
	Outside of Trust Sourced Total		**0**	**0**	**112,500**	**112,500**	**0**	**0**	**0**	**112,500**	**0**	**0**	**112,500**
			7,642,000	**-574,591**	**6,098,799**	**13,166,208**	**113,239**	**0**	**0**	**13,279,447**	**631,318**	**-33,896**	**12,682,025**

AGENDA ITEM

SFT 3542

TRUST PERFORMANCE REPORT TO END OF APRIL 2014

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

MAIN ISSUES:

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

MONITOR

1. **Symptomatic breast patients –** the target for 93% of patients to have been seen within 2 weeks was not met in April. Analysis has shown that demand is the main contributing factor to this: a 22% increase in referrals was noted in April in conjunction with an increase in referrals for suspected breast cancer of 30% in March and 14% increase in April, all which required review. Additional capacity was arranged to compensate for the loss of capacity due to bank holidays in both April and May and the performance is expected to improve for Month 2 (predicted Month 2 position is 96% with 92% for quarter 1 position).

PATIENT CHOICE

2. **Diagnostics** – whilst all patients were seen within 6 weeks for their diagnostic appointment, the continued pressure with increase demand compared with capacity has meant that some patients have waited in excess of 4 weeks for ultrasound, MRI, audiology and neurophysiology. The directorate management teams continue to review and implement plans to improve this position.

PARTNERSHIP WORKING

3. **Delayed transfers of care (DTOC)** – DTOCs remain a significant issue for our patients. Daily escalation internally and externally to support discharge is undertaken by the operational teams involved and from a strategic perspective, proactive engagement within the Better Care workstreams to influence service provision and need is being progressed and supported through the leadership of the Health and Wellbeing Board.

STAFF

4. **Appraisal rates** – the overall Trust position at the end of April deteriorated in performance to 77.4%. The Board should note that a new on-line appraisal system (SPiDA) was launched in April which we believe may have had a negative impact on the appraisals being completed and logged in time. This is however being investigated through the reviews at the Directorate performance meetings and an improvement in performance is anticipated in Month 2.

5. **Statutory Mandatory Training** – movement on performance in this area has been slower than expected. However, following the submission of requested action plans from the Directorates, which will be monitored via the monthly performance meeting, it is expected that this performance will improve.

VALUE AND EFFECTIVENESS

6. **Non-elective Surgical Length of Stay –** whilst some specialties have seen a reduction in the overall non-elective surgical length of stay and all specialties within surgery are reporting in the upper quartile of performance, focused work is being undertaken within the Patient Flow transformation workstream to understand the main issues contributing to delays, specifically in orthopaedics, to ensure all of our patients are being treated and discharged in a timely and effective manner.

7. **Coding** - the coding attainment levels remain below target due to capacity issues within the team relating to long term sickness and maternity leave. Additional resource has been employed via an agency which has stabilised the position and resource from within the informatics directorate continue to be re-deployed to support the coders manage the more complex coding. The department's staffing improves in June and will do so further in August, with additional staff also being interviewed in June.

ACTION REQUIRED BY THE BOARD:

To note the Trust's performance.

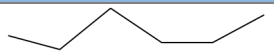
ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
Board Performance Report, April 2014

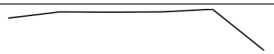
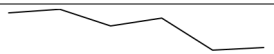
AUTHOR: KATE HANNAM
TITLE: CHIEF OPERATING OFFICER

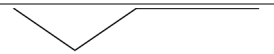
Trust Board Performance Report - April 2014

Salisbury NHS
NHS Foundation Trust

Monitor Assurance

Metric Name	Indicative Monthly Volume	Target Source	Target	Apr-14	YTD	Benchmark	Trend
Infection control – Clostridium difficile	5,800 discharges	Contract	21 cases	5	5		
Infection control - MRSA	5,800 discharges	Contract	0 cases (deminimis volume 6)	0	0		

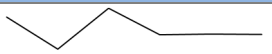
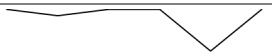
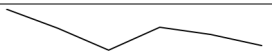
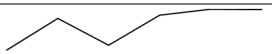
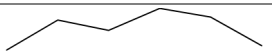
Metric Name	Indicative Monthly Volume	Target Source	Target	Apr-14	Quarter 1 to date	Benchmark	Trend
Patients treated within 18 weeks requiring admission	1,000 patients	Contract	90% treated within 18 weeks	91.6%	91.6%	92%	
Patients treated within 18 weeks not requiring admission	3,500 patients	Contract	95% treated within 18 weeks	96.4%	96.4%	97%	
Proportion of patients waiting less that 18 weeks for first treatment	10,300 patients	Contract	92% still waiting within 18 weeks	96.4%	N/A	95%	
Zero tolerance RTT waits > 52 weeks		Contract	Zero	0	0		

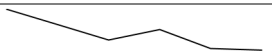
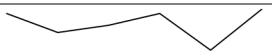
Metric Name	Indicative Monthly Volume	Target Source	Target	Apr-14	YTD	Benchmark	Trend
All Cancer two week waits	450 patients	Contract	93% patients within 2 weeks	93.8%	93.8%	95.4%	
Symptomatic Breast Cancer - two week waits	85 patients	Contract	93% patients within 2 weeks	90.5%	90.5%		
31 day wait standard	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	89.9%	89.9%	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% (Dec-13)	91.7% (Dec-13)		

A&E - Time in A&E department	3,600 patients	Contract	95% patients leave within 4 hours of arrival	96.2%	96.2%	94%	

