SALISBURY NHS FOUNDATION TRUST

TRUST BOARD

MONDAY 5 JUNE 2017, 1.30 PM

IN THE BOARD ROOM, SALISBURY DISTRICT HOSPITAL

A G E N D A

				Paper No.	Page No.
1.30 pm	**1**	**APOLOGIES FOR ABSENCE**			
	2	**DECLARATION OF INTERESTS**			
	3	**MINUTES** Public Board Meeting held on 3 April 2017			1
	4	**MATTERS ARISING**			
	5	**CHIEF EXECUTIVE**			
		1. Chief Executive's Report	CC-B	SFT 3889	9
2.00 pm	**6**	**STAFFING**			
		1. Workforce Performance Report including Nurse Staffing	HS/LW	SFT 3890	11
2.20 pm	**7**	**PATIENT CARE**			
		1 Quality Indicator Report to 30 April (month 1)	CB/LW	SFT 3891	39
		2. Report of Director of Infection Prevention Control	LW	SFT 3892	47
2.35 pm	**8**	**PERFORMANCE AND PLANNING**			
		1. Finance & Performance Committee Minutes – 27 March and 24 April 2017	NM	SFT 3893	85
		2. Financial Performance to 30 April (month 1)	MC	SFT 3894	-
		3. Progress against Targets and Performance Indicators to 30 April (month 1)	AH	SFT 3895	93
		4 Major Projects Report	LA	SFT 3896	103
		5. Capital Development Report	LA	SFT 3897	113
3.00 pm	**9**	**PAPERS FOR NOTING OR APPROVAL**			
		1 Voluntary Services Annual Report	HS	SFT 3898	123
		2 Audit Committee minutes – 13 March 2017	PK	SFT 3899	131

		3. Clinical Governance Committee minutes – 23 March 2017	MM/JR	SFT 3900	135
		4. Council of Governors draft minutes – 15 May 2017	NM	SFT 3901	143
		5. JBD minutes evidencing presentation of Assurance Framework and Risk Register	CC-B	SFT 3902	147
		6. Guardian of Safe Working – Annual Report	CB	SFT 3903	-

3.30 pm **10** **ANY OTHER URGENT BUSINESS**

11 **QUESTIONS FROM THE PUBLIC**

12 **NEXT MEETING**

The next public meeting will be held on Monday 7 August 2017, in the Board Room at Salisbury District Hospital starting at 1.30pm

SALISBURY NHS FOUNDATION TRUST

Minutes of the meeting of Salisbury NHS Foundation Trust Board Held on Monday 3 April 2017

Board Members Present:	Dr N Marsden	Chairman
	Ms T Baker	Non-Executive Director
	Mr M von Bertele	Non-Executive Director
	Dr C Blanshard	Medical Director
	Mrs C Charles-Barks	Chief Executive
	Mr M Cassells	Director of Finance and Procurement
	Mr A Hyett	Chief Operating Officer
	Mrs A Kingscott	Director of Human Resources and Organisational Development
	Mr P Kemp	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
	Dr M Marsh	Non-Executive Director
	Ms L Wilkinson	Director of Nursing
Corporate Directors Present:	Mr L Arnold	Director of Corporate Development
	Mr I Downie	Associate Non-Executive Director
	Mr S Long	Associate Non-Executive Director
In Attendance:	Mr P Butler	Head of Communications
	Mr D Seabrooke	Secretary to the Board
	Mr P LeFever	Wiltshire Health Watch
	Mrs L Turner	Public Governor
	Mr N Alward	Public Governor
	Dr A Lack	Lead Governor
	Dr J Lisle	Public Governor
	Sir R Jack	Public Governor
	Mr R Polkinghorne	Appointed Governor
	Dr R Robertson	Governor
	Mrs J Sanders	Public Governor
	Mr J Mangan	Public Governor
Apologies:	Prof J Reid	Non-Executive Director

ACTION

2259/00 DECLARATIONS OF INTEREST AND FIT AND PROPER/GOOD CHARACTER

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

2260/00 MINUTES – 6 FEBRUARY 2017

The minutes of the of the Board held on 6 February 2017 were agreed as a correct record subject to a correction in minute '2245/00':- transferring primary care should read transforming primary care.

2261/00 MATTERS ARISING

2246/01 Temporary Workforce – AK would circulate detailed information. **AK**

2246/01- AK confirmed that there was a solid return on investment in the Philippines recruitment for nurses and other campaigns continued to be monitored.

2247/01 Hip Fractures – CB informed the board that the Trust's compliance from the latest data with best practice tariff in this area was 80.5%

2248/04 The Board noted that the next steps for Lorenzo would be discussed at a future Board Seminar Day.

2262/00 CHIEF EXECUTIVE'S REPORT - SFT 3870 – PRESENTED BY CC-B

The Board received the report of the Chief Executive. CC-B highlighted the hospital summit which had focused on addressing Delayed Transfers of Care. A number of key actions had been agreed by partners and the Trust now had an Integrated Discharge Bureau in place.

The National Staff Survey had ranked Salisbury as the 7th best place to work. There were concerns about the number of staff reporting that they were working extra hours. CC-B thanked all those who had responded to the survey.

On the CQC Improvement Plan steady progress continued to be made and the Chairman joined CC-B in commending the response by the Spinal Service in securing compliance with the earlier warning notice in respect of outpatient backlogs.

CC-B highlighted the recent Pride in Practice event, the success of a number of staff including Louise Bell in winning awards and finally on the official opening of the new Breast Unit. She thanked all those that had given this fundraising campaign their support.

The Board noted the Chief Executive's report.

2263/00 STAFF

2263/01 Workforce Performance Report including Nurse Staffing - SFT 3871 - Presented by AK & LW

The Board received the Month 11 Workforce Report. AK informed the Board that on statutory/mandatory training the focus at that stage in the year had been on delivery to patients and she forecast a bulge in training compliance coming through in month 12 following the release of escalation accommodation. The sickness absence rate was tracking slightly above trajectory. The Trust was looking at links to armed services families returning to the area from Germany as a potential source of clinical skills and recruitment. The Trust was a fast follower for the new nurse associates and was looking closely at the new physician associates. AK highlighted the implementation of the 'IR 35' rules in relation to tax and national insurance deductions for staff contracted through a personal services company. It was noted that issues arising from IR 35 had been managed successfully.

It was noted that turnover in Estates was in part driven by the range of employment opportunities available to employees with this skill set.

It was noted that agency spend was reducing following the closure of escalation accommodation.

It was noted that three Filipino nurses had arrived recently and a further ten were in the UK and it was intended to recruit around 20 from this cohort. The Trust was currently in India planning 120 interviews with a view to making 75 job offers for 2018 intake.

In relation to a NED question it was noted that departmental sickness targets were based on past performance.

Finally the Board congratulated the executive on achieving the reduction in escalation accommodation.

Safer Staffing Report

It was noted that for February the percentage of nursing assistants was 115.4% which was due to a number of EU nurses operating as nursing assistants pending the completion of recruitment formalities. For registered nurses the percentage was 96.4.

Activity on maternity and NICU was flagging red/amber this was due to lower activity and similarly with Avon and Tamar, lower acuity. Twice daily review of nursing shifts was continuing.

Patient acuity was monitored three times daily through an on line tool which provided guidance towards the professional judgement on requirements and priorities.

The Board noted the report.

2263/02 Staff Survey Results 2016 – SFT 3872 – Presented by AK

The Board received the Staff Survey results. The Survey had this year been opened to £3800 employees and a response rate of 36% was reported. The Trust was felt to have retained a strong overall position with 18 of the 32 areas reported as being in the top 20%. The Trust was in the bottom 20% for extra hours worked and in relation to errors and near misses. Picker had highlighted three principal themes – a strong safety culture provided to patients and actions taken on staff well–being.

The Trust would be adding to the existing action plan in relation to reports of extra hours worked. It was suggested that engagement scores for 2016 were slightly reduced in 2015 as in 2015 there had been extensive staff engagement on the CQC visit that took place in December 2015.

The Chairman requested that Picker present the final findings to the Trust Board for the 2017 update. DS

2264/00 PATIENT CARE

2264/01 Quality Indicator Report to 28 February 2017 – SFT 3873- Presented by CB and LW

The Board received the Quality Indicator Report. CB informed the meeting that the hospital standardised mortality rate was increasing (119.5 – higher than expected) and that the standardised hospital mortality index had decreased to 104th which was in line with the trend for crude mortality. It was requested by the Chairman that there be a seminar briefing on mortality indicators at a future seminar day. DS

There was now a ring fenced/take bed in place. Stroke and TIA performance was improving. As noted previously a number of escalation beds had been closed during March subsequent to this report.

There had been no MRSAs and in February no C-Diffs reported. The year-end total for C-Diff was 13 against the ceiling of 19. There was however a change of definition for C-Diff that could affect future reports.

There had been no falls resulting in harm during February. Five non-clinical delivering single sex accommodation breaches had been reported but this had had reduced in March. Patient feedback continued to be positive.

In relation to a question by Cara Charles-Barks it was noted that there had been some difficulties in the Pembroke Suite in maintaining the balance between in-patients and day cases during the period of escalation.

Stroke performance was affected by staffing issues and recruitment difficulties. The Trust continued to develop the early supported discharge pathway with Wiltshire Health and Care to help address this.

2264/02 Customer Care Report – Quarter 3 - SFT 3874 – Presented by LW

The Board received the Quarter 3 Customer Care report. The number of complaints received was down against Quarter 2 and this had continued into Quarter 4. Activity levels on complaints were running at the same time as last year. Complaints continued to represent about 0.1% of activity. 100% of complaints were acknowledged within the time scale of 3 days and there were some delays in completing substantive responses. An action plan was being developed for submission to the Health Ombudsman in relation to the asthma pathway.

The Board noted the Customer Care Report.

2265/00 PERFORMANCE AND PLANNING

2265/01 Finance & Performance Committee Minutes – 23 January and 27 February 2017 – SFT 3875 Presented by NM

The Board received for information the confirmed minutes of the Finance and Performance Committee 23 January and 27 February 2017.

2265/02 Financial Performance to 28 February 2017 (Month 11) – SFT 3876 – Presented by MC

The Board received the Finance and Contracting Report. It was noted that there was a small surplus, slightly ahead of plan. The savings target would be offset by a stock adjustment to be made at the year end. Other

mitigations to the year end position included support from commissioners and the operating surplus from Trust's subsidiary companies. It was anticipated that the Trust would meet its 2016/17 control total. Quarter 4 Sustainability and Transformation Funding was all dependent on financial performance. Because of delays to receipt of Sustainability and Transformation Funding the cash position was down against plan. A number of capital schemes had gone through in March also affecting the position. The Trust's commercial activity continued to progress, for example the laundry was winning contracts and the My Trusty range was going into major national retail chains.

Discussions about future cash flow were continuing with NHS Improvement.

2265/03 Progress Against Targets and Performance Indicators to 28 February (month 11) – SFT 3877 – presented by AH

The Board received the Performance Indicator Report. AH informed the Board that Quarter 4 had been challenging for the Emergency Department and that year end performance was 90.8%. Work continued through the Emergency Department Local Delivery Board, the Perfect Week and the Delayed Transfers of Care Summit referred to by the Chief Executive in her update.

The Trust had requested a resubmission of its referral to treatment information for November, December and January as verification had established this as being over 92%. It was expected to make a late submission for February. AH highlighted issues with the MRI scanner capacity which affected Endoscopy performance under diagnostics. It was hoped to deliver the Cancer targets.

It was noted that the Trust continued to be among the top 20 performers under the Emergency Department.

The Board noted the report.

2265/04 Major Projects Report - SFT 3878 - Presented by LA

The Board received the Major Projects Report. LA highlighted the stabilisation plan for the Lorenzo system which included finalising and revising outcome forms and carrying on with training for staff. The data warehouse was now substantively complete and the Board noted that phase two of Lorenzo was red rated whilst the stabilisation phase continued.

LA undertook to circulate the Wiltshire Health and Care business plan to all the Board. He highlighted a major initiative by Wiltshire Health and Care to recruit rehabilitation support workers. Joint recruitment initiatives for therapy and rehabilitation and some nursing posts with Wiltshire Health and Care was noted. The Trust's PMO would also be providing support to Wiltshire Health and Care and the Chairman and Chief Executive would be meeting with their opposite numbers from Wiltshire Health and Care shortly. LA

The Board noted the Major Projects Report.

2265/05 Financial Estimates 2017/18 – SFT 3879a – Capital Programme 2017/18 – SFT 3879b - Presented by MC

The Board received the base estimates and Capital Programme for 2017/18.

MC informed the Board that the budget now being proposed included a 7.5% savings target which was planned to deliver a deficit of £7m. The Trust had not accepted its control total for 2017/18 as this was not considered viable. Cuts to the national tariff were continuing. The report described a number of assumptions for income and expenditure and MC highlighted the effect of Brexit on the value of the pound and therefore inflation. Within the Cost Improvement Programmes some featured income generation that commissioners may decide to reduce their spend for example by reducing activity through QUIPP schemes. No assumptions as to savings from the Electronic Patient Record had been made. Cost pressures of around £3m had been allowed for.

Paul Kemp expressed concern about the position being adopted as it produced zero cash flow for the organisation, included non-assigned saving targets and there was insufficient detail on the planning for workforce.

Turning to the capital programme 2017/18 it was noted that the value of the capital programme was tied to depreciation. The Trust's bid for a £6m loan to support the Electronic Patient Record implementation was still under consideration.

The Capital Control Group, the Joint Board of Directors and the Finance and Performance Committee had reviewed the programme which had been reduced in line with the available resource. MC highlighted the repositioning of the Acute Medical Unit which would be £2.2 spend over two years, which would result in greater efficiency. Some proposed schemes described as not funded may be reviewed by the Trust's charity. A contingency was available should urgent issues arise in year. Proposed investment in IT infrastructure would be handled through a managed service agreement or leasing. The Trust's eligibility to receive targeted IT infrastructure funding may be affected by its position on its control total. It was noted that NHS Improvement had issued information and guidance as to accessing cash support when required.

The Board approved the revenue budget and capital programme for 2017/18

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2266/00 PAPERS FOR NOTING OR APPROVAL

2266/01 Winter Resilience 2017-18 – SFT 3880 – Presented by AH

AH highlighted the implementation of the work boards and the Orthopaedic business case previously approved by the Board as means of supporting winter pressures in 2017/18. Members of the Board and also the Finance and Performance Committee had been discussing the proposed new modular building which would increase capacity by moving the Ophthalmology Outpatients service, creating a new 23 hour ward and additional medical beds in the hospital referred to in paragraph J of the Capital Programme Report.

It was recognised that a number of actions had been taken as a matter of urgency in support of this scheme to ensure that it was in place in time and the Board ratified these earlier actions.

2266/02 Audit Committee Minutes - 17 October 2016 - SFT 3881 – Presented by PK

The Board received the confirmed minutes of the Audit Committee held on 17 October 2016. Paul Kemp informed the Board that items in the minutes around a counter fraud report on medicines management and a limited assurance report in relation to Medical Devices had been followed up at the March 2017 meeting of the Committee. The Committee intended to close these items out at its 19 May meeting.

He informed the Board that the Council of Governors had as noted in the draft minutes of the 20 February Council meeting approved the appointment of external auditors from 1 April 2017.

2266/03 Clinical Governance Committee Minutes - 26 January and 23 February – SFT 3882 – Presented by MM

The Board noted the minutes of the Clinical Governance Committee of 26 January and 23 February 2017.

2266/04 Council of Governors – Draft Minutes 20 February 2017 – SFT 3883 – Presented by NM

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

2266/05 Joint Board of Directors Minutes Evidencing Presentation of Assurance Framework and Risk Register – SFT 3884 – Presented by CC-B

The Board noted the minute presented from JBD and noted the continuing review by the executive of the working of the Assurance Framework.

2266/06 Annual Statement on Major Incident Preparedness – SFT 3885 – Presented by AH

The Board received the annual statement. AH informed the Board that all 52 standards were now rated green.

The Board noted the report.

2267/00 ANY OTHER URGENT BUSINESS

<u>Appraisal Quality Assurance</u>

Michael Marsh informed the Board that the work of the Responsible Officer had been reviewed and a number of good practice areas identified. Christine Blanshard, the Responsible Officer would be reporting on areas of improvement that were understood to require additional resource.

2268/00 QUESTIONS FROM THE PUBLIC

In relation to a question from Lynn Taylor, LA stated that Dorset CCG were currently out to consultation about community provision. The recent Perfect Week had evidenced that the Trust discharged between 12 and 16 patients per week to the Shaftesbury Hospital. The Trust had in a discussion asked the CCG that an alternative be put in place before any closures were finalised. The Trust also used Shaftesbury Hospital as a base for peripheral clinics.

In relation to a question from Jenny Lisle about fatigue, tiredness and potential errors arising from the long hours evidenced in the staff survey it was noted that the Trust was working on ways to improve the resilience of staff and continued to use a range of means to assess this error.

2270/00 DEPARTING DIRECTORS – LAST PUBLIC BOARD

Directors joined the Chairman in thanking Alison Kingscott, Director of Human Resources and Organisational Development for her contribution since October 2012, in the running of the Trust and wished her well for the future.

Ian Downie and Steve Long had been appointed respectively as Non-Executive Directors in 2009 and 2008 and would be completing their terms on 31 May 2017.

2271/00 DATE OF NEXT MEETING

The next public meeting of the Board would be held on Monday 3 July 2017 at 1.30 pm in the Board Room.

Salisbury NHS Foundation Trust Board - 5 June 2017

SFT 3889

Title: Chief Executive's report

Report from: **Cara Charles-Barks**

Executive Summary: The written part of the Chief Executive's report sets out a range of significant and celebratory news in the life of the trust. It is an opportunity for the CEO to highlight achievements and also to provide the very latest news to the board,

Proposed Action: The board is invited to note the report

Supporting Information

NHS EMPLOYERS DIVERSITY AND INCLUSION PARTNERS PROGRAMME

We have been chosen as one of the Diversity and Inclusion Partners for this year's NHS Employers Programme. The programme gives trusts the opportunity to develop their existing equality and diversity policies and plans, further embed and integrate diversity and inclusion into the culture of their organisations and share best practice with other hospitals. There was fierce competition for places, so this is a fantastic achievement that highlights our existing approach and commitment in this area.

BREAKING THE RULES FOR AN OUTSTANDING PATIENT EXPERIENCE

To ensure we continue to provide an outstanding patient experience, in June we will be encouraging patients and staff to share and submit their experiences of hospital rules, habits, policies and procedures that could get in the way of improvements. Patients and staff will be able to do this by email and online survey, and through comments gathered at ward level. The rules will be collated and themed and shared with wards and departments so that work to understand and explore opportunities for change can be taken and, where possible, implemented as a result. Further details will be published shortly.