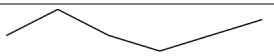
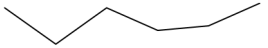
Quarterly Governance risk rate	Green: No evident concerns

Patient Choice

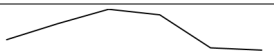
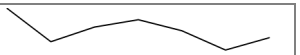
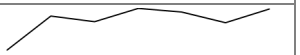
Metric Name	Indicative Monthly Volume	Target source	Target	Apr-14	YTD	Benchmark	Trend
Patients waiting less than 4 weeks for diagnostics	1,800 patients	Trust	98% of Diagnostic Waiting List <= 4 weeks	90.1%	90.1%	81%	
Patients waiting less than 6 weeks for diagnostics	1,800 patients	Contract	100% of Diagnostic Waiting list < 6 weeks	100.0%	100.0%	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	47.5%	47.5%	N/A	
Friends and Family - % likely to recommend Hospital	1,400 discharges			97.0%	97.0%	N/A	
A&E Clinical Target 1 - Effectiveness of Care - unplanned reattendance rate	3,600 patients	Contract	<5% ED attendances to have unplanned return	2.1%	2.1%	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	1.4%	1.4%	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	03:59	03:59	04:11	
A&E Clinical Target 4 - Time to initial assessment	3,600 patients	Contract	95th percentile ED time to initial assessment < 15 minutes	00:08	00:08	benchmark data not fit for purpose	
A&E Clinical Target 5 - Time to treatment	3,600 patients	Contract	Median time to treatment in ED < 60 minutes	57	57	benchmark data not fit for purpose	
Ambulance Handover Breaches	970 arrivals by ambulance	Contract	Patients waiting > 20 minutes for Ambulance Handover	4	4		
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	87.0%	87.0%	89%	
Cancelled operations on the day of surgery	2,100 elective admissions (incl. daycase)	Trust	< 0.7% elective patients cancelled	0.5%	0.5%	0.77%	
Cancelled operations rebooked within 28 days	20 cancellations per month	Contract	100% patients rebooked within 28 days of cancelled surgery	100.0%	100.0%	96%	

Metric Name	Indicative Monthly Volume	Target source	Target	Feb-14	2013-14	Benchmark	Trend
Market Share: NHS Wiltshire - Elective		Strategy		30.6%	29.1%		
Market Share: NHS Wiltshire - Non-Elective		Strategy		34.0%	35.3%		
Market Share: Core Practices - Elective		Strategy	Increase market share from 52% to 55% over 5 years	52.6%	52.0%		
Market Share: Core Practices - Non-Elective		Strategy		63.4%	64.5%		

Partnership working

Metric Name	Indicative Monthly Volume	Target source	Target	Apr-14	YTD	Benchmark	Trend
Delayed Transfers of Care - NHS				7	N/A		
Delayed Transfers of Care - Social Services			4 DTOCs based on 3 Wilts SS delays and ~1 other	12	N/A		
Outpatient Follow Up rates	15,000 attendances	Contract	Aspire for Follow up -New Rate <=1:1.6	1.7	1.7		

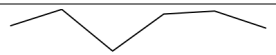
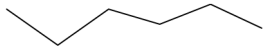
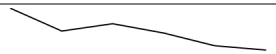
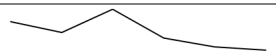
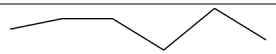
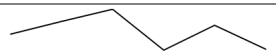
Staff

Metric Name	Indicative Monthly Volume	Target source	Target	Apr-14	YTD	Benchmark	Trend
Staff absence rate		Strategy	2.87% absence rate	3.15%	3.15%		
Staff turnover	2731 FTE	Strategy	12% over 12 months as a cumulative figure	N/A	3.72%		
Appraisal rates		Strategy	90% of Appraisals completed (rolling 12 months compliance rate)	77.4%	N/A		
Statutory and Mandatory Training levels		Strategy	100% of Training completed (rolling 12 month compliance rate)	67.7%	N/A		
Registered Nurses Vacancy Factor		Strategy	10%	4.5%	4.5%		
Nursing Support Vacancy Factor		Strategy	10%	10.6%	10.6%		
Trustwide Vacancy Factor		Strategy	10%	5.9%	5.9%		
Bank Spend		Strategy	To be determined	£506,209	£506,209		
Agency Spend		Strategy	To be determined	£478,517	£478,517		