SAVE 7 FINALISTS IN NATIONAL AWARDS

I want to congratulate the Save 7 team whose achievements have been recognised by the Health Service Journal (HSJ), as part of its annual Awards in London. With over 400 award entries, Save 7 reached the final eight in the Communications category highlighting the way in which all staff have been given the opportunity to participate in change and generate ideas that help improve practices that add value, improve efficiency and patient experience. Every application will now be added to HSJ solutions, which provides a database of best practice across the country.

NEW FREEDOM TO SPEAK UP GUARDIANS

I am personally committed to ensuring that our staff have the opportunity and appropriate channels to raise any issues that relate to their work and I'm pleased to welcome Hazel Hardyman, Lizzie Spicer and Pamela Permalloo-Bass, who have together taken on the role of Speak up Guardians. The Freedom to Speak Up Guardian is a nationally recognised role within the NHS and Guardians have direct access to me. Staff can speak confidentially with them about any issues around the quality of care, patient safety or issues that affect them or the wider hospital. They can help in ensuring that concerns are raised and listened to or signpost to other appropriate channels such as our Dignity at Work Ambassadors. In welcoming our three new Guardians, I would like to take this opportunity to thank Isabel McLennan for her commitment to the role. Isabel has now completed her term of office as our single Freedom to Speak up Guardian

CARERS' WEEK

Our staff will be raising awareness of caring and the challenges that all carers face as part of national Carers' Week which starts on June 13. On Tuesday, June 14, there will be a carers' information and enquiry stand in Springs Restaurant from 9:30am until 4:30pm. We will be holding a carers' information trolley dash across all clinical areas and there will also be an afternoon tea party for staff, followed by a 10 minute presentation on why carers are key people. National Carers' Week gives us an opportunity to acknowledge the tremendous support that carers give to family, friends or people that need their help and also the significant contribution that they make to our society.

WALK FOR WARDS

I would like to use my report to thank our staff and the local community for the fantastic support that they give us and to highlight Walk for Wards, which takes place on Sunday, 2nd July at Wilton House. This is such an enjoyable event that is free to enter with a minimum sponsorship of £15 per person, which can be directed towards the charitable fund of any ward or department within the hospital. Walkers have the choice of a 3km, 5km or 10km route and are provided with a free lunch and free entry to the Wilton House grounds after the event. Last year, over 2,000 people registered making it a really enjoyable and successful day.

Salisbury NHS Foundation Trust Board - 5 June 2017

SFT 3890

Title: Workforce Performance Report and Safer Staffing Report

Report from: Hilary Salisbury, Deputy Director of HR

Executive Summary:

Appraisal compliance for non-medical staff has slightly increased this month from 79% to 80%. Medical staff appraisal compliance has increased this month from 86% to 91%.

- **Mandatory training compliance has increased again this month from 83% to 84%, which is slightly below target (85%).**
- **The Trust vacancy rate has increased to 7% this month. A number of recruitment initiatives are planned to recruit to unfilled posts.**
- **Staff sickness for the last year remains above target at 3.4%. This compares favourably with latest NHS sickness rate of 4.24%. The reasons for this rise are being monitored and action being taken by Directorate teams.**
- **The Trust's Turnover rate in month 1 is 11.0%, which has increased from last month.**

Reasons for turnover are being monitored and initiatives taken forward at Trust and Directorate level. The overall turnover trend for the last 2 years is stable, with the Trust's turnover rate in line with or better than other Hospitals locally.

Proposed Action: The Board is invited to note the report

Supporting Information

Detailed in accompanying slides

SFT 3890

Workforce Report
M1
2017-18

Summary

Salisbury NHS Foundation Trust

- Appraisal compliance for non-medical staff has slightly increased this month from 79% to 80%. Medical staff appraisal compliance has increased this month from 86% to 91%.
- Mandatory training compliance has increased again this month from 83% to 84%, which is slightly below target (85%).
- The Trust vacancy rate has increased to 7% this month. A number of recruitment initiatives are planned to recruit to unfilled posts.
- Staff sickness for the last year remains above target at 3.4%. This compares favourably with latest NHS sickness rate of 4.24%. The reasons for this rise are being monitored and action being taken by Directorate teams.
- The Trust's Turnover rate in month 1 is 11.0%, which has increased from last month. Reasons for turnover are being monitored and initiatives taken forward at Trust and Directorate level. The overall turnover trend for the last 2 years is stable, with the Trust's turnover rate in line with or better than other Hospitals locally.

- **Note : The use of "FTE" in this report denotes "Full Time Equivalent"**

Achievements in Month

Salisbury NHS Foundation Trust

- The first two nurses recruited during the recent recruitment trip to India are due to arrive in June. A total of 75 job offers were made during the trip.
- Simulation training has become fully embedded in Paediatrics, with regular dates planned to facilitate 'in situ' scenarios. This involves all disciplines participating in caring for the deteriorating child or infant within their clinical areas.
- Monthly safeguarding SIM sessions have been piloted, and are now live for all staff requiring level 3 safeguarding training.
- Multidisciplinary simulation sessions have been designed for the deteriorating adult and are being held for staff throughout the Trust who can benefit from caring for a deteriorating ITU patient in their department.
- We have supported a rebranding of our "Dignity at Work Ambassadors" programme through updating promotional materials
- We have delivered bespoke Equality, Diversity and Inclusion training for 25 of our European nurses to date
- The Trust has joined a design group with Thames Valley and Wessex Leadership Academy Compassionate Inclusion Leadership programme

Directorate Headlines

Salisbury NHS Foundation Trust

Directorate Health Score		
Clinical Support & Family Services	2 Green, 2 Amber, 1 Red	AMBER
Facilities	2 Green, 1 Amber, 1 Red	AMBER
Medicine	3 Green, 1 Amber, 1 Red	GREEN
Musculo Skeletal	2 Green, 2 Amber, 1 Red	AMBER
Surgery	2 Green, 2 Amber, 1 Red	AMBER
Corporate	2 Green, 3 Amber, 1 Red	AMBER
Quality	3 Green, 1 Red	GREEN

Clinical Support and Family Services	M11	M12	M1	
Agency Spend	£83,951	£104,839	£90,975	AMBER
Stat/Mad Training % Compliance	84	86	87	GREEN
Appraisals % Non Medical	84	84	83	AMBER
Appraisals % Medical	87	83	87	GREEN
Sickness %. Target 2.50%	2.51	2.58	2.53	RED

Facilities	M11	M12	M1	
Agency Spend	£18,285	£19,358	£10,759	AMBER
Stat/Mad Training % Compliance	92	93	92	GREEN
Appraisals % Non Medical	97	96	98	GREEN
Sickness %. Target 3.50%	4.34	4.55	4.04	RED

Medicine	M11	M12	M1	
Agency Spend	£304,058	£290,645	£255,248	GREEN
Stat/Mad Training % Compliance	70	74	77	AMBER
Appraisals % Non Medical	65	64	68	RED
Appraisals % Medical	90	90	92	GREEN
Sickness %. Target 3.40%	3.73	3.88	3.06	GREEN

Musculo Skeletal	M11	M12	M1	
Agency Spend	£97,441	£109,743	£94,814	AMBER
Stat/Mad Training % Compliance	82	85	86	GREEN
Appraisals % Non Medical	70	71	76	AMBER
Appraisals % Medical	86	88	95	GREEN
Sickness %. Target 2.75%	3.44	3.52	3.07	RED

Surgery	M11	M12	M1	
Agency Spend	£72,689	£120,950	£58,608	AMBER
Stat/Mad Training % Compliance	83	86	85	GREEN
Appraisals % Non Medical	81	80	80	AMBER
Appraisals % Medical	89	84	89	GREEN
Sickness %. Target 3.40%	4.24	4.34	4.31	RED

Corporate	M11	M12	M1	
Agency Spend	£1,492	£60,238	£3,361	AMBER
Stat/Mad Training % Compliance	81	79	79	AMBER
Appraisals % Non Medical	84	79	80	AMBER
Sickness % Finance/Procurement. Target 1.90%	3.40	3.20	2.45	RED
Sickness % HR &OD. Target 2.00%	3.54	3.45	1.51	GREEN
Sickness % Corporate Dev. Target 3.00%	3.09	3.09	2.81	GREEN

Quality	M11	M12	M1	
Agency Spend	£0	£0	£0	GREEN
Stat/Mad Training % Compliance	96	95	92	GREEN
Appraisals % Non Medical	86	88	87	GREEN
Sickness %. Target 3.00%	1.04	1.11	4.49	RED

Additional Notes

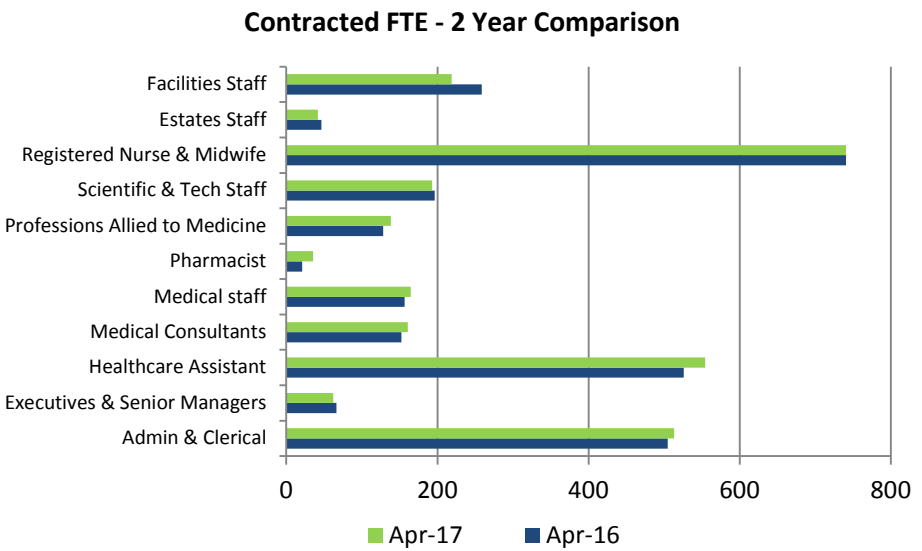
1. RAG ratings show where extra support is being provided to Directorates through the Directorate performance management structure.
2. Worsening trend and below Trust "Red" RAG rating threshold = RED. Improving trend, or above Green RAG rating threshold = GREEN. Otherwise = AMBER. Sickness worse than target = Red, Sickness better than target = Green

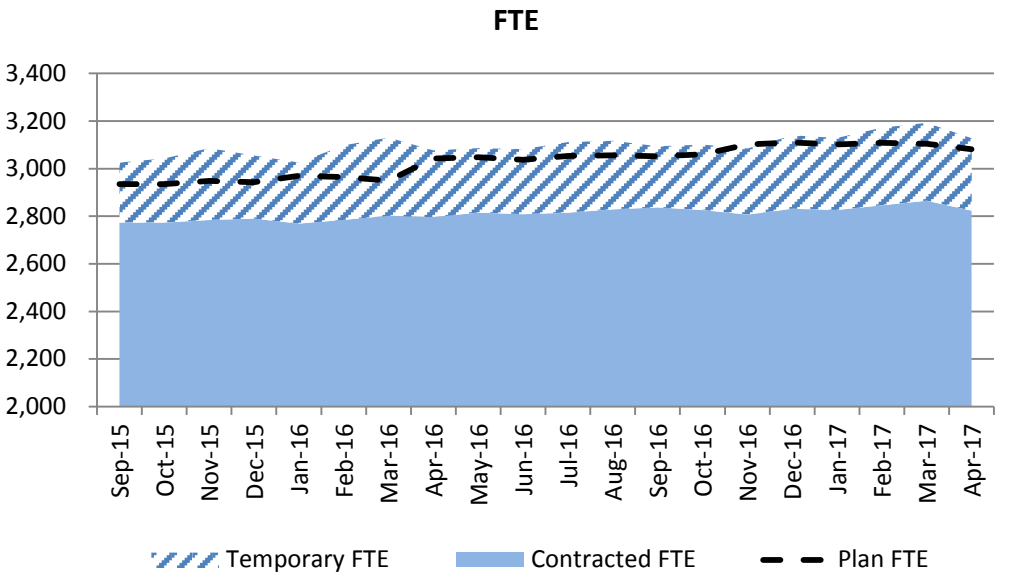
Workforce M1

Salisbury NHS Foundation Trust

April 17

Contracted Total FTE
2,823
(April 16 - 2,797)





Additional Notes

1. Overall staffing numbers remain over plan this month. The use of temporary staff is seen mainly in registered nursing and nursing assistants.

2. There have been increases in the number of contracted staff (FTE) up by 26 FTE compared with April 2016, due to recruitment to replace temporary staff and additional posts. Key areas of increase are:

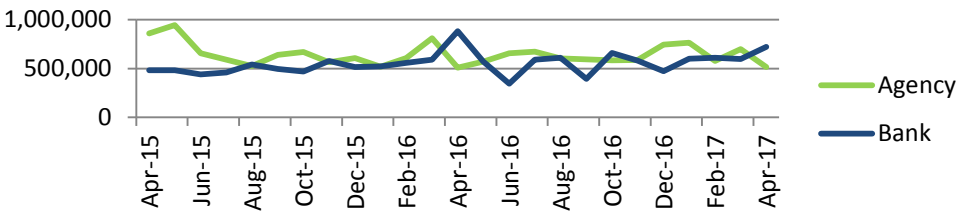
- **Healthcare Assistant: 28 FTE**
- **Pharmacist: 14 FTE**

Temporary Workforce
M1

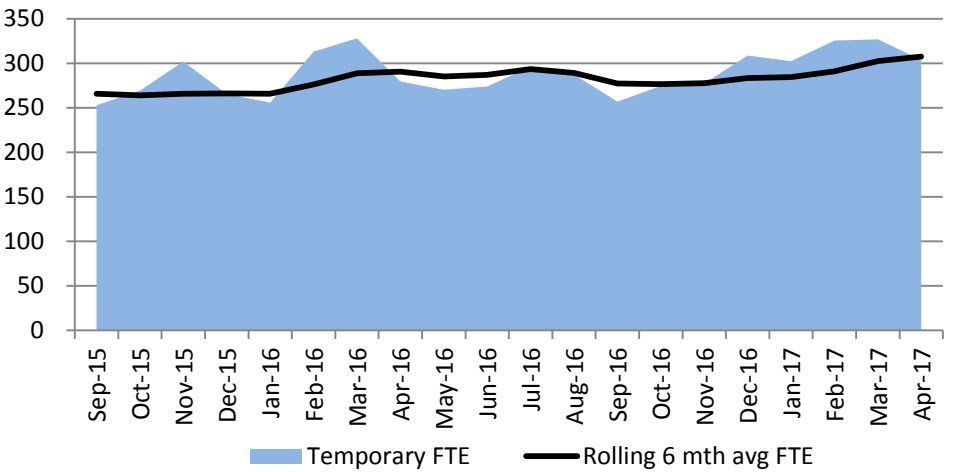
Salisbury NHS Foundation Trust

Temporary FTE 304 (April 16 - 280)

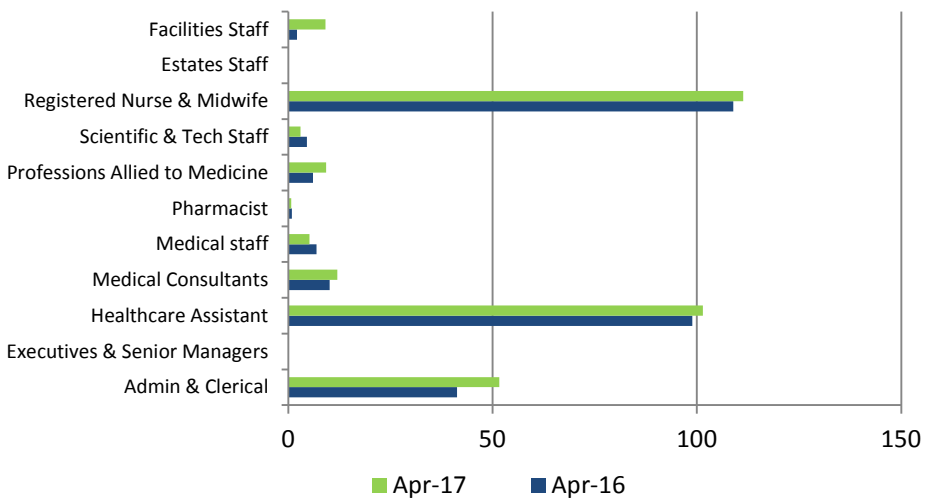
Agency and Bank Spend



Temporary FTE



Temporary FTE - 2 Year Comparison



Additional Notes

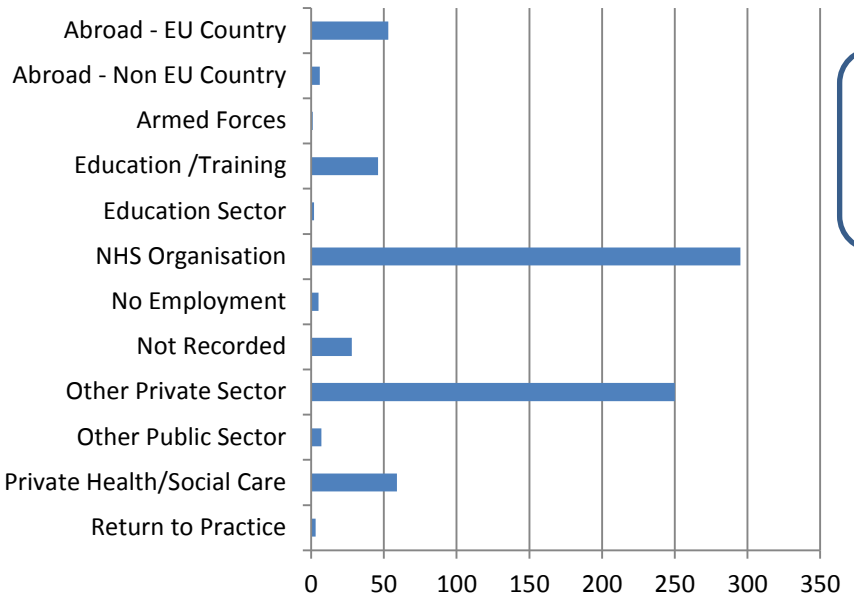
1. **Agency costs for the year to date stood at £514k, compared to £507k for the same period in 2016/17. Agency costs for April showed a decrease of £185k compared to the previous month.**
2. **Bank costs stood at £721k for the year to date, compared to £878k for the same period in 2016/17. Bank costs for April showed an increase of £124k compared to the previous month.**

Note: Temporary FTE includes bank and agency staff.

Starters – Source of Recruitment M1

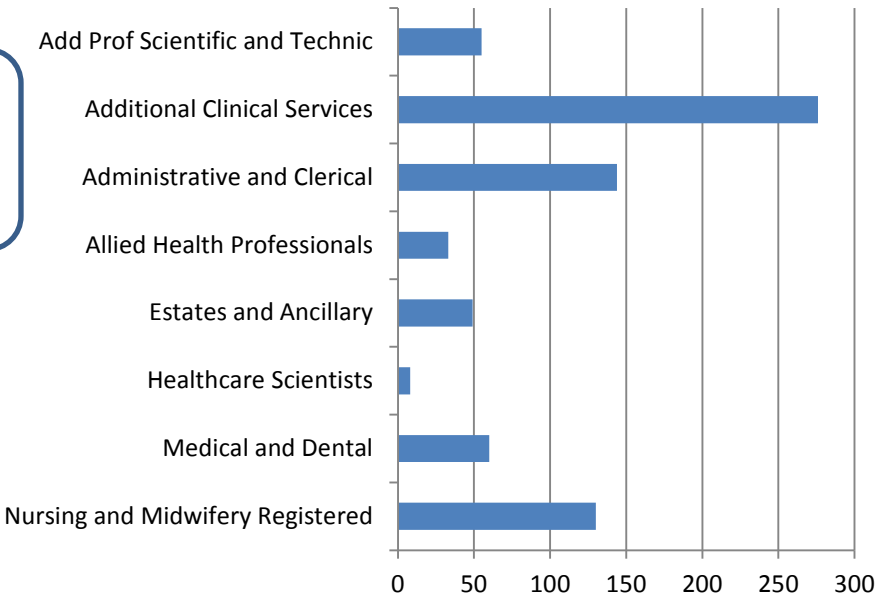
Salisbury NHS Foundation Trust

Number of Starters by Source of Recruitment



Number of M1 Starters 69

Number of Starters by Skills Group



Additional Notes

1. **There were 69 starters in month 1 compared to 32 in month 12.**
2. **As last month, the most common source of recruitment to the Trust was from other NHS Organisations; with the most popular NHS organisations being Southampton University NHS Trust, followed by Basingstoke and Dorset Healthcare NHS Trust, Royal Bournemouth and Christchurch Hospitals NHS Trust.**
3. **The skills group with the greatest number of starters was "Additional Clinical Services". This group includes Nursing and Therapy assistants.**

Figures are based on previous 12 months data and exclude trainee medical staff.

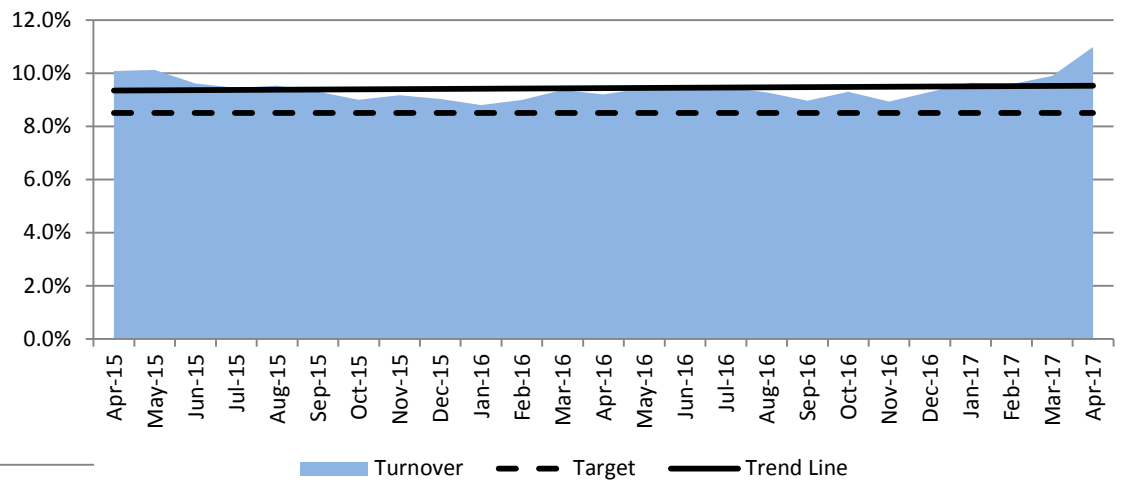
Labour Turnover
M1

Salisbury NHS
NHS Foundation Trust

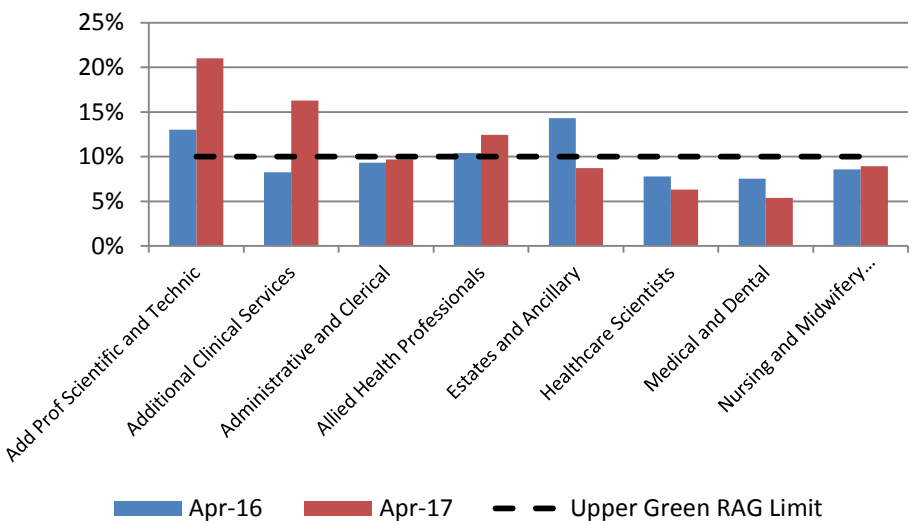
April 17

11.0%
(April 16 – 9.5%)

Labour Turnover



Labour Turnover by Skills Group



Additional Notes

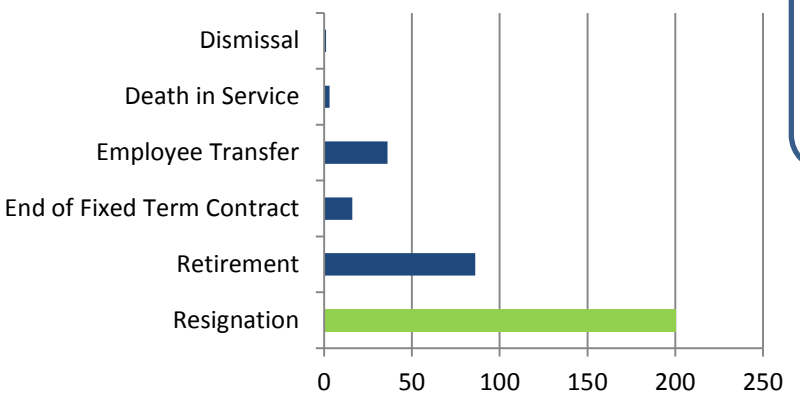
Note: Turnover figures are based on previous 12 months, and exclude bank staff and foundation and training doctors.

1. **Turnover in the year to April 2017 stood at 11.0% compared to 9.5% in the year to April 2016.**
2. **Groups with turnover higher than the Trust's 7-10% green Red/Amber/Green rating are being monitored closely at Directorate level and actions taken as appropriate.**
3. **The overall turnover trend is being closely monitored at Trust and Directorate performance meetings.**
4. **The Trust is conducting a review of the Exit Questionnaire process to encourage uptake and identify themes.**

Leavers
M1

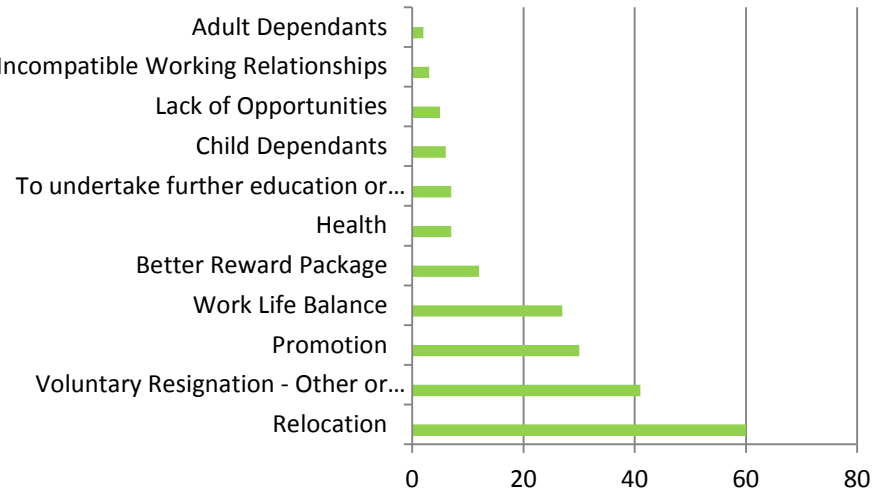
Salisbury NHS
NHS Foundation Trust

Number of Leavers by Reason

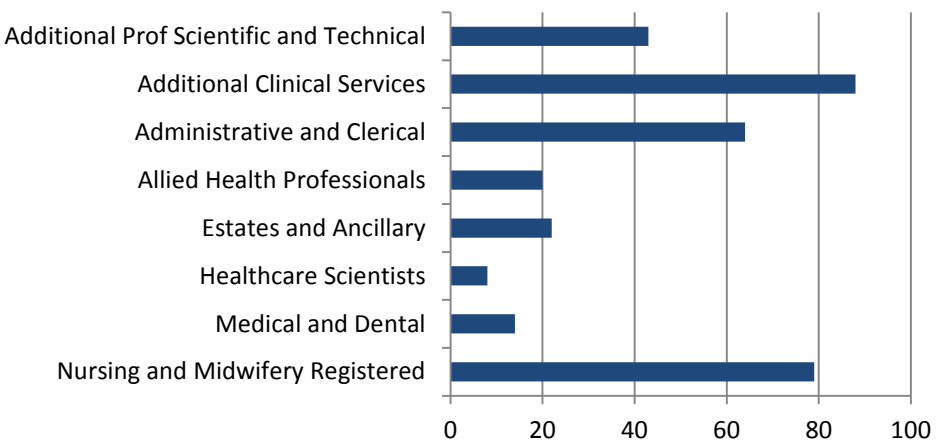


Number of M1 Leavers
50
(April 2016 - 19)

Number of Resignations



Number of Leavers by Skills Group



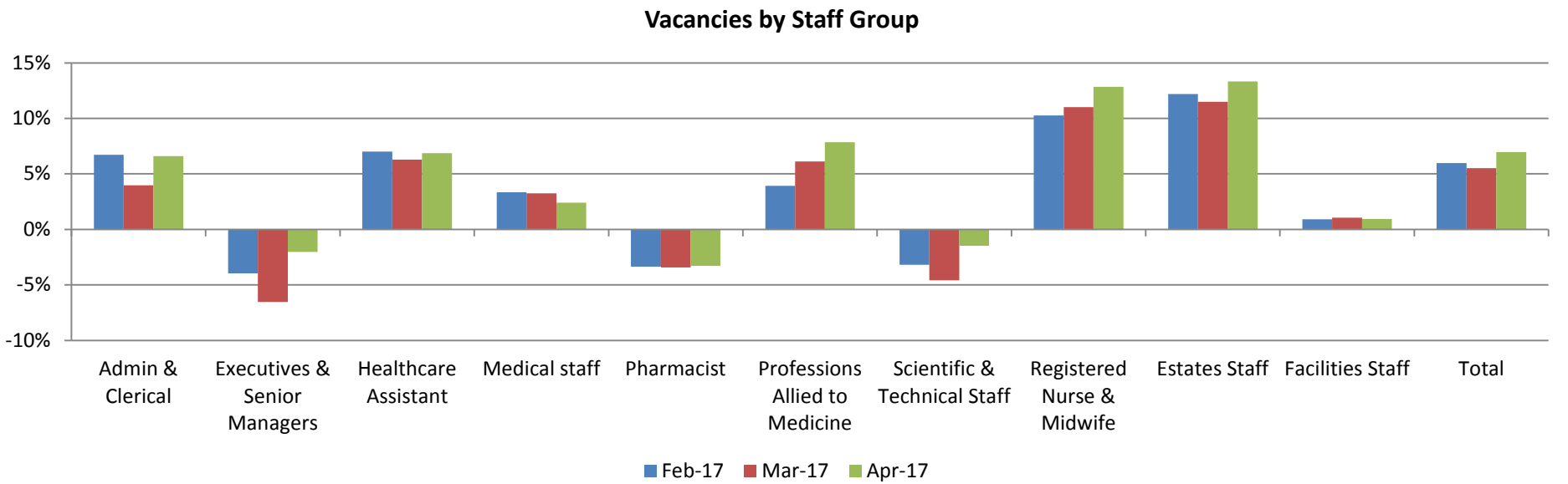
Additional Notes

1. **The most common reason for resignation was 'Relocation' which includes: family relocation due to re-basing of military partners.**
2. **All leavers can access an Exit Questionnaire or Interview. The Trust is conducting a review of the Exit Questionnaire process to encourage uptake and identify themes. These themes are fed back to managers for action.**

Note: Figures based on previous 12 months data.

Vacancies by Skills Group
M1

Salisbury NHS
NHS Foundation Trust



Additional Notes

1. The overall vacancy rate has increased to 7%, with some small changes within the workforce.

2. 75 job offers have been made following the recruitment trip to India.

3. Nursing excludes Corporate Staff and includes those with direct clinical care only.

4. Where there are recognised gaps, risk assessments are conducted to establish the impact and identify mitigating actions.

5. Some areas shown over establishment do not have a budgeted establishment as such, but earn income to cover staff costs. Others may be as a result of staff movements to cover projects, for example in Informatics, or overlap of staff for handover reasons.

Note: Vacancies shown as positive and over establishments shown as negative.

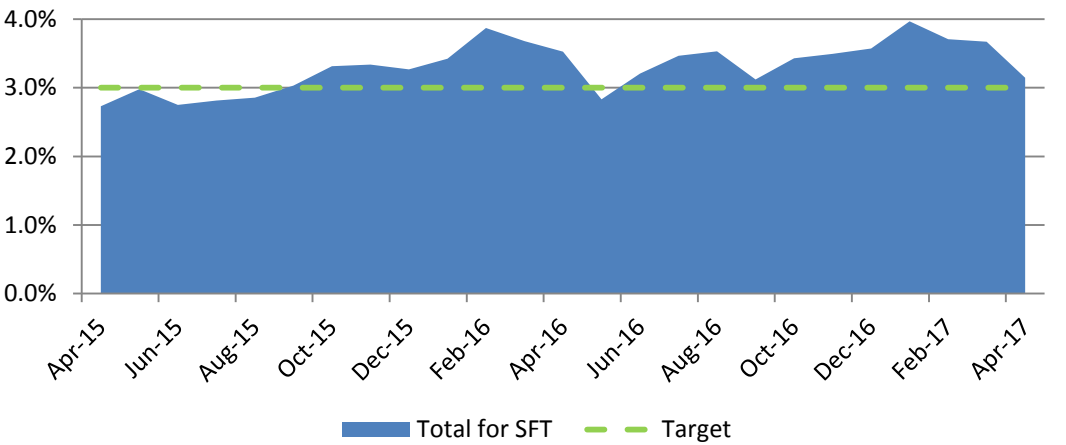
Sickness
M1

Salisbury NHS Foundation Trust

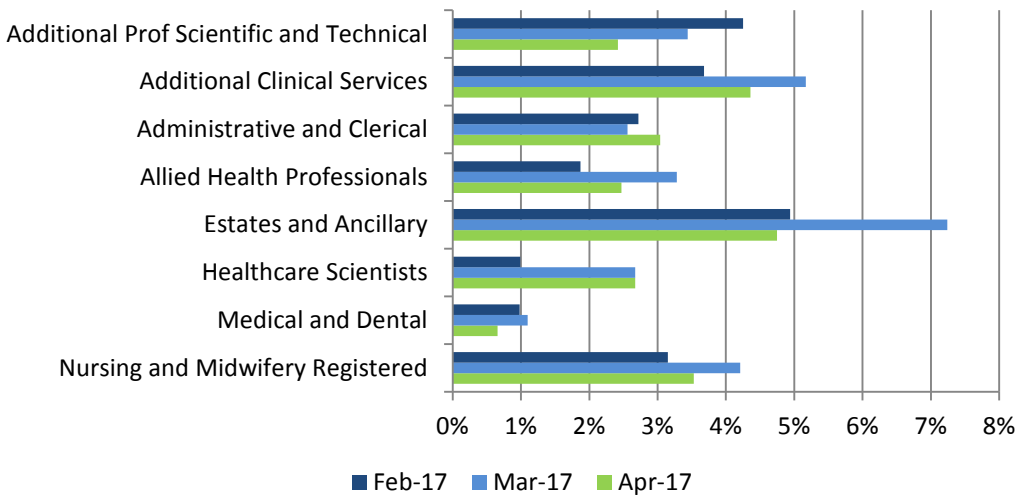
April 17

Percentage
3.42%
(April 16 – 3.23%)

Sickness Absence vs Target



Sickness Absence by Skills Group



Additional Notes

1. Each directorate has a set maximum tolerance for sickness and this is regularly monitored at performance meetings.

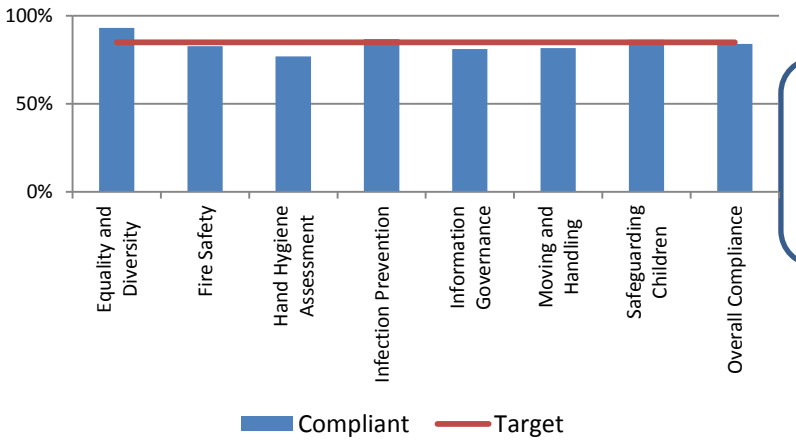
2. The most common reasons for sickness this month were, 'Anxiety, stress, depression, other psychiatric illnesses' and 'Other known causes – not elsewhere classified'. Occupational Health form regular discussions at Operational Management Board.