Trust Board Performance Report - April 2014

Salisbury NHS
NHS Foundation Trust

Value and Effectiveness

Metric Name	Indicative Monthly Volume	Target source	Target	Apr-14	YTD	Benchmark	Trend
Elective Medical Length of Stay	40 Medical G&A overnight stays	Trust	3.48 days	3.6	3.5	Benchmark data not fit for purpose	
Non-Elective Medical Length of Stay	900 Medical G&A overnight stays	Trust	7.78 days	7.7	7.6	15.7	
Elective Surgical Length of Stay	480 Surgical G&A overnight stays	Trust	2.19 days	3.0	3.0	3.5	
Non-Elective Surgical Length of Stay	750 Surgical G&A overnight stays	Trust	3.15 days	3.6	3.7	3.0	
Hip replacements discharged within 5 days	25 patients	Trust	60% patients discharged within 5 days	66.7%	66.7%		
Knee replacements discharged within 5 days	24 patients	Trust	60% patients discharged within 5 days	70.6%	70.6%		
Coding - % coded within 1 week of discharge	5,800 discharges	Trust		23.3%	23.3%		
Coding - % coded within 5 days of month end	5,800 discharges	Trust		46.2%	46.2%		
NHS no. coverage	230,000 patients	Contract	95% of patients with activity in last 3 years to have validated NHS no.	97.7%	97.9%		
1st Outpatient DNA rate	5,500 appointments	Contract	No more than 7.5% patients to not attend 1st outpatient appointment	5.8%	5.8%	7.8%	
Elective Theatre Utilisation - Main Theatres	530 cases	Trust	Data recently obtained from new theatre system, no target set at this point	97.6%	97.6%		
Elective Theatre Utilisation - Day Surgery	860 cases	Trust	Data recently obtained from new theatre system, no target set at this point	79.6%	79.2%		
Non-elective Theatre Utilisation - Main Theatres	370 cases	Trust	Data recently obtained from new theatre system, no target set at this point	82.5%	82.5%		
Daycase Rates for selected procedures	350 patients	Trust	80% of selected elective surgical cases to be treated as daycase	78.3%	78.3%	78.7%	
Financial risk rating (FRR)	3. Regulatory concerns in one or more components. Significant breach unlikely						

Cells with black dotted outlines indicate provisional data

JOINT BOARD OF DIRECTORS (JBD) MINUTES FROM 16 APRIL 2014 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 – 16 April 2014

ASSURANCE FRAMEWORK REVIEW AND UPDATE
The joint board received the current Assurance Framework and noted gaps in control in relation to risk 1.2 (improving safety) and 2.2 (impact of poor performance. In relation to these risks, the rollout of Sepsis 6 and root cause analysis of CDiff incidents was continuing. Staff focus groups were also being established to better understand the incidence of staff reporting witnessing near misses and also experiencing violence from patients and the public. There were newly identified positive assurances in relation to improving SHMI and HSMR. Many staff survey indicators were positive. In relation to risk 5.1 (failure to secure income), contracts including CQUIN with main commissioners were agreed in principle.

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

Salisbury NHS

NHS Foundation Trust

SFT 3544

MINUTES OF THE CLINICAL GOVERNANCE COMMITTEE
held at 10am-12pm, Thursday 27TH MARCH 2014
in the Boardroom, Salisbury District Hospital

Present:

Lydia Brown (Chair)	Steve Long	Sarah Mullally
Peter Hill	Christine Blanshard	Tracey Nutter
Fiona Hyett	Mark Stabb	

In attendance:	Item
Helena Eagles (Minute-taker)	
Ian Harvey, Debbie Butler, Beckie Benson, Nicky House, Sarah Hennell, Stuart Henderson, Felicity Morgan	CGC0303 (Directorate Report)
Maggie Cherry, Sue Wheeler-Mallows	(Patient Story)
Fenella Hill	CGC0312,13,14

Apologies:

Claire Gorzanski, Kate Hannam, Sally Tomlin, Nigel Atkinson, Hazel Hardyman

Lydia Brown welcomed everyone to the Committee and confirmed the meeting was quorate.

CGC0301 MINUTES OF THE MEETING HELD ON 27th February 2014

HE was asked to amend the information regarding the BNF on p.13 and a line regarding risk assessments on p.14 (post meeting note – complete). The Committee approved the Minutes as an accurate record of the meeting on this basis.

CGC0302 MATTERS ARISING/ACTION TRACKER

Nov 2013 CGC01104 Dementia Strategy Mid-Year Report.
HE has distributed an updated version of the Dementia Quality Report. Complete.

Nov 2013 CGC111 Internal Audit Report
On agenda as item CGC0304. Complete.

Feb 2014 CGC0206 How CGC Receives Complaints
Steve Long, Katrina Glaister & Hazel Hardyman to meeting and discuss how to formalise the arrangement for SL to sample complaints – rolled to May 2014.

Feb 2014 CGC0208 Major Issues Report
Complete.

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STRATEGY

CGC0303 MEDICINE & CANCER DIRECTORATE REPORT

The teams from Medicine and Cancer delivered a Powerpoint presentation to the Committee.

The presentation focused on patient feedback, safety issues, Whiteparish Acute Medical Unit, Hospice, Cancer Services, challenges, Service Improvement Awards.

Dr Stuart Henderson gave a summary regarding ensuring safety, quality and timely care on Whiteparish ward and the improvements that have been made.

Improvements and challenges in Whiteparish highlighted included Pharmacy errors, documentation errors, link with primary care, using performance data to guide service improvement with a focus on how the multidisciplinary team work to achieve.

Sarah Hennell discussed the Palliative Care Services, highlighting various areas including the refurbishment which should be complete by May 2014. Future challenges discussed were the impact of an ageing population and the specialist palliative care funding review.

Nicky House reported on the Cancer Services, highlighting strategic priorities such as early diagnosis – BCOC, clinical excellence / collaboration, survivorship / long term conditions, acute care, commissioning intentions, cancer related emergencies, cancer wait times and MDT effectiveness.