3. The skills group with the highest sickness rate was "Estates and Ancillary" with 4.8%, followed by "Additional Clinical Services" with 4.4%, which compare with the national NHS average sickness rates for these groups of 6.4% and 6.2% respectively.

Mandatory Training
M1

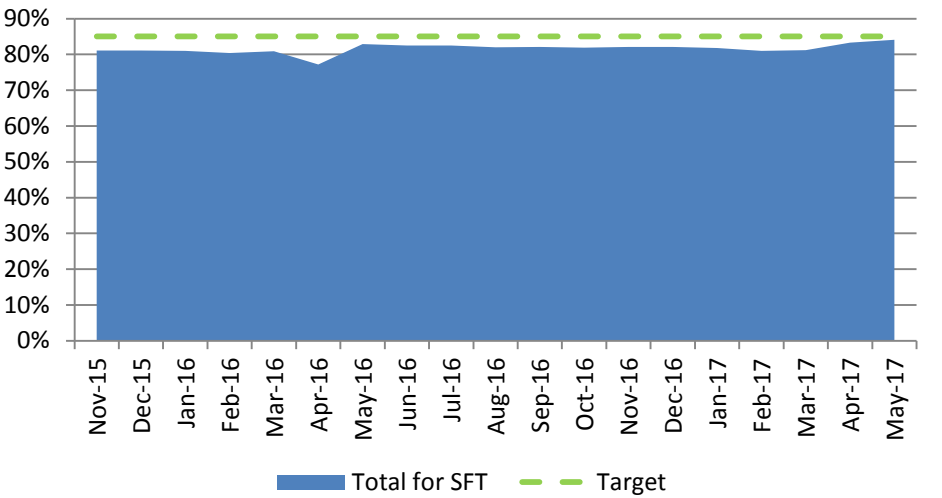
Salisbury NHS Foundation Trust

MLE Compliance by Category

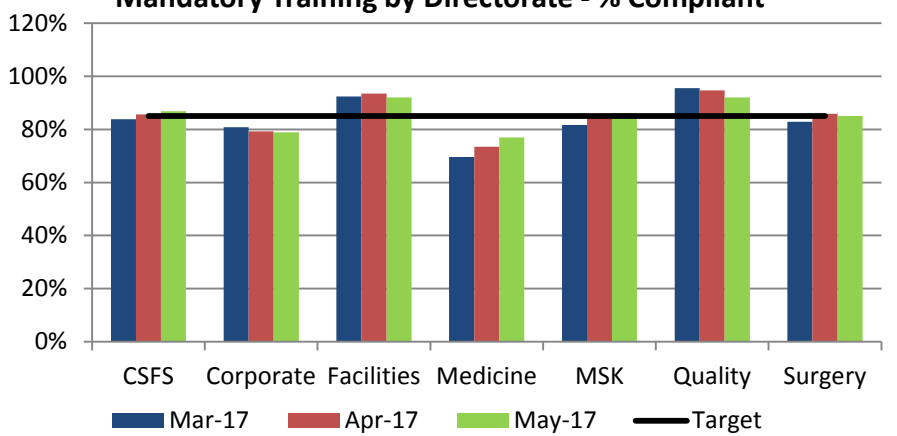


Compliance Percentage 84.1% (May 2016 – 82.9%)

Mandatory Training Compliance vs Target



Mandatory Training by Directorate - % Compliant



Additional Notes

1. The percentage of staff up to date with their mandatory training has increased this month from 83.3% to 84.1% against a target of 85%.
2. The directorates with the highest compliance rate were Facilities and Quality both with 92.0%, and the directorate with the lowest compliance rate was Medicine at 76.9%.
3. Highest compliance is in Equality and Diversity, currently at 93.1%, lowest compliance is in Hand Hygiene training, this is now being recorded in live time to give an up to date picture, currently at 76.9%.

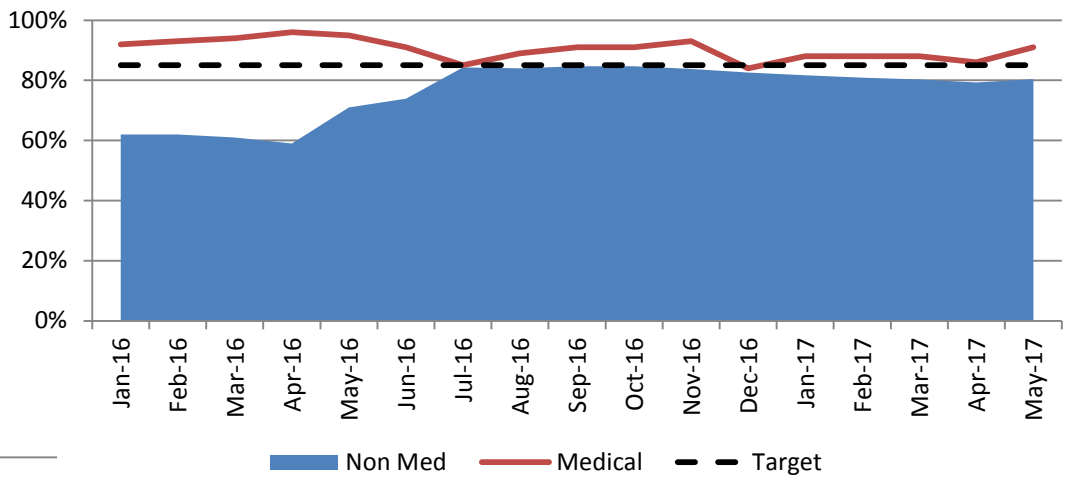
Appraisals
M1

Salisbury NHS
NHS Foundation Trust

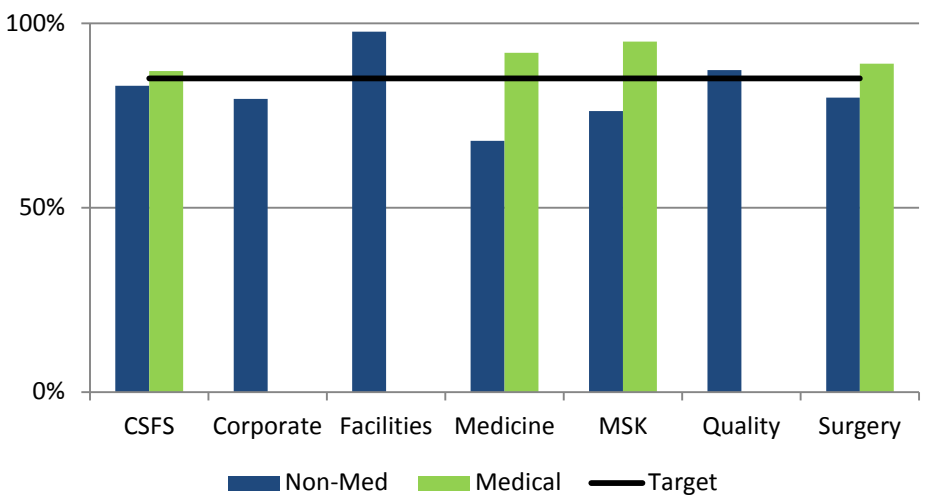
May 17

Compliance percentage - 80% non medical, 91% medical.

Appraisal Compliance vs Target



Annual Appraisal by Directorate - % Compliant



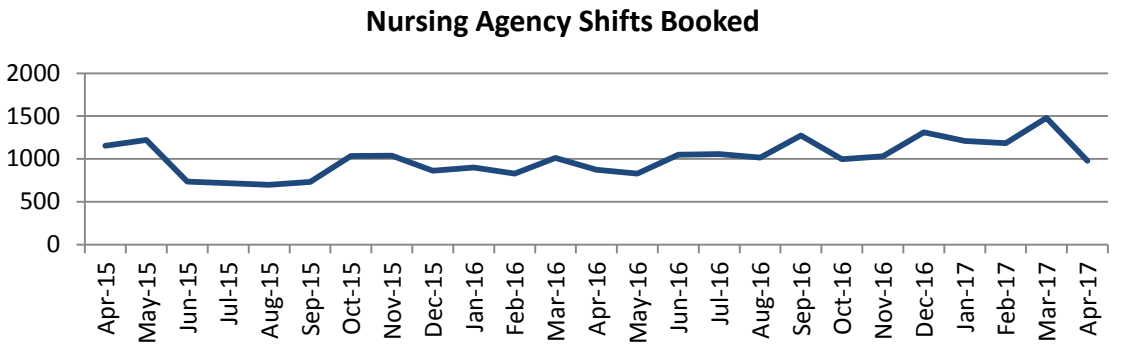
Additional Notes

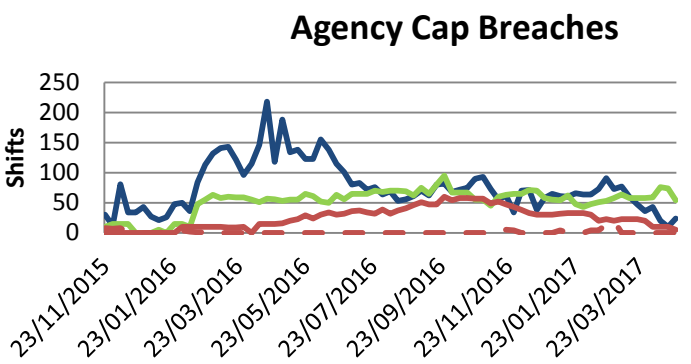
1. **Appraisal compliance for non-medical staff has slightly increased from 79% to 80% this month. Data is taken from a 13 month window to more accurately reflect activity. Detailed non-compliance reports are now live and available to managers (providing the names of non-compliant individuals) for further action.**
2. **The percentage of Medical staff with an annual appraisal in the last 12 months has increased from 86% to 91% this month.**

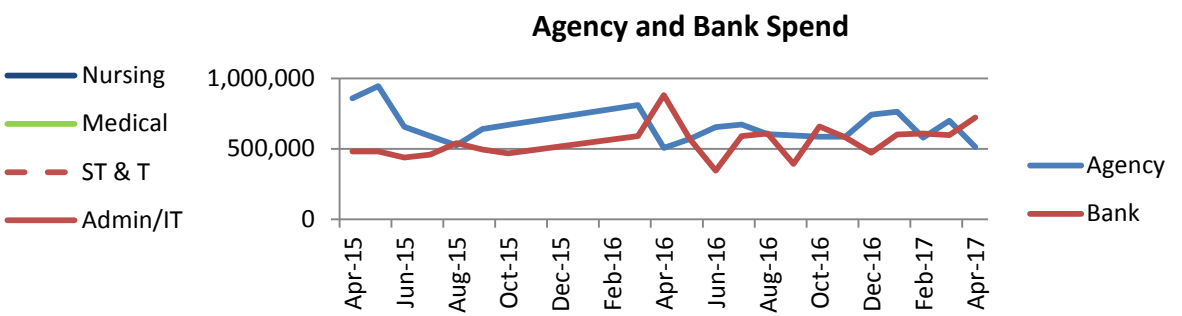
Agency Cap Breaches
M1

Salisbury NHS
NHS Foundation Trust

Agency Nursing Shifts 978
Agency Nursing Cap Breaches 97 (10%)
Agency Medical Shifts 278
Agency Medical Cap Breaches 263 (95%)







Additional Notes

1. **The data shows the trend on agency usage since April 2015 . The breaches of the NHS Improvement caps reveals that the cost of agency is not reducing across all shifts and that the cost for agency, when it is used last minute, can be considerably high. The trend for the number of shifts booked for nursing (agency) has increased since June 2015.**
2. **A "Mastervend" contract has been implemented for the supply of locum Medical staff, and efforts are being made to recruit to hard to fill vacancies, to reduce reliance on agency.**

Key Risks/Assurances

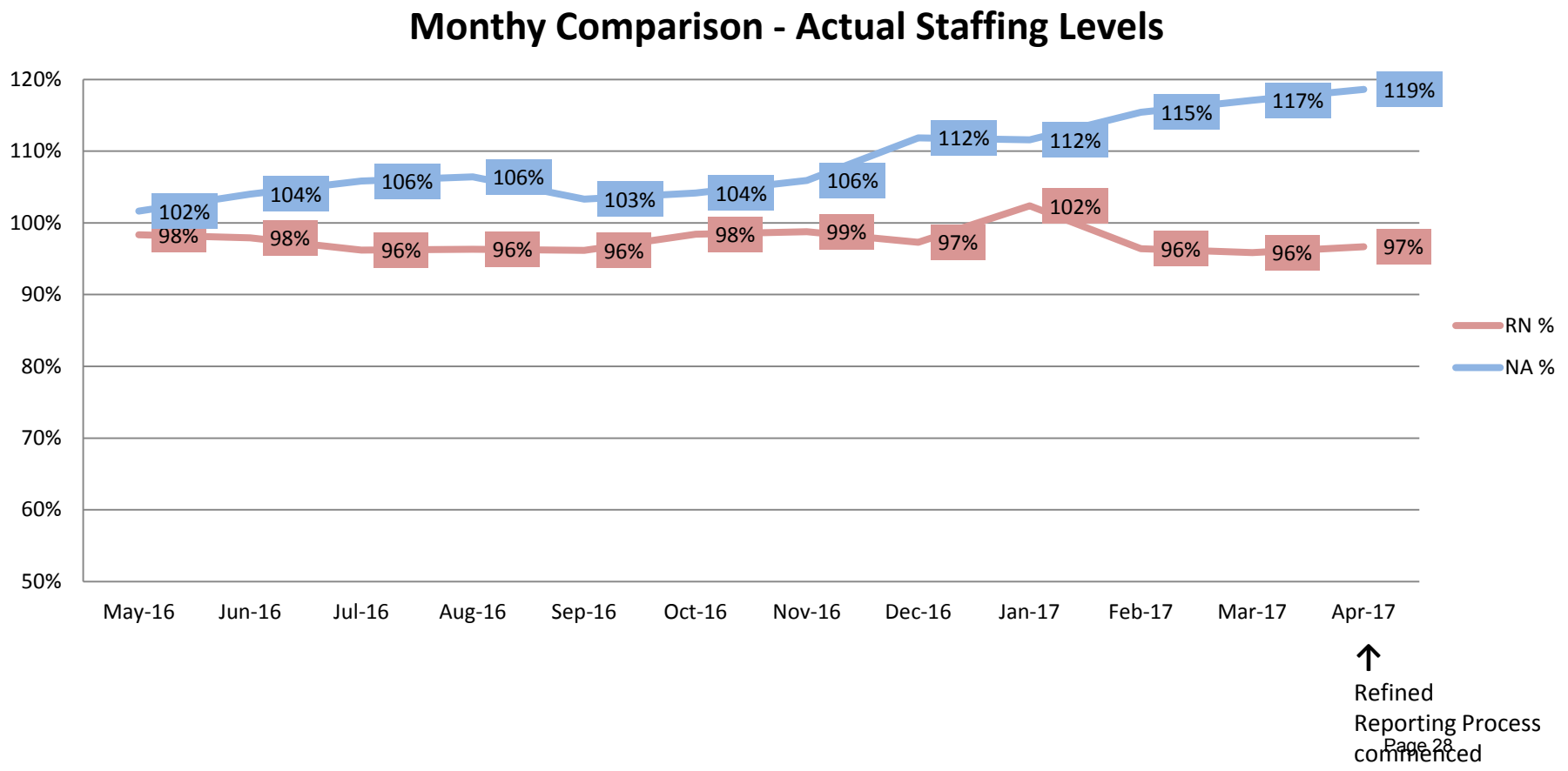
Salisbury NHS Foundation Trust

- A “Mastervend” contract has been implemented for the supply of locum Medical staff, and efforts are being made to recruit to hard to fill vacancies, to reduce reliance on agency. We are developing our own internal bank for the supply of locum medical staff and have implemented standardised Trust medical locum rates.
- NHS Improvement cap breaches for the supply of Nursing agency shifts have reduced, with a number of new contracts successfully negotiated with agencies for the supply of agency staff. Booking of all agency locum staff has been re-sited in the bank office so there is more resilience around identifying and supplying agency shifts.
- Appraisal compliance has increased slightly this month and is just below target. Information is accessible to managers allowing for transparency and better targeted action.
- There has been an increase in turnover this month. This trend is being closely monitored at Trust and Directorate performance meetings which focus on specific hot spots.
- Recruitment - a number of work streams are in place, looking at hard to fill gaps across the Trust, using agencies to recruit overseas doctors, and introducing a co-ordinated approach to ensure safe staffing levels.

Safe Staffing NQB Report – April 2017

Monthly Comparisons – Actual Staffing Levels

	Registered Nurses			Nursing Assistants			Combined			Skill Mix	
Month	Planned hours	Actual Hours	%	Planned Hours	Actual Hours	%	Planned Hours	Actual Hours	%	RN	NA
Apr-17	56374.2	54505.9	97%	32811.3	38917.0	119%	89185.5	93422.9	105%	58%	42%



Overview of Nurse Staffing Hours – April 2017

Day	RN	NA
Total Planned Hours	33538.4	20910.3
Total Actual Hours	31451.43	24904.78
Fill Rate (%)	**93.80%**	**119.10%**

Night	RN	NA
Total Planned Hours	22835.75	11901
Total Actual Hours	23054.42	14012.25
Fill Rate (%)	**101.0%**	**117.7%**

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

Nursing Hours by Day Shifts

Row Labels	Day RN Planned	Day RN Actual	Day RN Fill Rate	Day NA Planned	Day NA Actual	Day NA Fill Rate
Medicine	**14547.62**	**12704.82**	**89.1%**	**9884.25**	**12718.67**	**124.1%**
Breamore	1120.75	805.00	71.8%	749.50	1301.00	173.6%
Durrington	1055.00	969.75	91.9%	897.00	882.50	98.4%
Farley	2044.75	1513.75	74.0%	1368.50	2344.00	171.3%
Hospice	861.50	940.33	109.2%	636.00	581.25	91.4%
Pembroke	798.55	780.92	97.8%	322.00	305.00	94.7%
Pitton	1729.33	1548.58	89.5%	1135.00	1209.33	106.5%
Redlynch	1455.48	1413.48	97.1%	1103.50	1265.25	114.7%
Tisbury	1906.00	1761.00	92.4%	655.25	927.25	141.5%
Whiteparish	1727.50	1684.75	97.5%	1045.50	1135.58	108.6%
Winterslow	1848.75	1287.25	69.6%	1972.00	2767.50	140.3%
Surgery	**5768.92**	**5939.17**	**103.2%**	**2399.05**	**2388.05**	**98.7%**
Britford	1895.42	2011.17	106.1%	1116.75	1151.75	103.1%
Downton	1197.25	1230.42	102.8%	936.30	902.30	96.4%
Radnor	2676.25	2697.58	100.8%	346.00	334.00	96.5%
MSK	**8653.58**	**8045.20**	**92.7%**	**7306.25**	**8509.82**	**124.3%**
Amesbury	1590.50	1523.25	95.8%	1356.00	1839.75	135.7%
Avon	1413.92	1270.83	90%	1883.67	1756.17	93.2%
Burns	1320.33	1284.62	97.3%	563.33	1047.08	185.9%
Chilmark	1527.75	1455.25	95.3%	1076.75	1336.75	124.1%
Laverstock	1548.42	1464.50	94.6%	916.50	920.00	100.4%
Tamar	1252.67	1046.75	83.6%	1510.00	1610.07	106.6%
CSFS	**4568.28**	**4762.25**	**103.2%**	**1320.75**	**1288.25**	**98.7%**
Maternity	2506.73	2666.75	106.4%	975.75	946.25	97.0%
NICU	1030.55	1080.00	104.8%	0.00	0.00	100.0%
Sarum	1031.00	1015.50	98.5%	345.00	342.00	99.1%
Grand Total	**33538.40**	**31451.43**	**93.9%**	**20910.30**	**24904.78**	**117.2%**

Key:	Less than 80%	Between 80 - 90%	Between 90 - 115%	Greater than 115%

Nursing Hours by Night Shifts

Row Labels	Night RN Planned	Night RN Actual	Night RN Fill Rate	Night NA Planned	Night NA Actual	Night NA Fill Rate
Medicine	**9518.50**	**9772.92**	**103.0%**	**5568.50**	**7019.08**	**122.0%**
Breamore	690.00	701.33	101.6%	690.00	759.00	110.0%
Durrington	690.00	667.50	96.7%	690.00	701.50	101.7%
Farley	1023.50	1046.50	102.2%	690.00	942.50	136.6%
Hospice	570.00	570.00	100.0%	405.00	422.50	104.3%
Pembroke	690.00	690.00	100.0%	0.00	79.33	100.0%
Pitton	1035.00	1384.25	133.7%	690.00	665.75	96.5%
Redlynch	1035.00	1023.50	98.9%	690.00	782.50	113.4%
Tisbury	1370.00	1289.33	94.1%	345.00	495.50	143.6%
Whiteparish	1380.00	1222.50	88.6%	345.00	527.50	152.9%
Winterslow	1035.00	1178.00	113.8%	1023.50	1643.00	160.5%
Surgery	**4220.50**	**4256.75**	**100.1%**	**1698.00**	**1747.08**	**102.4%**
Britford	1035.00	1057.25	102.1%	755.00	701.08	92.9%
Downton	690.00	667.00	96.7%	598.00	724.00	121.1%
Radnor	2495.50	2532.50	101.5%	345.00	322.00	93.3%
MSK	**4693.50**	**4742.50**	**101.6%**	**3565.00**	**4229.33**	**131.1%**
Amesbury	1035.00	1033.50	99.9%	690.00	667.00	96.7%
Avon	880.00	860.50	97.8%	900.00	910.00	101.1%
Burns	690.00	712.67	103.3%	345.00	963.83	279.4%
Chilmark	570.00	598.50	105.0%	570.00	549.00	96.3%
Laverstock	920.00	908.50	98.8%	460.00	460.00	100.0%
Tamar	598.50	628.83	105.1%	600.00	679.50	113.3%
CSFS	**4403.25**	**4282.25**	**98.5%**	**1069.50**	**1016.75**	**98.3%**
Maternity	2356.25	2223.75	94.4%	1035.00	982.25	94.9%
NICU	1012.00	1023.50	101.1%	0.00	0.00	100.0%
Sarum	1035.00	1035.00	100.0%	34.50	34.50	100.0%
Grand Total	**22835.75**	**23054.42**	**101.6%**	**11901.00**	**14012.25**	**118.6%**

Key:	Less than 80%	Between 80 - 90%	Between 90 - 115%	Greater than 115%

Overview of Areas with Red/Amber

Flag	Ward	%	RN	NA	Shift	Mitigation
Red	**Breamore**	72%	√		Day	All core required shifts were covered by experienced 3 x Band 4 staff accounting for 28% of the overstaffing for NA shifts within the unit.
Red	**Farley**	74%	√		Day	As per Breamore, Farley has Band 4 staff who cover the required core RN shifts. This will be reflected within some of the overstaffing figures for NA shifts
Red	**Winterslow**	70%	√		Day	Likewise, this ward utilises skilled Band 4 staff to cover core RN shifts demonstrating a corresponding increase in NA shifts . Band 4 staff are recorded as unqualified.
Amber	**Pitton**	89%	√		Day	Although the unit ran a shift down, the person allocated as the unit co-ordinator changed role to undertake direct patient care ensuring all care was safely provided.
Amber	**Tamar**	84%	√		Day	Other trained staff within the Spinal unit support wards if shifts cannot be covered between Avon and Tamar staff. These may be outpatient RN staff or the practice educator. These staff are not recorded on e-roster
Amber	**Whiteparish**	89%	√		Night	These night shifts were covered by skilled Band 4 staff as per Breamore, Farley and Winterslow. This is reflected within the overstaffing figures

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

Mitigation of Risk for Red/Amber

- The reporting data extraction has been refined to more accurately reflect the staffing levels against patient acuity and dependency demand.
- The data is extracted directly from the e-roster system and may account for a slight alteration of an overall circa 3% change to previous reports.

- This month demonstrates a continued and sustained rise of NA cover now at 119% increasing the gap between RN and NA cover. This is reflected in the skill mix of RN 58/ NA 42. However, against this, there is a 1% growth of RN cover. The first increase for 2 months.
- There is a reduction of 50% of wards flagging Red/Amber. All understaffing is within RN Day shifts (with the exception of Whiteparish) ensuring the night hours are well supported.

- As per last month, understaffing of many RN shifts are counterbalanced by overstaffing levels of NA staff many of whom are skilled Band 4 staff reflecting the increased trend of NA cover.
- Increases in NA levels also demonstrate the continued need to provide safe 1:1 enhanced care for patients at risk across the Trust particularly in Medicine and Burns.
- The work undertaken to correct the maternity templates alongside the drive to accurately reflect unrequired shifts has resulted in more precise records with maternity not flagging for the first time in many months .

Mitigation of Risk for Red/Amber

Breamore/Farley/Winterslow/Whiteparish

- All three wards carry highly skilled Band 4 staff who cover RN shifts. No core shifts that required cover were unfilled.
- All were risk assessed on a shift by shift basis. However, as reported previously, the shifts are recorded as “unfilled” due to the Band 4 staff being recorded as Unqualified within the eroster system.

Pitton

- Continues to have high patient acuity resulting in extra demand for two tracheostomy patients requiring 1:1 RN care.
- The unit did run a shift down on occasions. To compensate for this, the ward co-ordinator changed roles to undertake direct patient care ensuring safe care provision.

Tamar

- The unit is carrying RN vacancies. Both Avon and Tamar wards work together to support peak patient demands in a shift. Some shifts are covered by staff who are not recorded within e-roster (Practice Educator and outpatients RN staff).
- There may be a process issue where some shifts that were not required (subject to a risk assessment) may have been recorded as unfilled rather than unrequired.

Overview of Overstaffed Areas >115%

(Medical Directorate)

Ward	%	RN	NA	Shift	Comments
Breamore	174%		√	Day	The increase in NA cover includes 28% of daytime support for RN unfilled shifts by skilled B4 staff enabling night shifts are fully covered by Band 5 RN staff. The other 30% NA cover for those patients requiring enhanced care following patient acuity and dependency and risk assessments.
Farley	171%		√	Day	26% of increased NA day cover using skilled Band 4 staff supporting uncovered RN day shifts. As per Breamore, this is to ensure there is full RN cover at night. The remaining 37% increased cover for both shifts is due to enhanced care following patient assessments which identify any patients who are at risk due to confusion, mentally ill or at risk of harm from falls.
Farley	137%		√	Night	
Tisbury	141%		√	Day	This is due to a Band 4 who is supernummary to numbers plus the use of skilled overseas Band 4 staff who are recorded as unqualified within the system , who are yet to pass their IELTS. This cohort of staff cover RN shifts (due to their skills) ensuring all RN shfits are covered.
Tisbury	144%		√	Night	
Winterslow	140%		√	Day	This is due to qualified Band 4 staff covering RN shifts plus and additional percentage required for both shifts due to patient need / enhanced patient care following patient assessments which identify any patients who are at risk due to confusion, mentally ill or at risk of harm from falls.
Winterslow	160%		√	Night	
Whiteparish	153%		√	Night	Some overstaffing is due to skilled Unqualified Band 4 staff covering core RN shifts. Others were for enhanced care for patients requiring enhanced care following patient acuity and dependency and risk assessments.
Pitton	134%	√		Night	Extra cover is used for increased levels of patient acuity due to patient needs based on risk assessments and acuity levels. This was for 1:1 RN care for 2 high acuity tracheostomy patients.
Pembroke	120%		√	Day	This is thought to be rostering process error where an Open University student has been inadvertently rostered when away on placement.

Overview of Overstaffed Areas >115%

(MSK & Surgery)

Ward	%	RN	NA	Shift	Comments
Burns	186%		√	Day	Burns unit continued to have x2 Section 3 patients under the mental health act following mental health assessments. Both patients were in side rooms with burns needs overseen (subject to shift by shift risk assessments) by one RMN whenever possible supported by NA staff A third patient) also required 1:1 NA enhanced care to ensure patient safety needs were met. This was assessed on a shift by shift basis .
Burns	279%		√	Night	
Amesbury	136%		√	Day	The ward had a patient deemed at risk due to confusion, mentally ill or at risk of harm from falls who required 1:1 enhanced care . This was provided by a band 2 during the day
Chilmark	124%		√	Day	A new Band 2 member of staff (who had not worked in an acute hospital setting before) was supernummary resulting in additional numbers
Downton	121%		√	Night	This is due to an approved increase in the budget to permit extra NA night shift cover which was not reflected within the rosters.

Over-staffing

Burns

- Several patients had high level complex needs requiring 1:1 care. Being in side rooms with burns increases the demand to observe patients safely.
- There was the continuation of 2 patients who were under section due to mental health needs. Overseen where needed by an RMN (subject to shift by shift risk assessments) with care needs strengthened with 1:1 support provided for both patients by Unqualified staff.
- A third patient was assessed as at risk due to confusion, mentally ill or at risk of harm from falls & required 1:1 enhanced care . Rather than 24/7 this was assessed on a shift by shift basis depending on the patient's health needs at the time to ensure all safety needs were met.

Breamore /Farley/Winterslow/Whiteparish

- All 4 wards had increases in NA cover for 1:1 enhanced care for patients deemed at risk to meet the demands of patient safety .
- In addition, both wards have competent Band 4 staff who are recorded as "Unqualified" but who have the skills to cover any unfilled RN day shifts. By doing this all wards ensured core shifts were filled and (night shifts in particular) had complete RN cover.

Pitton :- Two tracheostomy patients required 1:1 RN care each. This put the unit over budget for staffing during April 2017

Downton :- There were changes within the budgeted template that did not reflect an alteration in Band 2 levels giving an impression of overstaffing. This is being corrected for May reporting.

Tisbury:- The unit has a supernummary Band 4 member of staff. In addition, RN cover is balanced by the use of other skilled overseas Band 4 staff who are recorded as unqualified whilst waiting to pass IELTS.

Pembroke:- Considered to be a rostering process error where an OU student is rostered for ward care whilst elsewhere on placement. The correct process is being reiterated within the unit.

Amesbury:- Band 2 special for a patient requiring 1:1 enhanced care for patients deemed at risk to meet the demands of patient safety .

Chilmark:- Supernummary new Band 2 staff member

Actions taken to mitigate risk

Highly skilled Band 4 staff are utilised to cover RN shift.

Many RN shifts are covered this way but recorded as unfilled due to this cohort of staff not having a formal registration. The corresponding figures of NA overstaffing .reflect this process

The nurse-in-charge of individual wards in discussion with the DSN/ADSN review the following on a shift by shift basis.

- The accounting of the staff skills set when deciding on the band of staff needed.
- All shifts are gauged with staff moved across wards by Directorate Senior Nurses and Clinical Site Team as required. This ensures safe levels of care are maintained whilst trying to reduce reliance on expensive temporary staff
- Staffing levels are reduced when beds empty/ procedure lists reduced whilst maintaining appropriate staffing ratios
- Shifts that are difficult to cover (nights and weekends) are prioritised.
- If all of the above measures have been taken there may be a requirement that staff on training days are brought back to work clinically as required and / or Sisters on supervisory shifts work clinically.
- CCOT team support wards where acuity of patients high.

Salisbury NHS Foundation Trust Board - 5 June 2017

SFT 3891

Title: Trust Quality Indicators report – April 2017

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

Executive Summary:

- 1 case of hospital apportioned C Difficile.
- 1 new serious incident inquiry commissioned in April.
- A new chart – the number of in-hospital cardiac arrests and futile CPR attempts – no cardiac arrests in March 17.
- A decrease in the crude mortality rate in April 17. SHMI is 104 and 102.5 adjusted for palliative care to September 2016. HSMR decreased to 116.4 in January 17 and is higher than expected. Weekend HSMR is 121.0 to January 17 and is higher than expected. The Board received a mortality presentation at the May meeting.
- A significant improvement in Q4 of hip fracture patients being operated on within 36 – 48 hours. Those that waited beyond 48 hours were waiting for medical review/further investigations (3) and waiting for theatre (2). Best Practice Tariff compliance improved to 90% in Q4.
- An increase in grade 2 pressure ulcers and one grade 3 pressure ulcer which is under investigation. A new measure included of grade 2 pressure ulcers per 1000 bed days.
- In April 17 there were no falls resulting in moderate or major harm. A new falls reduction strategy was presented to the Clinical Risk Group in May 17.
- 95% delivery of CT scan within 12 hours for stroke patients. A reduction in stroke patients spending 90% of their stay on the stroke unit due to delayed admission to the stroke unit (9) and 1 patient not admitted to the unit at all. Patients arriving on the stroke unit within 4 hours improved but remains below the national benchmark – transferred at 3 hrs 51 minutes to 3 hrs 59 minutes from ED (4), & waiting to see first doctor (2), admitted to AMU (2) and SSEU (1) delay in ED waiting for bed (1).
- A slight reduction in high risk TIA patients seen within 24 hours. Those not seen within 24 hours related to no available morning clinic and consultant availability. Latest Sentinel Stroke National Stroke Audit Programme (SSNAP) grade B.
- Escalation bed capacity reduced in April. Ward moves between 22.00 and 06.00 reported by month only. A plan is in place to reconfigure the bed base over the next 6 months in preparation for next winter.
- For the second month running there were no non-clinical mixed sex accommodation breaches.
- Real time feedback improved in April for patients rating the quality of their care – negative comments related to food, communication and noise. The Friends and Family test of patients who would recommend ED, wards, the maternity service and care as a day case and outpatients was sustained.

Proposed Action: To note the report

Supporting Information: Trust Quality indicator report – April 2017

Salisbury NHS
NHS Foundation Trust

Trust Quality Indicators - April 2017

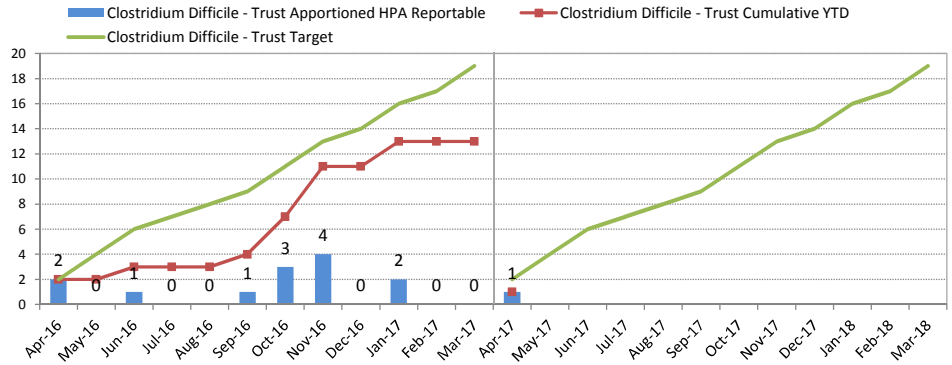
Quality Measures

Infection Control	2016-17 YTD	2017-18 YTD
MRSA (Trust Apportioned)	0	0

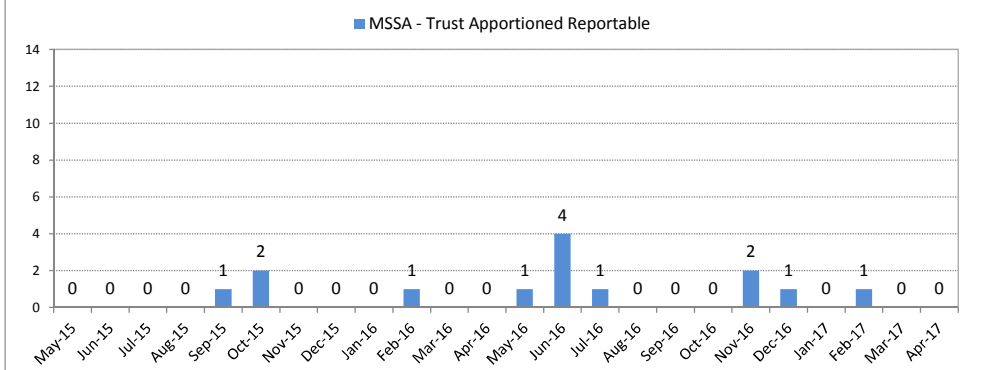
Trust Incidents	2016-17 YTD	2017-18 YTD
Never Events	2	0
Serious Incidents Requiring Investigation	47 *	1

* Of these commissioned, 1 has been downgraded following a formal agreement with the CCG, as it did not meet the SI definition