Medicine Directorate Challenges:

- Large, busy Directorate
- Unpredictable - primarily emergency workload
- Complex patient group
- Increasing dependency & acuity of patients, long term conditions
- Capacity issues
- External pressures/delayed transfers to other providers
- Staffing and training

Service Improvement Successes:

- Trust Projects – won by Carmen Carroll and Fiona Rossiter for using coloured crockery
- Learning Initiated Projects – won by Kate Bennett and Lynda Isaac – Rapidly Accessing Rehabilitation for the Elderly
- Pinder Award winner – Dawn Whitmarsh – Whiteparish AMU
- Customer Care Award Team – winner Dermatology, runner up – Emergency Department
- Governors Volunteer of the Year – runner up – Hospice
- Chairman's Outstanding Contribution Award – Carolyn Sawyer – Pembroke Unit

TN will speak to the Medicine Directorate as the Committee would have liked to have seen more focus on priorities and measurable quality with less description. More emphasis on where the Directorate has concerns/worries and would like to be supported is required.

LB agreed and thanked the team for their presentation.

CGC0303 PATIENT STORY

Sue Wheeler-Mallows presented a historical story from Nov 2012-Jan 2013 about her elderly mother's experience on Winterslow in the last few weeks of her life.

At the time problems concerns were raised regarding various areas and the subsequent changes and improvement in processes were fully discussed, Mrs Wheeler-Mallows had been involved in some of the improvement work.

Many improvements have been made on Winterslow and Lynda Isaacs (previous Senior Sister) has had good communication with Mrs Wheeler-Mallows regarding the changes. Real-time feedback and Friends & family responses are much improved now.

TN noted that though this was an important patient story it was somewhat out of date and TN would have liked to have heard a more current patient story. The Committee agreed.

Action: LB confirmed that she would speak with MC about future patient stories and their content and LB will further consider Directorate reports and deadlines for papers for the CGC. **LB**

CGC0304 INTERNAL AUDIT PROGRAMME & DRAFT INTERNAL AUDIT PLAN

Due to time constraints these reports were not presented but have been read and approved by Committee members.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC0305 COMPLAINTS REPORT QUARTER 3

TN presented the report.

The new format for complaints report was discussed by the Clinical Governance Committee in February. The format of this quarter's report to the Board reflects the changes requested by the Committee.

74 complaints were received in quarter 3. This compares to 87 complaints in quarter 2 this year and 87 complaints for the same period in the previous year. A breakdown of numbers and themes according to Datix is on the main report.

TN explained that this report has come to CGC first rather than Trust Board to get internal review and did the Committee want this approach moving forward; this was agreed.

FHy discussed the alterations made since the first version of the report. Originally the report was significantly longer but FHy has worked hard with Katrina Glaister to pull out the themes which will be easier too see over a longer time period.

The Committee agreed it would be beneficial to hear more about how complainants felt at the end of the process and what % of complaints corresponds to the various directorate complaint themes.

Action: Hazel Hardyman to analyse all complaints in the quarter, also to review attitudes of medical staff to see if further learning is needed. **HH**

TN – the Parliamentary Ombudsman has never upheld a complaint event although there was always some learning that came out of the process.

The Committee approved and noted the report.

CGC0306 NATIONAL MATERNITY SURVEY 2013 – CQC BENCHMARK REPORT AND LOCAL ACTION PLANS

Salisbury NHS Foundation Trust participated in the third national Maternity Services survey between March and September 2013. Previous national surveys have taken place in 2007 and 2010. Questionnaires were sent to 300 mothers who had given birth during January and February 2013. A target 60% response rate was set. The Trust achieved 62% compared with the national average of 46%.

Each Trust was provided with three separate benchmark reports covering antenatal care, labour and birth, and postnatal care. However, only the results from the labour and birth data have been published on the Care Quality Commission's (CQC) website due to the fact that not all Trusts were able to identify whether mothers who gave birth at a particular site also received their antenatal and/or postnatal care at the same site.

This report was not presented but was read by all Committee members, there were no comments.

The report was approved and noted by the Committee.

ASSURING CLINICAL EFFECTIVENESS

CGC307 QUALITY INDICATOR REPORT FEB 2014 (FOR INFORMATION)

- One case of C difficile. 20 cases so far this year against a threshold of

21. Target is 18 in 14/15. The Board noticed that the Trust had reached 21 during March.

- A decrease in grade 2 pressure ulcers.

- Safety Thermometer – 92% 'harm free care'. A decrease in patients with a new hospital acquired pressure ulcer. Ongoing cluster reviews.

- A decrease in SHMI to 106 to June 2013 (103 when adjusted for palliative care) and is as expected. HSMR has declined again to 109 in December 13 but remains higher than expected. Key actions:
  - Implementation of the Sepsis Six campaign.
  - Reducing missed doses of medication.
  - Reducing patient moves and handoffs.
  - Weekly mortality reviews with immediate dissemination of learning points.

- Patients arriving on the stroke unit within 4 hours has declined. This relates to patients transferred from ED out of hours and the stroke team are working with them to resolve. Patients spending 90% of their time on the stroke unit has declined related to one patient. 100% of patients had a CT scan within 12 hours. A reduction in TIA referrals seen within 24 hours; the stroke team are working with referring clinicians to improve use of referral pathways.

- There were no non-clinical same sex accommodation breaches. Escalation bed capacity increased slightly but ward moves remain low.

- Two falls resulting in major harm.

- Friends and Family test – the best response rate yet for wards, ED and Maternity Services. Roll out to day case areas and OPD has commenced.

CB – HSMR is declining, no never events so far this year. The next Clinical Governance Half Day focuses on post-operative safety. There have been less patient moves and we are better at managing theatre capacity though we have seen some issues with the GPs not using the correct referral pathway.
The Committee noted the report.

TN – we have seen good improvement on pressure ulcers, particularly regarding grades 3 & 4. More work will be done on this as we move into next year.

The Board noted the report.

CGC0308 MAJOR ISSUES REPORT

1. DH consultation on new criminal offence of ill-treatment and wilful neglect.
2. NHS England never events taskforce reports.
3. CQUINS 14/15 and local quality requirements agreed.
4. The Library service wins a national award for good practice.
5. Cleft service published an evidence based handbook
6. Datixweb roll out begins

The report was not presented but the Committee had read the report and had no further comments. No decision was made regarding reducing the report to quarterly frequency.

The Board noted the report.

CGC0309 MORTALITY WORKING GROUP REPORT

CB presented the report. Dr Will Garrett, the HSMI and HSMR figures are the monthly reported figures so they differ from those gives in the Quality indicators Report which are rolling averages. HSMR is not really designed to look at deaths in palliative care patients. Weekly mortality reviews continue and we have seen an improvement in the use of the Sepsis 6 proforma and UTI pathway.

Some issues relating to coding were corrected and nearly all deaths are reviewed within a week or two of the patient dying and any learning is fully disseminated.

PH and CB discussed a cluster of respiratory issues for which Dr Catherine Thompson has provided assurance. CT had done an audit of community acquired pneumonia and the only action to come out of this regarded prescribing oxygen on drug charts.

SL – CB's leadership is very reassuring. Consideration needs to be given to how we communicate this to the governors and wider public in a language that reassures them.

SM – the CGC will continue to watch morbidity rates to ensure SFT continues on the right path.

The Board noted the report.

CGC0310 DRAFT QUALITY ACCOUNT

Stakeholder engagement:

27/11/13 - Age UK – 25 people
11/12/13 - Warminster Health and Social Care Group – 15 people
11/12/13 - Governors Patient Experience Advisory Group – 8 governors
16/1/14 - OT professional forum – 12 OTs including the Professional lead
17/1/14 - Presented at the CG half day in the lecture theatre – 70 + people
12/2/14 - Discussed with Emma Cooper, Healthwatch, CEO and Paul Lefever, SFT Healthwatch link
13/2/14 - CQRM meeting with Wiltshire, West Hampshire and Dorset CGs
17/2/14 - Child Health departmental meeting
24/2/14 - Council of Governors and Trust Board meeting
26/2/14 - Clinical Management Board
6/3/14 - Nursing, Midwifery and AHP Forum
X/3/14 - Clinical Governance Committee

CB presented the report. CGz had done a tremendous amount of work but we are constrained by the wording and format we have to use for this document, including the large appendix. We are waiting for end of year figures, this document has been through the Readership Panel who made some suggestions with regard to jargon and wording and the document has also been to Clinical Management Board.

TN suggested that it may be good for the governors to look at previous quality accounts to see the improvements which have been made over the years.

The Committee noted and approved the report.

CGC0311 EXTERNAL ENQUIRIES & EXTERNAL AGENGY VISITS BIANNUAL REPORT

National Reviews

- Three reports were published during the reporting period.
- Recommendations from four reports are outstanding from previous reporting periods but work is progressing and there is no cause for concern.

National Confidential Enquiries

- One report was published in November 2013.
- Recommendations from four reports are outstanding from previous reporting periods, two of which were reported as making slow progress at the time of the last update in June 2013:-

  a) **Are We There Yet?** One recommendation remains outstanding relating to the need for a local time critical paediatric transfer policy. This is under development.

  b) **An Age Old Problem** The risk associated with non-compliance of the outstanding recommendations has been identified as high but a business case to resolve the issues is being re-submitted in March 2014.

External Agency Visits

- A total of 14 visits have taken place between July 2013 and January 2014.
- Actions from 9 visits in previous reporting periods are outstanding but work is progressing and there is no cause for concern.

National Audits

- A total of 13 reports have been published between July 2013 and January 2014. These are presented to the Clinical Management Board and action plans agreed accordingly.
- Details of national audit reports received prior to this reporting period are not contained within this report but are available from the Clinical Audit Department upon request.

CB summarised the content of the report and asked for questions. There were no comments.

The Committee noted the report.

ASSURING SAFETY

CGC0312 RAISING CONCERNS POLICY UPDATE

The Raising Concerns 'Whistleblowing' Policy was extensively re-written during 2013. Since its relaunch in August 2013, one concern has been received. Subsequent investigations identified that this concern was unfounded. No further concerns have been received.

It is difficult to identify whether concerns are not being raised because staff or members of the public do not have concerns, or whether concerns are raised through other routes such as incident reporting, safeguarding or the management structures.

The Trust will continue to promote the use of the Policy through posters and the Cascade Brief system. A further report will be presented to the Clinical Governance Committee in March 2015 and the Policy is due for review in August that year.

CB – it is hard to provide assurance on this topic as though we revised and relaunched the policy in response to the Francis Report only 1 concern was raised since August 2013 and this concern was found to be unfounded.

MS confirmed that a number of Trusts were having difficulty with providing assurance on this matter and MS might be able to share more information outside of the meeting which could help.

Action: MS to follow up on providing assurance regarding whistleblowing and the Quality Directorate team will lead on how to assure this and report back in June 2014.	**MS/ Quality Team**

The Committee noted the report.