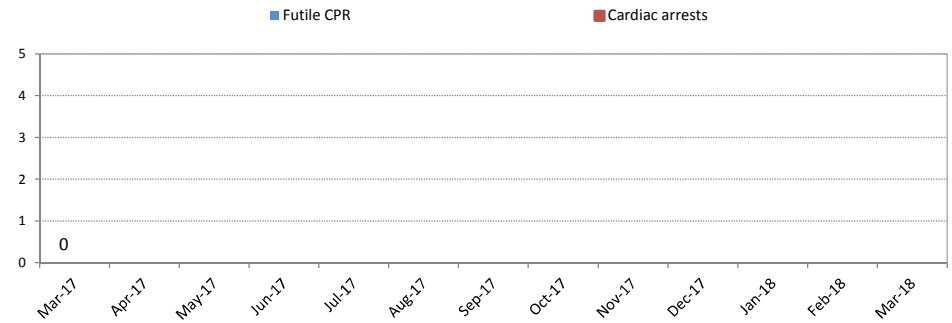
Clostridium Difficile - Trust Apportioned



MSSA - Trust Apportioned

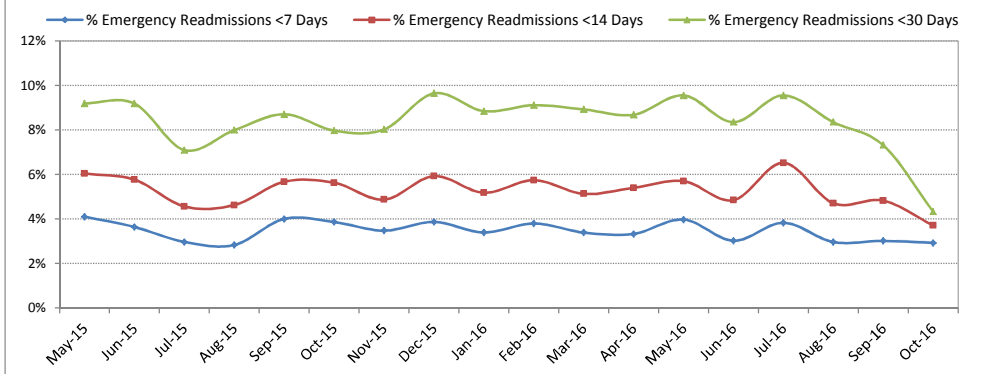


In hospital Cardiac arrests and futile CPR

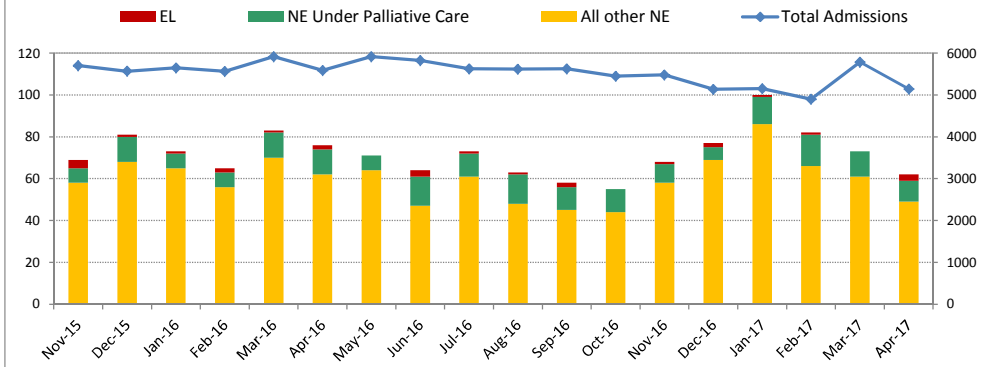


Please note cardiac arrests which occurred in ED, ITU, CCU and Paediatrics are excluded.
Data from Mar-17 onwards

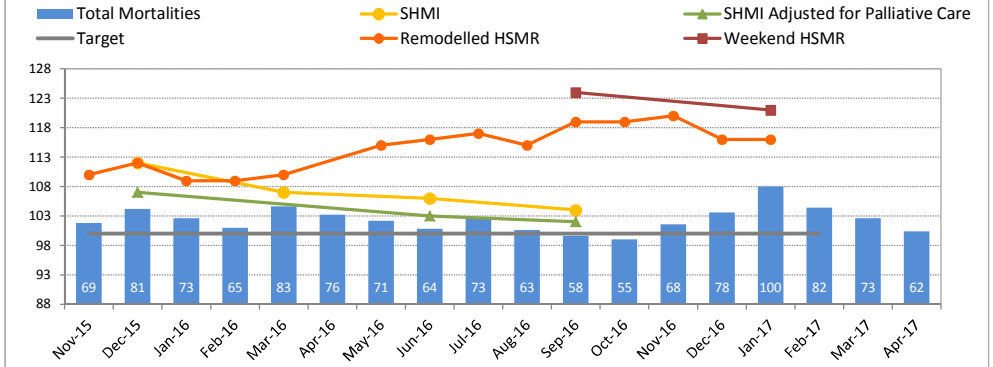
Emergency Readmissions within 7, 14 & 30 days of Discharge



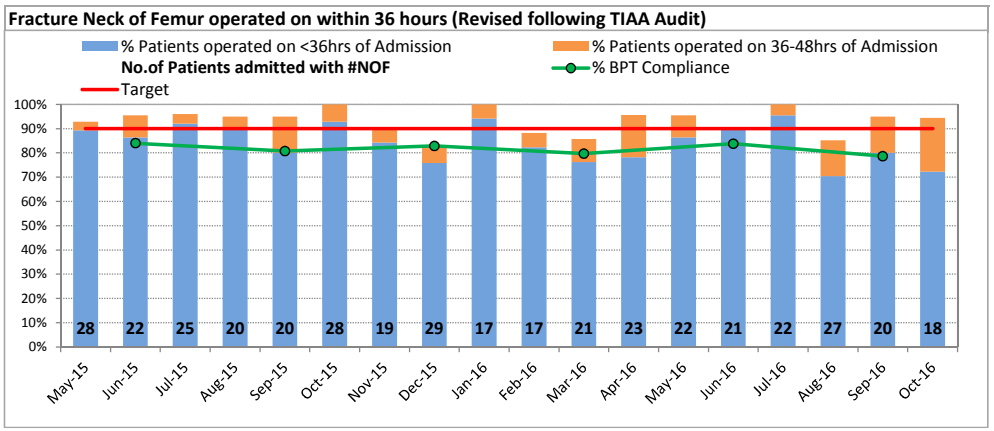
Hospital Mortalities



HSMR and SHMI



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

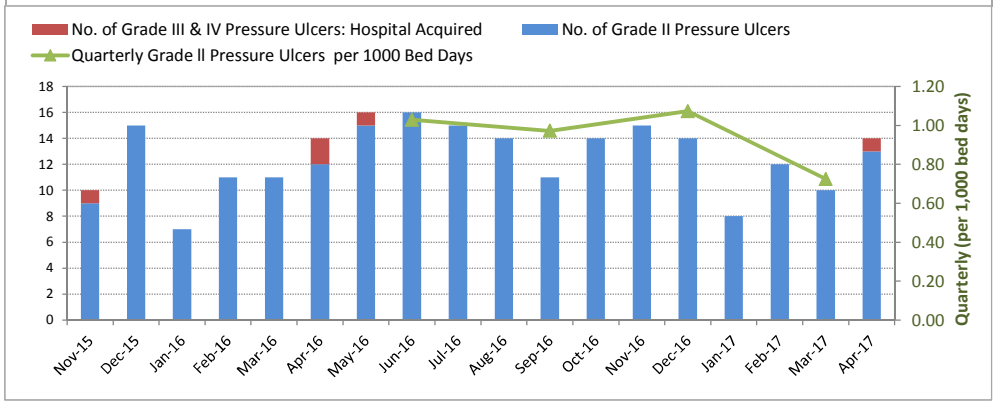


Salisbury NHS
NHS Foundation Trust

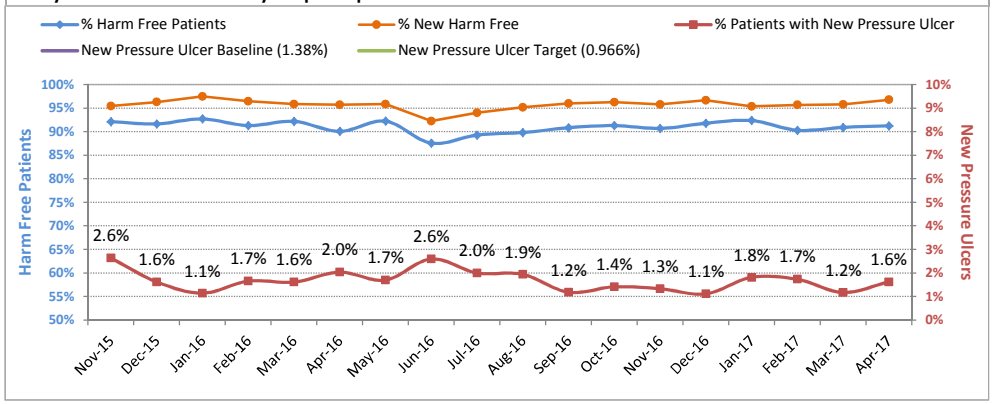
Trust Quality Indicators - April 2017

Quality Measures

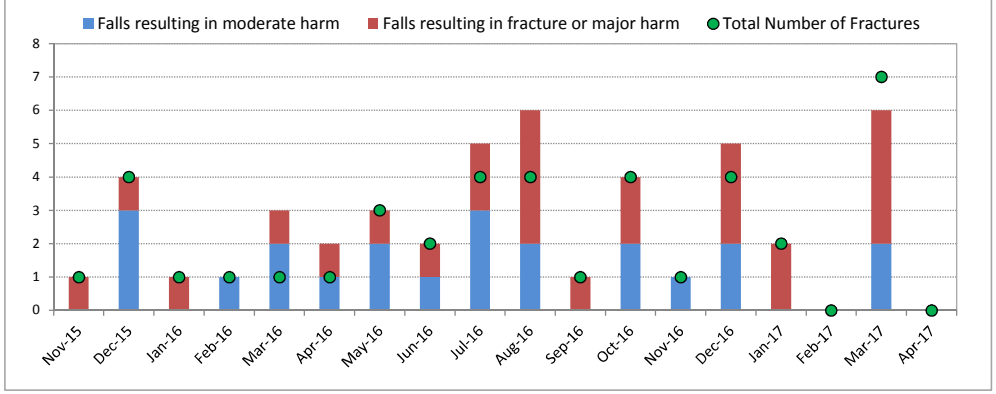
Pressure Ulcers



Safety Thermometer - One Day Snapshot per Month

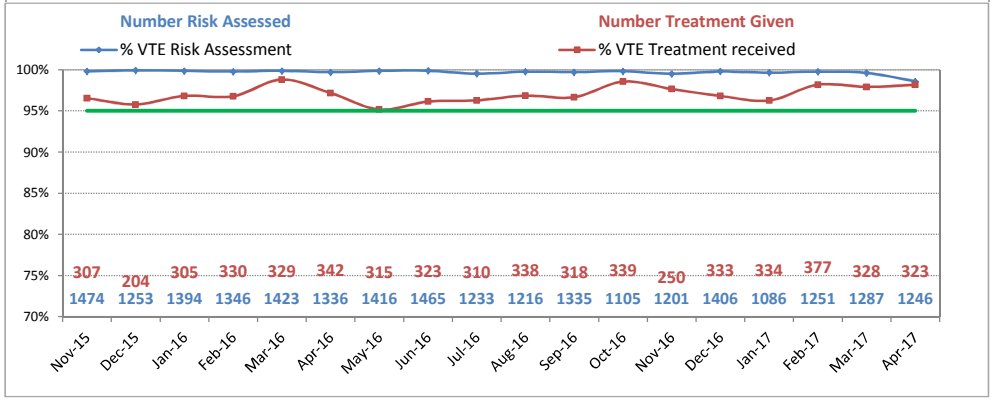


Patient Falls in Hospital



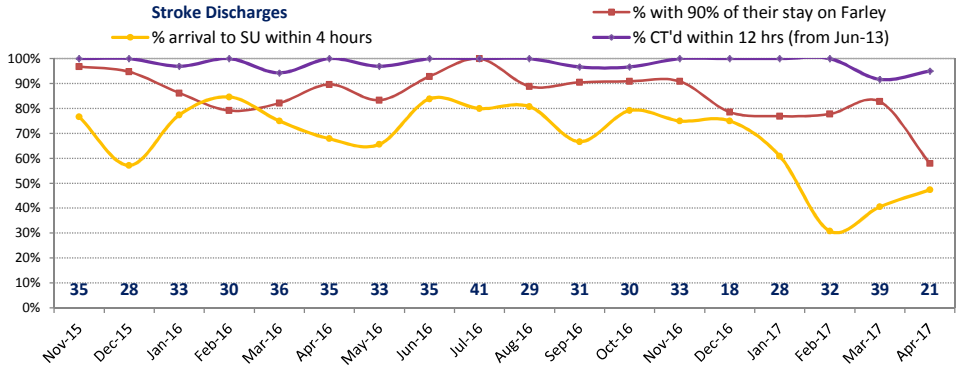
Please note, in Mar-17 1 patient has 2 fractures.

Venous Thrombous Embolism: Risk Assessment & Prophylaxis

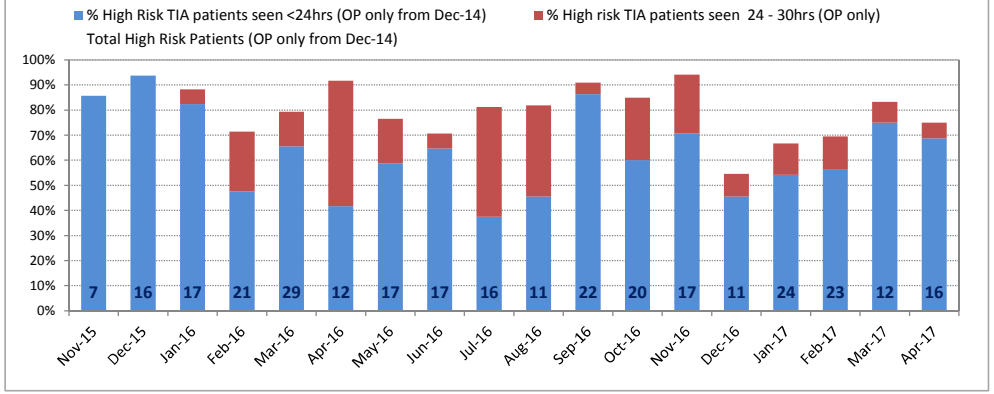


Please note, due to the time it takes to complete Clinical Coding, the current months Fracture Neck of Femur data will be subject to change over the following months.

Stroke Care



TIA Referrals



SSNAP Case Ascertainment Audit

Highest level = Grade A

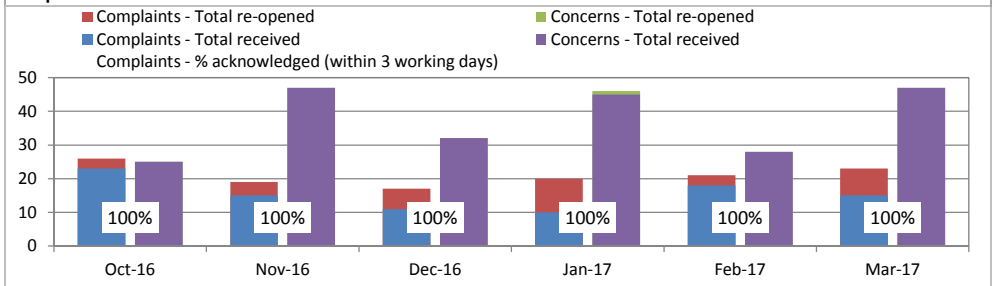
Lowest level = Grade E

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

Tri-annually	Apr - Jul	Aug - Nov	Dec - Mar
2016-17	B	B	

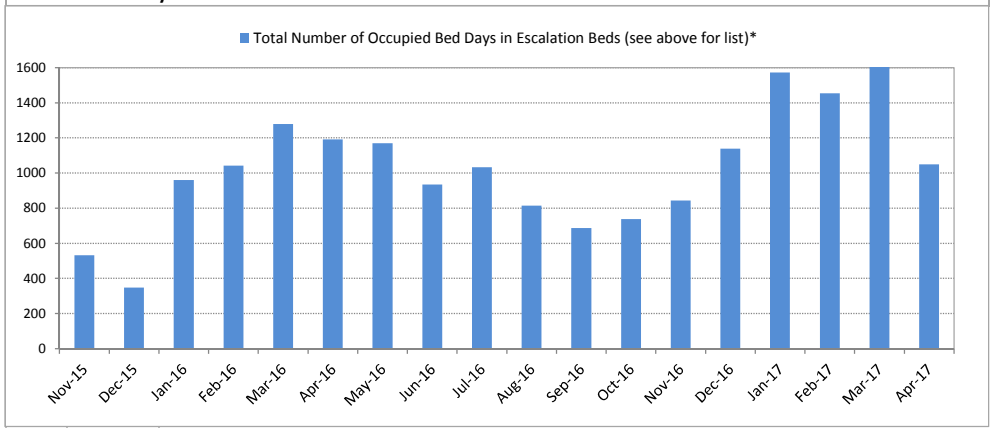
*From April 2016 escalation capacity includes beds on Breamore, DSU, Clarendon, Endoscopy, Avon, Britford SAU overnight stays, Whiteparish AMU overnight stays, Clarendon NHS, Pembroke Suite and Burns assessment room.