CGC0313 RISK REPORT CARD QUARTER 3

- 1064 incidents reported over the quarter
- 0 incident categorised as catastrophic
- 5 incidents categorised as major
- 2 major incidents due to fractures within the quarter
- 0 Never Events reported within the quarter
- 4 new Clinical Reviews commissioned within the quarter
- 0 new Non-clinical Review commissioned within the quarter
- 2 new Serious Incident Inquiries commissioned within the quarter
- 0 Local Reviews commissioned within the quarter

TN – Datixweb is now in place and training is ongoing. More realtime feedback will be available regarding incidents. Fenella Hill is managing the implementation very well.

The Q3 report feels a bit dated now but going forward these reports will be able to come to CGC much sooner.

The decline in reporting numbers was discussed and FHi explained that this depends upon how many of the Risk Team are available to input data. At month 11 more incidents have been put on than last year, and there is likely to be a 6-7% increase in reported incidents this year. Datixweb will reinvigorate incident reporting.

The Committee noted the report.

CGC0314 ASSURANCE FRAMEWORK

FHi presented the report.

Minor updates related to C.difficile rates and SHMI has slightly declined which is positive news. The assurance framework of Datixweb is that the risk register will feed straight into the assurance framework.

PH, FHi and TN discussed falls and action points and why the action points have not affected the risk rating. Falls remain at the highest risk as even with complete 1:1 specialling this would be likely to stay the same.

TN – it is worth noting a concern about risks rated 12 and above but there are a number of risks which rate around a 9 which may also be a risk for the organisation. On Datixweb all risks regardless of the score will go on so themes can be reviewed; this will be a big benefit from the new system.

FHi – Datixweb will also create some automatic triggers across the organisation in real-time and this will be very good.

The Committee noted the report.

PAPERS FOR NOTING

The Committee noted the following:-

CGC0315 Clinical Risk Group minutes (January)
CGC0316 Clinical Management Board minutes (February)
CGC0317 Infection Prevention & Control Committee minutes (January)
CGC0318 Children & Young People's Quality & Safety Board minutes (January minutes will come to May CGC)
CGC0319 Integrated Safeguarding Committee minutes (February)
CGC0320 Information Governance Group (February minutes will come to May CGC)

CGC0321 ANY OTHER URGENT BUSINESS

LB wished TN well in her new role and thanked TN for all her support and hard work at SFT.

SM asked TN whether she was leaving content in the knowledge that assurance and governance arrangements at SFT are effective. TN agreed that she was content with the assurance and governance arrangements. FHy will be covering 2 roles and TN noted that the Quality Department is under pressure. The interviews for the new Director of Nursing will be on 10th April 2014.

NEXT MEETING

Thursday 22nd May, 10am-12pm, Boardroom.

SALISBURY NHS FOUNDATION TRUST

Minutes of the Council of Governors Meeting – Part 1
At Salisbury District Hospital
Held on Monday 12 May 2014

Governors Present:	Nick Marsden (Chairman) Beth Robertson (Lead Governor) Robert Coate Chris Horwood June Griffin John Carvell Celeste Collins Carole Noonan Rob Polkinghorne John Markwell Andrew Farrow Paul Goldman Raymond Jack Lynda Viney Christine White Alastair Lack Sarah Bealey Brian Fisk Mandy Cripps Nick Sherman Shaun Fountain	**Apologies:**	Bill Moss Colette Martindale Chris Wain Mary Monnington Madeline Hewitt

In Attendance:
Peter Hill (Chief Executive)
David Seabrooke (Head of Corporate Governance)
Isabel Cardoso (Membership Manager)
Lydia Brown (Non-Executive Director)
Fiona Hyett (Interim Director of Nursing)
Patrick Butler (Communications Manager)

ACTION

1. WELCOME AND APOLOGIES

It was noted that Robert Coate, Celeste Collins, Paul Goldman and Bill Moss would be standing down as Governors having completed the maximum three terms of office.

The Chairman called on those present to reflect on their time with the Trust and thanked them for their work.

The Chairman also welcomed Chris Horwood to his first meeting of the Council since being appointed by Wessex Community Action as a Nominated Governor. The successor to Bill Moss, Councillor John Noeken from Wiltshire Council was in attendance.

It was noted that Lorna Wilkinson had been appointed as Director of Nursing and she was expected to take up her duties in early August. It was agreed that a summary profile of the successful candidate be circulated to Governors.

2. MINUTES OF THE PUBLIC MEETING HELD ON 10 FEBRUARY AND MINUTES OF THE JOINT MEETING WITH THE BOARD OF DIRECTORS 24 FEBRUARY

The Council received the draft minutes mentioned above for approval.

It was noted under Item 1 of the minutes of 10 February that the reference to nine years should be eight years and there was a missing 'to' at the top of the page 4.

With these amendments the minutes were approved.

3. MATTERS ARISING

Peter Hill gave an update on key developments as follows:

- On Outpatients the Capital spend on the centralisation of Outpatients was continuing, other aspects including efficiency were progressing.

- The works to Springs Entrance as previously discussed were on track for completion in autumn 2014. [post-meeting note – the project is delayed by two months for additional ground survey work]

It was also noted that the tendering exercise to select a development partner to take forward the South side of the site was on-going. A further update would be provided at the 21 July meeting of the Council.

4. TRUST PERFORMANCE TO 31 MARCH 2014

The Council received a replacement Performance Report setting out the year end figures. PH reported that the Trust had a successful year in relation to key performance indicators and infection control. The Trust's registration status with the CQC was "no concern" and the Governance Risk Rating with Monitor was Green.

It was noted that under 18 weeks that Orthopaedics was a pressure point, Maxillo-Facial and Oral Surgery had seen reductions in capacity, but more referrals. A plan to repatriate work that had been undertaken by New Hall was being developed that would reduce waiting times and ensure that the Trust had the capacity to carry out any additional surgery.