Complaints and Concerns

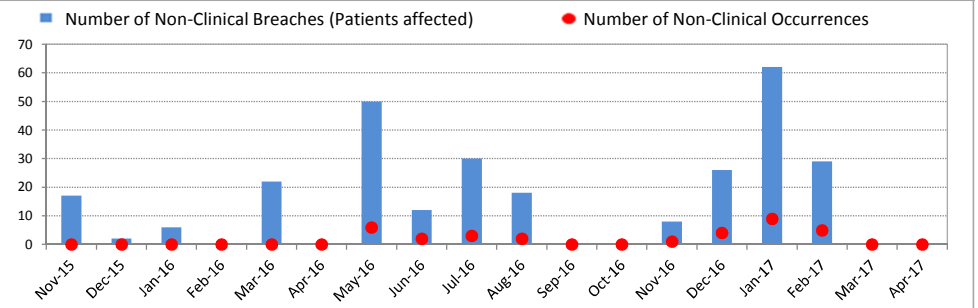


	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Complaints - Total received	23	15	11	10	18	15
Complaints - Total re-opened	3	4	6	10	3	8
Concerns - Total received	25	47	32	45	28	47
Concerns - Total re-opened	0	0	0	1	0	0

Escalation Bed Days

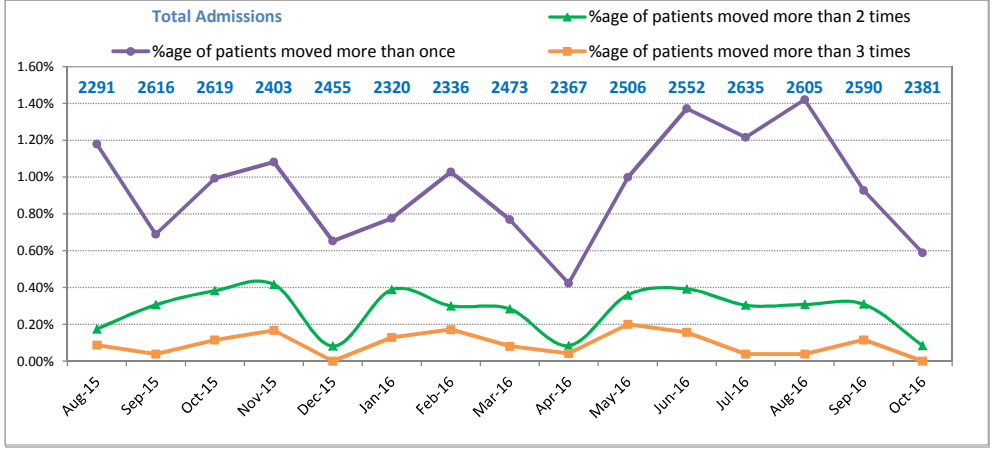


Delivering Same Sex Accommodation



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
■	17	2	6	0	22	0	50	12	30	18	0	0	8	26	62	29	0	0
●	0	0	0	0	0	0	6	2	3	2	0	0	1	4	9	5	0	0

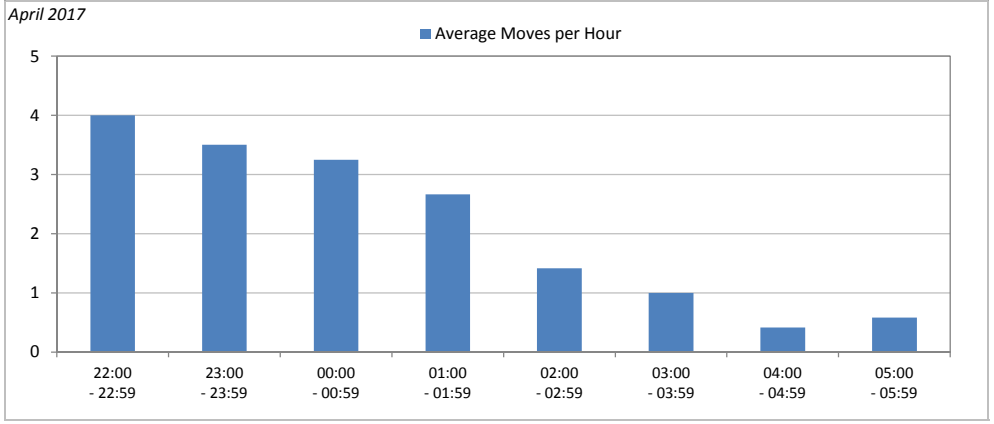
Patients moving multiple times during their Inpatient Stay



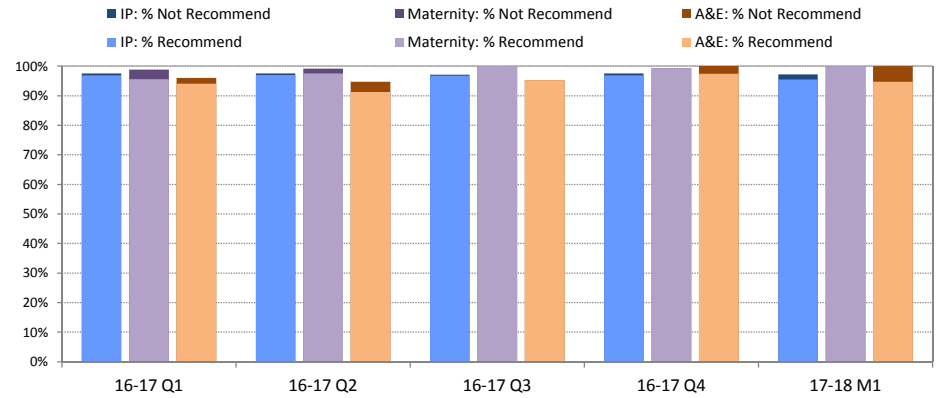
Please note, the number of Non-Clinical Breach Ocurrences is being reported from May 2016.

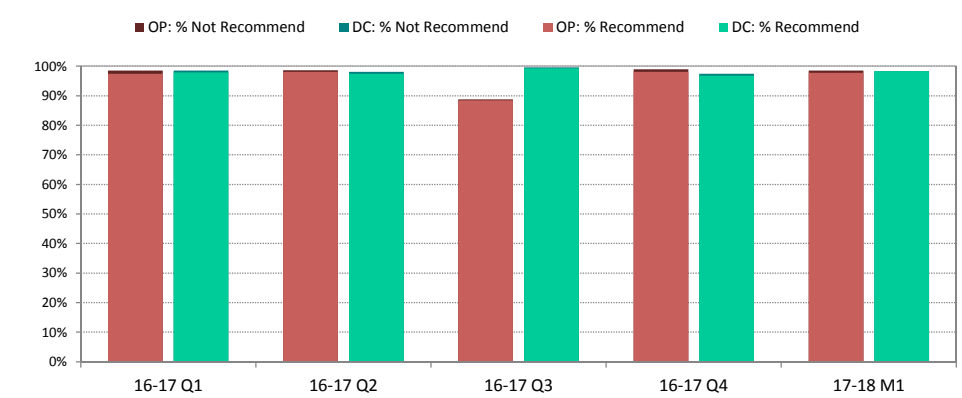
Ward moves between 22:00 and 06:00

April 2017

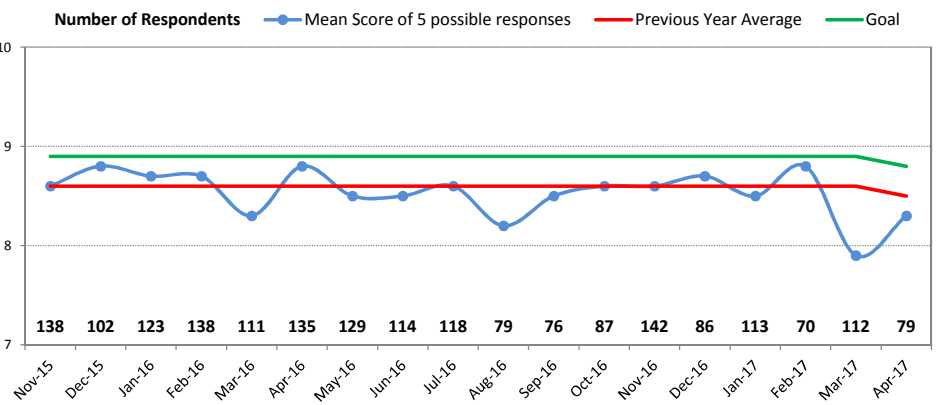


Friends & Family Test: Responses by Area

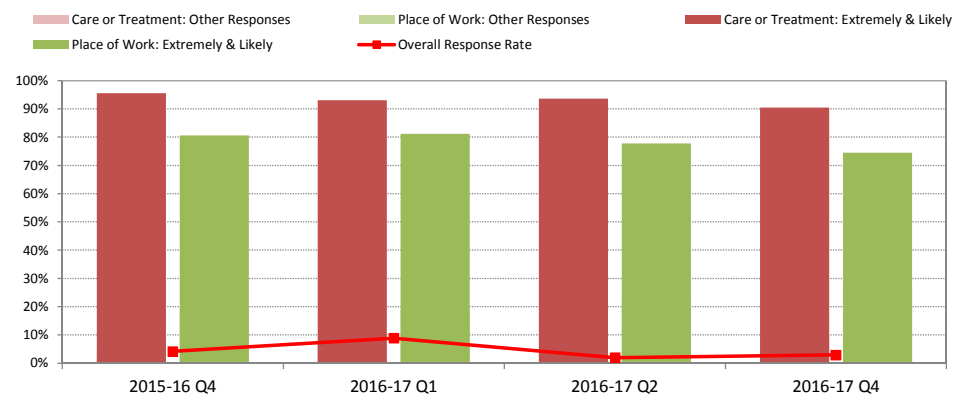




Real Time Feedback: Overall how would you rate the quality of care you received?



Friends & Family Test: Staff (% Responses)



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

Title: Annual Report of Director of Infection Prevention and Control

Report from:
Lorna Wilkinson, Director of Nursing & Director of Infection Prevention & Control

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

The purpose of this DIPC Report is to inform the Trust Board of the progress made against the 2016/17 Annual Action Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

Proposed Action:

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

2. **Record that the Board continues to acknowledge their collective responsibility as described above and detailed within the DIPC report.**

Supporting Information

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.

Mandatory surveillance

The Trust has performed well when benchmarked to other providers in the South West and has achieved below trajectory numbers of MRSA bacteraemia and Clostridium difficile infections.

- MRSA bacteraemia cases – There have been no MRSA bacteraemia cases identified during the reported period, this is for the second year.
- Clostridium difficile – There have been 13 Trust apportioned C.difficile cases 2016/17, which did not exceed the target set for the Trust by NHS England of no more than 19 cases.

- MSSA bacteraemia cases – There have been 10 Trust apportioned cases during the reported period, which is an increase on the previous year. Actions are focused on device management.
- Surgical Site Infection Surveillance (SSIS) – surgical site infection surveillance was carried out for patients undergoing knee replacement surgery, with 1 reported infection.

Antimicrobial Stewardship

- There has been focussed work on this subject and the outcome is that there has been a marked decrease in the consumption of antibiotics when measured against recent years, with >90% inpatient antibiotic prescriptions reviewed within 72 hours.

Decontamination

- A new Decontamination Lead has been appointed
- Theatre tray tracking introduced
- Reduction in previously reported issues with theatre trays (damaged drapes, slow turnaround)

Cleaning services

- The Trust sustained high scores in the 2016 PLACE assessment.

Key Challenges:

- Mandatory training compliance which, although improving remains below the Trust target of 85%
- Comprehensive work continues (along with independent advice) on the water safety agenda (Legionella and Pseudomonas). However, working with such a large and complex water system poses challenges, and positive counts have been identified during the year. There are robust monitoring and mitigation activities in place.
- There is an increasing occurrence of complex multi-resistant organisms, which the team through the described assurance framework will keep pace with.

Salisbury NHS
NHS Foundation Trust

Director of Infection Prevention & Control (DIPC)

Annual Report 2016/17

Lorna Wilkinson
DIPC

May 2017 (Final v.2.1)

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1. Introduction

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated 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 2016/17 Annual Action Plan (Appendix 1), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

The reported year has been a busy time for Infection Prevention & Control but the Trust has achieved good outcomes in a second year of no reported Trust apportioned MRSA bacteraemias, and 13 reported Trust apportioned Clostridium difficile cases against a trajectory of <19. Concerted effort has been put into antimicrobial stewardship and some dramatic decreases in consumption can be seen in section 11. Other achievements to note can be seen in the improved Patient Led Assessment of the Care Environment (PLACE) scores (section 15) and the reduction in reported issues with theatre trays (section 12).

2. Governance Arrangements

The work towards achieving the objectives of the Annual Action Plan 2016/17 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), which completes the governance arrangements (Appendix 2).

3. Infection Control Arrangements

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

The IP&CT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 2 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

4. Assurance Activity

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

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the IPCT

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

5. Budget Allocation for Infection Prevention & Control Nursing Team

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

Pay

Nursing	£140K
Administrative	£18K

Non-Pay

Non- staff	£3K

Income - £1k

Training

Training budgets are held centrally in the Trust.

6. HCAI Management and Statistics

6.1 HCAI

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

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

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

During 2016/17, the Trust has experienced one period of increased incidence (PII) and one outbreak of C.difficile, and one outbreak of viral gastroenteritis (Norovirus), which are discussed below.

The Trust has had **no** declared outbreaks of:

- Staphylococcus aureus, including Methicillin Resistant Staphylococcus aureus (MRSA)
- Methicillin Sensitive Staphylococcus aureus (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Acinetobacter baumannii
- Chickenpox (Varicella zoster)

- Extended Spectrum Beta Lactamase (ESBL) producers
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza
- Vancomycin Resistant Enterococcus (VRE)

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

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on capacity are high. In such instances, risk based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bed space. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators, with additional written documentation provided to support staff in the ongoing management of these patients.

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

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

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

During quarter 1 of 2016/17, a patient known to be previously CPE positive was nursed within the medical and surgical directorates during two inpatient admissions to the Trust. This patient was strictly isolated in a sideroom facility from admission on both occasions.

6.3 Clostridium difficile (C.difficile)
During quarter 2 of 2016/17, a period of increased incidence (PII) of C.difficile was declared internally for an inpatient area within the medical directorate (Farley Ward). Both Trust apportioned cases were **not** reportable to PHE (toxin negative) and both patients had not been nursed in the same bay/area. However, the ICD arranged for both stool samples to be sent to the External Reference Laboratory for ribotyping. These samples were identified to be of different ribotypes (011 and 'sporadic').

During quarter 3 of 2016/17, a second PII was declared internally for the Trust. From the ribotyping of two Trust apportioned reportable cases identified from an inpatient area within the medical directorate (Redlynch Ward). They could be linked (ribotype 014) and an outbreak of C.difficile was declared retrospectively. Also in quarter 3, two Trust apportioned reportable cases were identified from another ward within the medical directorate (Pitton Ward) where the patients had been nursed in separate bays. These samples were sent for ribotyping and were also identified to be the same ribotype (014).

All four samples were identified to be the same polymerase chain reaction (PCR) ribotype (014). The ribotyping results show a predominant strain and therefore, enhanced fingerprinting was undertaken by the C.difficile Ribotyping Network for England (CDRNE) External Reference Laboratory.

The External Reference Laboratory confirmed that the two clusters of isolates were very closely related, and the possibility of transmission of C.difficile could not be ruled out. Therefore, there was evidence to suggest transmission of C.difficile PCR ribotype 014 clones, within the healthcare setting could have occurred. A full root cause analysis (RCA) has been undertaken and will be signed off in quarter 1 of 2017/18.

In response to the above, additional walkrounds (21) were undertaken by the ICNs with the involvement of the Deputy DIPC, DIPC and/or Directorate Senior Nurses (DSNs). Findings were fedback to the clinical leader/nurse in charge at the time and any resultant actions required agreed. This work has also been supported by the 'caring in confidence' safety walkrounds completed by the Deputy DIPC within each clinical directorate.

6.4 Influenza

During 2016/17, patients continued to be admitted to the Trust with respiratory illnesses and 'flu-like' symptoms. When required, patients were isolated within sideroom facilities on admission; some patients were managed within the bay setting. In both situations, patient contacts were identified for follow up. When a positive influenza result is confirmed, appropriate antiviral prophylaxis is provided as per PHE guidance. The IPCT provide support and guidance to staff groups within the ward teams in the ongoing management of identified patients, including the wearing of personal protective equipment (PPE).

During quarter 4 of 2016/17, a total of 28 inpatient influenza cases were identified during January (predominantly Influenza A), with ten cases in February and one case in March. In addition, a number of cases of Respiratory Syncytial Virus (RSV) were identified from in-house testing. Inpatients identified with RSV were isolated within sideroom facilities, under respiratory precautions whilst symptomatic.

6.5 Invasive Group A Streptococcus (iGAS)

During quarter 1 of 2016/17, there were three cases of invasive Group A streptococcal infection identified for patients admitted to the Trust. These were unrelated cases, and the patients were nursed at separate times within the surgical and medical directorates. Two of these cases were identified from sampling whilst the patients were in the Emergency Department, and the third case was from an inpatient admitted with symptoms of infection.

During quarter 4 of 2016/17, there was one case of invasive Group A streptococcal infection identified for a patient admitted to the Trust from a Nursing Home. This case was identified from sampling whilst the patient was in the Emergency Department. Patients identified with invasive Group A streptococcus were isolated within sideroom facilities, and ongoing management advice was provided by the IPCT.

6.6 MRSA

During quarter 2 of 2016/17, one bay on a medical ward was closed as a direct result of MRSA colonisation found in one patient. During quarter 3 of 2016/17, a total of three bays were closed, each one within separate ward areas (medical and musculoskeletal directorates), as a direct result of MRSA colonisation of one patient. The management of these bays was in accordance with Trust policy.

The Trust continues to screen patients for MRSA in accordance with national guidelines, with screening either undertaken prior to admission (for planned or elective admissions) or immediately following admission to the Trust (emergency admissions). The Trust is currently reviewing screening processes following the publication of updated national guidance.

6.7 Norovirus

The Trust has experienced a fairly consistent level of activity associated with patients experiencing diarrhoea and vomiting. This included patients admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission period.

During quarter 3 of 2016/17, the Trust declared an outbreak of viral gastroenteritis (Norovirus), from 21st to 28th December 2016, following the closure of two wards within the medical and musculoskeletal directorates (Tisbury CCU and Amesbury Suite). Closure ensured the safe management of patients and continued service provision. The Trust Norovirus Outbreak management policy was followed with the appropriate internal and external personnel involved. A 'Lookback' exercise was completed during quarter 4 of 2016/17 (February) for this Norovirus outbreak. Recommendations have been made with identified actions for final agreement by the DIPC and IPCWG members during quarter 1 of 2017/18.

During quarter 4 of 2016/17, the level of diarrhoea and/or vomiting activity continued with the closure of 21 bays in clinical areas across the medical and musculoskeletal directorates at different times. All occurrences were managed as per policy.

6.8 Salmonella

During quarter 2 of 2016/17, two patients who were nursed on a ward within the Clinical Support and Family Services directorate, were identified to be positive for Salmonella, although the cases were not linked. The first patient had been admitted to a sideroom facility on the ward with symptoms attributed to gastroenteritis. The patient was discharged from hospital the following day, and Salmonella was identified from a stool culture taken whilst in hospital. The result was communicated to PHE, for further follow up.

The second patient had returned from recent travel abroad, and was isolated in a sideroom facility on admission due to ongoing symptoms of profuse diarrhoea and fever. Salmonella typhi was identified from a blood culture sample 2 days after admission, and PHE notified in order to instigate the required screening of close family contacts in the community.

Management advice and education was provided to the ward staff by the ICNs, and additional environmental cleaning undertaken by Housekeeping. Patient information leaflets were also accessed to provide additional information.