The Council noted the Summary Performance Report to 31 March 2014.

5. FINANCE REPORT

The Council received the summary Financial Performance Report to 31 March 2014 which reported that the Trust had achieved its plan for the year and a generally satisfactory year end position.

In relation to the CNST payment it was noted that the proposed increase to the Trust's contribution was £1m and this had been reduced by £1/3m following representations made by the Trust.

6. NURSING SKILL MIX

FH referred to the paper considered by the Trust Board at its 7 April meeting. The Board had approved in the 2014/15 estimates an investment of £800k for ward staffing and part of this would be used to provide more capacity for ward sisters to enable them to undertake a management and leadership role more consistently.

The Trust continued to review staffing guidelines particularly in the light of the draft NICE guidance which recognised the need for flexibility and local discretion.

The requirement from the National Quality Board was as set out in the board report for greater transparency including the publication of ward level information in the hospital giving planned and actual numbers for each shift supported by monthly reporting to the Trust Board and a six monthly Skill Mix Review.

The Chairman confirmed that the Trust Board would continue to review this issue on a regular basis and that the recent deployment of an electronic rostering system would support the process.

There continued to be reliance on agency nursing although the Trust was working to reduce this and where necessary reliance on locum medical staff. There were some instances were twelve hour shifts were the normal practice and this was felt to be a suitable approach in some situations. Issues around the time taken to administer medicines were being addressed under productive ward work.

The Council thanked FH for the update on the Board's handling on this matter.

7. AUDIT COMMITTEE TERMS OF REFERENCE

The Council received a report setting out for consultation the terms of reference of the Trust Board Audit Committee. The Governors requested that the membership of the Audit Committee be set out more clearly. It was noted that only non-executive directors could be members of the committee, that the membership was a minimum of three non-executive directors and that the Foundation Trust Chairman could not be a member. At present, there were four non-executives appointed to the Audit Committee.

8. FEEDBACK REPORTS

The Council received notes prepared by the non-executive directors arising from the 14 April Governor/NED meeting. There was general agreement that these should continue in the present format.

The Council received the notes of the South Wiltshire Rural Constituency meeting held in Tisbury on 14 April. Governors were reminded of the West Wiltshire Constituency meeting taking place on 13 May at Warminster Civic Centre.

It was suggested in relation to a military appointed governor that the first priority was to identify a suitable candidate to take on this role. After

this, a straightforward amendment to the Trust's constitution would be necessary to create the additional post.

The Council was reminded that the next informal meeting was scheduled for Monday 16th June.

9. WORKING GROUP REPORTS

The Council of Governors received approved minutes of the Membership and Communications Group, Performance Committee, Nominations Committee, Strategy Review Group and the Patient Experience Group. There was concern that the notes arising from recent meetings of the Membership and Communications Group and the Strategy Review Group had not been available to be presented at this meeting of the Council of Governors.

The Council also discussed the use of NHS Net for email. John Carvell undertook to discuss revisiting this with the IT Department. He also reminded Governors of the programme of Medicine for Members lectures.

10. DATES OF FUTURE MEETINGS

The Council received a note reminding them of forthcoming Council meetings, development sessions, informal meetings, the AGM, and Trust Board Meeting in 2014.

PAPER: SFT 3546

CAPITAL DEVELOPMENT REPORT FOR THE PERIOD FEBRUARY – MAY 2014

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 (January 2014).

MAIN ISSUES:

Springs main entrance redevelopment (7087C0)

This project will comprise two single storey extensions to the existing SDH North building, internal alterations close to the corridor end of Springs restaurant, creation of a new main entrance lobby with retail space, replacement of the covered pedestrian walkway and minor alterations within car park 8. Due to other building schemes in that area, and the requirement for full ground survey investigations, work on site is now expected to start on site toward the end of 2014 with completion expected in early summer 2015.

Dementia patient care project in Redlynch and Pitton Wards (7086C0)

Following the receipt of DoH funding (£800k), the refurbished Redlynch Ward opened in February and has been very positively received by patients and visitors. A second phase of work in Pitton Ward (currently decanted to Braemore ward) was started at the end of April and will complete at the end of July 2014.

Hospice refurbishment

Following more successful bidding, funding of £526k was secured from the DoH to carry out refurbishment within the Hospice. The work began on site on 3rd February and building work is planned for completion in May 2014, with the service moving back on 2nd June.

ITU Expansion

A £1.2m major redevelopment of Radnor Ward Intensive Therapy Unit is currently being designed. This development will increase the potential bed capacity from 8 to 12. The work will begin in August once Braemore is available to provide a decant facility for Downton ward, with Radnor temporarily being hosted on Downton. The work will be complete by mid December.

Other SDH Site Redevelopment schemes

Work is continuing to investigate development opportunities for the vacated areas of SDH South. The approval of the Trust's strategic service review and the estates review now gives the opportunity to engage with the two preferred bidders in detail dialogue. An initial list of potential schemes has been shared with each bidder for further joint working. An invitation to negotiate will be published during May outlining how the proposed joint venture will work and provide a basis for the Trust to appoint a preferred partner.

Second CT Scanner

Sufficient funding was secured to purchase two new CT Scanners. It is planned for the new additional scanner to be purchased and operational by the autumn, whilst the replacement scanner for the current scanner should be in place during late summer.

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 2013/14 (Appendix A)

Laurence Arnold
Director of Corporate Development

APPENDIX A

Other significant schemes in the Approved Capital Programme for 2013/14

Building and Works schemes	Completion date	Budget cost incl VAT
Efficiency schemes (7703C0) Funding available to support efficiency projects with rapid payback revenue savings.	March 2014	£396k
Main Theatres Laminar Flow system (7070C0) This scheme will see Theatre 5 converted into a laminar flow facility.	2014/15	£185k
Spinal Treatment Centre refurbishment (7049C0) Replacement of single glazed windows with double glazed units along with range of smaller refurbishment items prioritised for 2013/14 programme. Remainder of scheme may be amalgamated with other works planned in Spinal Treatment Centre for economy of scale in 2014/15.	2014/15	£270k
Main Entrance Level 3 upgrade (7098C0) Scheme to improve patient flow and service and accommodate centralised outpatient reception. The building works completed in March with a new reception desk due to be installed in June. The self check in kiosks have been ordered and the technical implications of their installation being reviewed.	March 2014 Summer 2014	£125k
Main Chillers replacement (7212C0) Project 1st phase to replace the main chiller units located in SDH north with modern compliant and energy efficient plant.	March 2014 (now complete)	£484k

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	£390k 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. 2nd year of 2.	March 2015	£190k (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.	March 2015	£175k (this year)
Lift Refurbishment Programme (7056C0) A programme to upgrade all the lifts in Phase 1 building. Year 3 of 3.	March 2015	£130k
SDU – x2 New Washers (7006C0) To replace two of the five SDU washers which are more than ten years old	September 2014	£100k

APPENDIX A (cont)

Information Technology schemes	Completion date	Budget cost incl VAT
Server Virtualisation (7702C0) This scheme aims to decommission 168 of the 191 IT servers and convert them to virtual servers running in 14 physical hardware platforms. A lot of investigation work has been necessary on this project. There are 40 physical servers left of which approximately 35 can never be virtualised. A first take of benefits realization has been undertaken which indicates a cost avoidance of over £1 million in not having to buy and build new physical servers.	March 2014	£1,250k overall
Clinician's View (7932C0) Phase 2 (Single Sign On (SSO)) will allow staff to log in once and access the same patient's records from various systems is now part of the Citrix upgrade (to XenApp). Plan in place to rollout on wards starting in June. Phase 3 (Electronic Document Management) – the proof of concept was successful. Hierarchy for files agreed. Tables being set up to align signature blocks to files to enable storage of clinic letters in Trust's EDM (Windip) – more than two million historic clinic letters due to be processed.	June 2014 Mid June '14	
PACS/RIS (7943C0) Main project now complete - work progressing on XDS (Cross Data Sharing)	October 2014	
Order Comms and Results Reporting (7942C0) First phase complete (all path and radiology requested electronically). Second phase sees sexual health electronic requesting and rollout into primary care – radiology requesting and ability for GPs to look up results ordered in secondary care.	September 2014	£45k
Blood Tracking Phase 2 (7996C0) Project to allow tracking of blood from "vein to vein". 100 % Traceability is a regulatory requirement under the Blood Safety and Quality regulations (2005). First phase went live on		

6th May – electronic booking in and out of blood fridge. Second phase is electronic requesting and label printing at bedside.	Early 2015	£337K
Electronic Prescribing and Medicines Administration (EPMA) (7961C0) In collaboration with 3 other Trusts to procure system. HM Treasury approval given for funding to proceed to tender. Four shortlisted suppliers demonstrating their system at the end of July. Contract award in October with go live programmed for April 2015.	April 2015	£152K
Patient Observation and Escalation Tool (POET) Following successful bid to DoH funds, the Trust is developing its in-house product to record bedside observations, present them back to staff and to produce an early warning score for escalation (phase 1). Phase 2 will see greater linkages with Trust systems and the automatic escalation to responsible clinicians via text, bleep and email. Good clinical engagement has allowed production of specification for first stage to be produced to time.	Sept '14 rollout	£267k

APPENDIX A (cont)

Medical Devices schemes	Completion date	Budget cost incl VAT
Bed Replacement Programme (7131C0) The bed replacement programme is now in it's second year. So far, 120 beds have been replaced. Areas with new beds include Redlynch Ward, Winterslow Ward, Farley Stroke Unit, Burns Unit and the Pembroke Suite.	Year 2 of a 4 year programme	£150k (2014/15)
Hysteroscopes (7136C0) There has been a slight delay with both the delivery and the sterilisation of the equipment required to run this service.	June 2014	£40k
Theatres Operating Lights (7128C0) The phased replacement programme is now in year 2. Theatres 5, 6 and 8 in Main Theatres and Theatre C in the Day Surgery Unit have been replaced. Theatres A, B, D and E in Day Surgery will be replaced this financial year.	September 2014	£115k
Anaesthetic Machines (7106C0) The machines in the Obstetric Theatre and DSU recovery are in need of replacement. The plan is to standardise the machines with those already being used around the Trust – to reduce risk and enable flexible working.	September 2014	£100k
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. Evaluations are currently being undertaken.	June 2015	£110k
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. A working group has been established under the Transformation umbrella to look at specialities on a rolling programme.	December 2015	£300k

Medical Devices schemes	Completion date	Budget cost incl VAT
The aim is to rationalise trays whilst replacing old instrumentation.		
Vascular Unit Ultrasound Machine (7125C0) Machines are currently being evaluated.	September 2014	£90k