6.9 Panton-Valentine leukocidin Staphylococcus aureus (PVL-SA)

A patient, who had been nursed on a ward within the Clinical Support and Family Services directorate, was identified to be PVL-SA positive following discharge from hospital. The patient had an existing wound, which was swabbed on admission. Following the receipt of the positive result, and discussion with the Consultant Microbiologist a number of actions were undertaken to include the completion of terminal environmental cleaning of the room occupied by the patient whilst on the ward, and identification of any patients nursed in the same area.

6.10 Vancomycin Resistant Enterococcus (VRE)

During 2016/17, new cases of VRE have been identified, with a number of patients also identified to be VRE positive either in the community, or on admission to the Trust. When inpatient cases have been identified, required actions were agreed following discussion with a Consultant Microbiologist. These have included strict isolation precautions, the completion of additional environmental and equipment cleaning, and where indicated screening of identified patient contacts, with the continuation of antibiotic stewardship.

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

6.11 Multi drug resistant Acinetobacter baumannii (MDRAB)

During quarter 4 of 2016/17, a patient who had transferred from another Trust to a ward within the musculoskeletal directorate was identified with a resistant Acinetobacter species from extensive transfer screening. This patient had previously been identified to have MDRAB in a number of sites and other resistant organisms whilst at the other Trust.

As the patient was a planned transfer, the ICNs were able to communicate with the clinicians involved in the patient's care, Consultant Microbiologists, ward team, and IPCT at the previous Trust, in order to safely manage this patient on transfer. The ICNs have continued to support the ward team in the ongoing management of this patient, whom it has been agreed will need to be strictly isolated throughout their inpatient episode.

7. Mandatory Surveillance

7.1 Surgical Site Infection Surveillance (SSIS)

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

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

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

The Trust complies with this annual requirement to undertake SSIS, and the surveillance category completed for 2016/17 was for knee replacement surgery.

During quarter 3 of 2016/17, the ICNs completed data collection and follow up for patients who had undergone knee replacement surgery during the previous two quarters. The data was submitted to PHE within the agreed timeframe. Of the 114 knee replacement procedures recorded, one deep surgical site infection was identified, as defined by the criteria set by PHE. Formal reports outlining progress and outcomes with SSIS were presented at the IPCC meetings and disseminated to relevant Trust personnel.

The commencement and facilitation of the SSIS process is dependent on the availability of web reports from the Informatics Department (IT). Due to the data warehouse issues, there has been a delay in activating this system for quarter 1 of 2017/18 but data is being collated manually by the ICNs.

7.2 Methicillin Resistant Staphylococcus aureus (MRSA)

The PHE Mandatory enhanced MRSA bacteraemia surveillance scheme (updated March 2016), is used to measure the effectiveness of infection prevention and control practices in all NHS Trusts. The rationale for the surveillance is that it is sometimes difficult to distinguish between colonisation and true infection caused by MRSA, but culture of the bacterium from blood almost always represents significant infection.

The Trust has continued to report MRSA screening rates for all elective and emergency admissions from April 2016 to October 2016, to ensure continued improvement in reducing infections. The facilitation of this audit process is dependent on the availability of web reports from IT, which have not been available since quarter 3 of 2016/17. IT have now completed work to resolve the situation, and anticipate that the web reports would be running and available from the start of April 2017.

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

During 2016/17, the IPCWG have continued to review MRSA screening options to potentially reduce the number of screens for patients **not** admitted to identified 'high risk' areas, as per Department of Health (DH) guidance (2015). A final options paper will be written for presentation to the IPCC during 2017/18.

Tables 1 and **2** below relate to the overall compliance for both elective admission and emergency admission MRSA screening audit figures, for 1st April 2016 to 31st October 2016. Figures are provided for April 2015 to October 2015 for comparison.

Table 1: MRSA Compliance Data – Elective Admissions

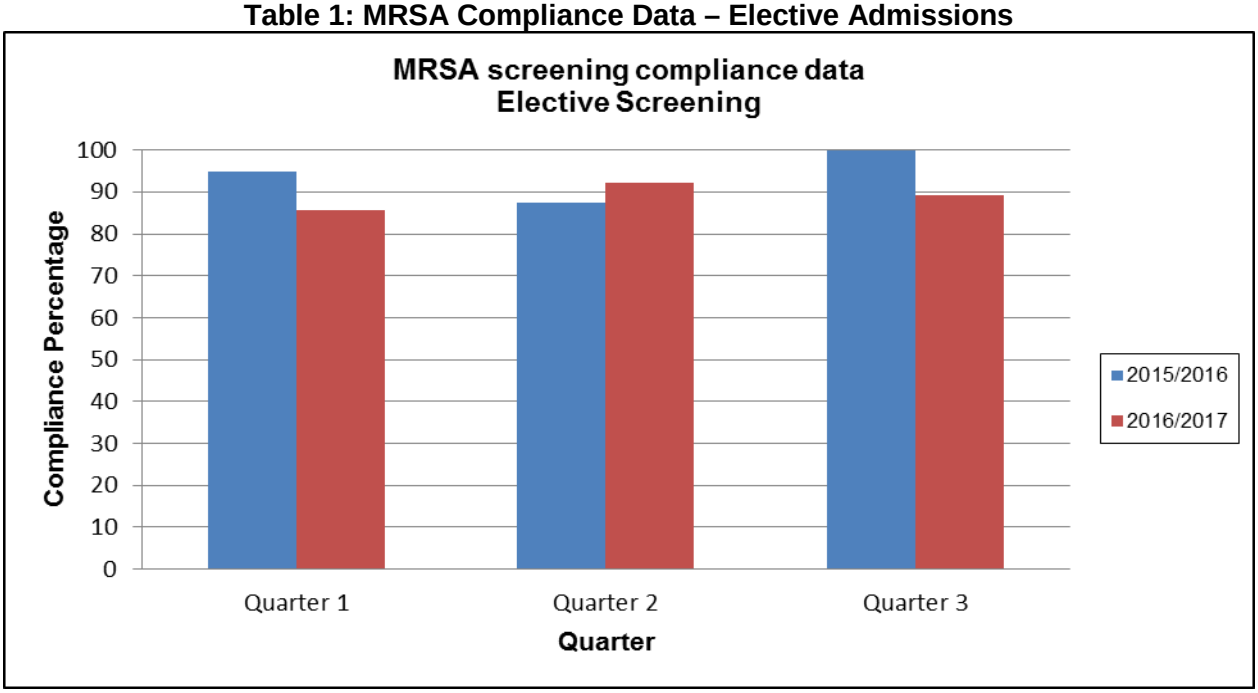
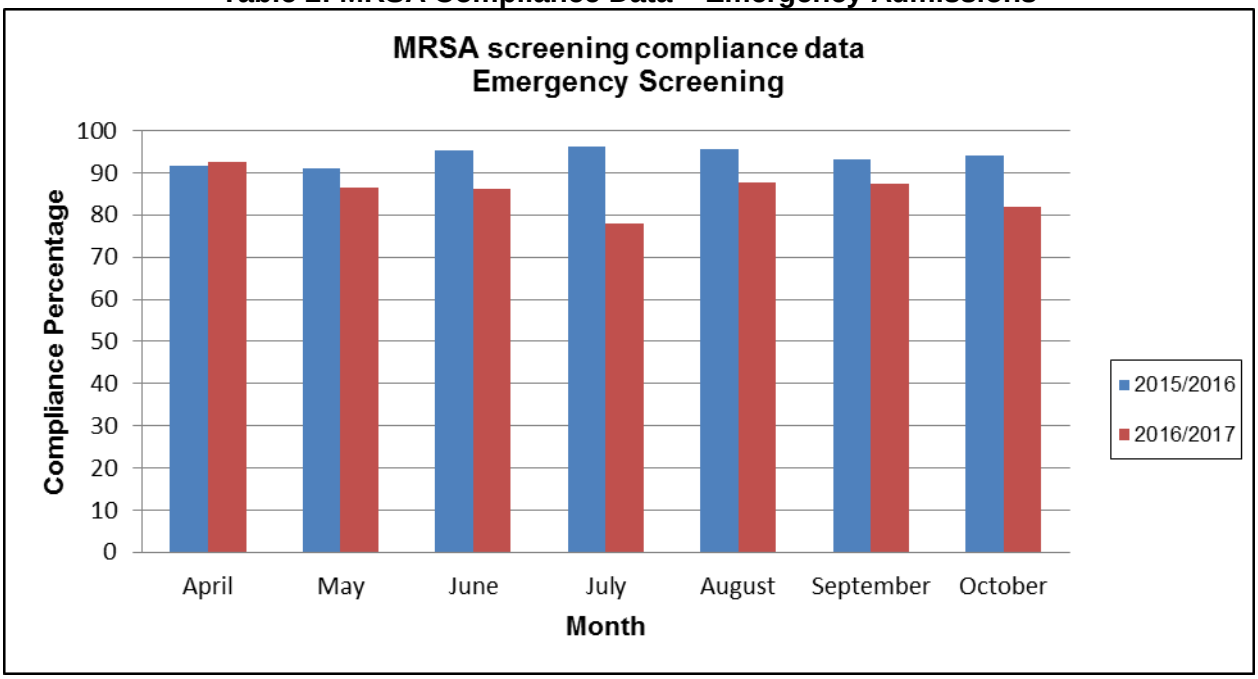


Table 2: MRSA Compliance Data – Emergency Admissions



Overall emergency screening compliance rates have fallen. Feedback received from the clinical areas indicates that the increased patient activity has contributed to this. The ICNs continue to support areas to ensure an improvement with screening compliance, and the IPCWG continues to consider a risk based approach as per national guidance.

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

MRSA Bacteraemia Trust apportioned cases include patients that are –

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

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

The Trust's MRSA Trust apportioned cases target for 2016/17 is zero, which has been achieved. A Post Infection Review (PIR) investigation was undertaken by the relevant CCG for the non-Trust apportioned cases identified during August and October 2016. Both cases were assigned to the relevant CCG.

Table 3: Breakdown of total number of Trust cases recorded April 2016 to March 2017 (Figures in brackets show number of cases recorded April 2015 to March 2016)

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

7.3 Clostridium difficile

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

7.4 Monitoring and diagnostic C.difficile testing

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

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

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

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

All patients with a stool sample confirming the presence of C.difficile require the implementation of strict infection control measures and practices e.g. isolation in a sideroom facility, the completion of terminal and enhanced cleaning by Housekeeping and a review by the relevant clinicians to

determine if C.difficile treatment is indicated. The formal reporting process to PHE is managed by the ICNs under direction of the DIPC and ICD, and has had an impact on the team's workload.

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

Table 4: Breakdown of reportable cases recorded for all inpatients April 2016 to March 2017 (Figures in brackets show number of inpatient reportable cases April 2015 to March 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**2 (0)**	**0 (1)**	**1 (3)**	**0 (2)**	**0 (3)**	**1 (3)**	**4 (2)**	**5 (0)**	**0 (1)**	**4 (1)**	**1 (4)**	**2 (1)**	**20 (21)**
Non Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (1)	0 (1)	0 (1)	1 (1)	1 (0)	0 (1)	2 (1)	1 (0)	2 (0)	**7 (6)**
Trust apportioned cases	2 (0)	0 (1)	1 (3)	0 (1)	0 (2)	1 (2)	3 (1)	4 (0)	0 (0)	2 (0)	0 (4)	0 (1)	**13 (15)**

Table 5: Breakdown of total number of reportable C.difficile cases recorded April 2016 to March 2017 (Figures in brackets show total number of reportable cases recorded April 2015 to March 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**2 (0)**	**0 (1)**	**1 (3)**	**0 (2)**	**0 (3)**	**1 (3)**	**4 (2)**	**5 (0)**	**0 (1)**	**4 (1)**	**1 (4)**	**2 (1)**	**20 (21)**
Community Hospitals	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
General Practitioners (GPs)	2 (4)	2 (1)	0 (1)	1 (0)	0 (2)	1 (3)	2 (1)	2 (1)	3 (1)	0 (0)	4 (1)	2 (1)	**19 (16)**
Residential/Nursing Home	0 (0)	0 (0)	0 (0)	0 (1)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	**0 (1)**
Other (e.g. Coroner, Private Hospital, Day Attender, ED, Outpatient)	0 (1)	1 (1)	0 (0)	1 (1)	0 (0)	0 (0)	0 (0)	1 (0)	1 (0)	0 (0)	0 (0)	0 (0)	**4 (3)**
Total	**4 (5)**	**3 (3)**	**1 (4)**	**2 (4)**	**0 (5)**	**2 (6)**	**6 (3)**	**8 (1)**	**4 (2)**	**4 (1)**	**5 (5)**	**4 (2)**	**43 (41)**

(Of note: In a single patient, a positive test occurring after a previous positive test is considered a new episode after 28 days).

The Trust reported 13 Trust apportioned C.difficile cases for 2016/17 which did not exceed the target set for the Trust by NHS England of <19 for the full year. For each inpatient episode, an infection control incident investigation is completed. This process has been led by the ICNs, with the increased involvement of staff in the relevant clinical areas and the Antimicrobial Pharmacist (or area Pharmacist), to complete the required documentation.

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

Multidisciplinary C.difficile ward rounds have continued by the ICD and/or Consultant Microbiologist and ICNs, with the involvement of the Antimicrobial Pharmacist when required. Attendees can include the DIPC, Deputy DIPC and Medical Director. These rounds provide an opportunity to formally review and assess the patient's progress and management in relation to C.difficile. The group members also ensure that information is shared with the ward teams and this is supported by an entry within the patient healthcare records. The membership of this group has been reviewed, and a Gastroenterologist and Dietician will be involved as required. During 2016/17, no Trust apportioned cases have been submitted to the 'Appeals Panel Process' for the relevant CCG.

7.5 Methicillin Sensitive Staphylococcus aureus (MSSA)

The Trust continues to report MSSA bacteraemia cases via the HCAI DCS website. Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 6: MSSA bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2016 to March 2017
(Figures in brackets show number of cases recorded April 2015 to March 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**5 (3)**	**4 (2)**	**6 (1)**	**5 (2)**	**4 (2)**	**0 (6)**	**4 (5)**	**4 (5)**	**1 (1)**	**2 (5)**	**5 (3)**	**2 (1)**	**42* (36)**
Non Trust apportioned cases	5 (3)	3 (2)	2 (1)	4 (2)	4 (2)	0 (5)	4 (3)	2 (5)	0 (1)	2 (5)	4 (2)	2 (1)	**32 (32)**
Trust apportioned cases	0 (0)	1 (0)	4 (0)	1 (0)	0 (0)	0 (1)	0 (2)	2 (0)	1 (0)	0 (0)	1 (1)	0 (0)	**10 (4)**

*November 2016 – an additional MSSA bacteraemia case was identified from blood cultures taken whilst a patient was attending Salisbury Dialysis Unit, and not admitted to the Trust.

During 2016/17, there have been 10 Trust apportioned cases identified. The ICNs undertake an infection control incident investigation for all Trust apportioned inpatient cases, in conjunction with relevant staff from the clinical area concerned. During quarter 2, the DIPC requested all incident review investigations be presented to the IPCWG members for information and discussion.

Emphasis has been placed on the need for continued monitoring of invasive devices by staff, adherence to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation.

7.6 Escherichia coli (E.coli)

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

Table 7: E.coli Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2016 to March 2017
(Figures in brackets show total number of cases recorded from April 2015 to March 2016)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**11 (6)**	**6 (9)**	**8 (10)**	**13 (11)**	**8 (12)**	**12 (7)**	**14 (8)**	**14 (6)**	**11 (9)**	**6 (9)**	**12 (8)**	**7 (12)**	**122 (107)**
Non Trust apportioned cases	10 (6)	5 (7)	5 (8)	9 (10)	7 (9)	12 (6)	8 (5)	9 (4)	8 (8)	5 (8)	10 (6)	6 (9)	**94 (86)**
Trust apportioned cases	1 (0)	1 (2)	3 (2)	4 (1)	1 (3)	0 (1)	6 (3)	5 (2)	3 (1)	1 (1)	2 (2)	1 (3)	**28 (21)**

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

Of the 28 Trust apportioned cases identified during 2016/17, 8 were determined as likely HCAI related, 16 cases as possibly HCAI related, one case was not likely to be HCAI related and for 3 cases it was not known if it was HCAI related. This data was entered onto the HCAI DCS website. Where concern is highlighted by the Microbiologist for an individual case, further investigation is undertaken. For these Trust apportioned cases, no further follow up was identified.

7.7 Mandatory Reporting update

For 2017/18 (from April 2017), there will be changes regarding the mandatory reporting requirements for Trusts. This is in relation to the classification of C.difficile cases with a focus on previous healthcare interactions/episodes. Following further clarification from PHE, the definition of Trust apportioned and non-Trust apportioned cases has not changed. In addition, the incidence of gram negative bloodstream infections *(Klebsiella sp. and Pseudomonas aeruginosa)* reported at the Trust will now require investigation and data entry onto the PHE DCS website.

8. Hand Hygiene

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

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

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the directorates of measures implemented to improve non- compliance. This target is reflected in the

clinical leaders and DSNs personal objectives, with ongoing work required by the DMTs to sustain improvements. To promote hand hygiene compliance the ICNs continue to train and update the Infection Control Link Professionals (ICLPs) to undertake hand hygiene assessments for staff in their own areas. This has proved successful in raising the profile of hand hygiene behaviour and compliance with BBE. It also provides an alternative opportunity for staff to complete their annual mandatory hand hygiene assessment. The directorates are encouraged to share successes within individual areas at the MMG meetings.

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

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

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

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

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

For 2016/17, the overall compliance rate from external auditing of 16 inpatient areas was 78.25%. This is an increase on the previously reported overall compliance of 70.63% from auditing of 11 inpatient clinical areas during 2015/16.

Detailed analysis was undertaken to identify the key areas of non-compliance, which was predominantly staff missing moment number 5, handwashing after contact with patient surroundings. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on the audit findings.

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

Extra hand hygiene assessment sessions have been undertaken, as demonstrated by **Table 8**.

Table 8: Additional Hand Hygiene Sessions

2016/17 Month	Total number of hand hygiene sessions held using a UV light box	Total number of attendees
April	15	285
May	15	284
June	18	399
July	8	197
August	21	398
September	20	367
October	11	382
November	15	367
December	11	250
January	12	178
February	11	249
March	9	242
TOTAL	**166**	**3598**

9. Audit

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme (Appendix 3). The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have been involved with the following audit work during 2016/17, including the follow up and outcomes from auditing against infection control policies. Reports are generated for each completed audit and resulting action plans approved by the IPCWG. In addition, the following formal reports were presented to the Clinical Management Board (CMB) in August 2016 (reports are available from the IPCT):

- 2% Chlorhexidine Gluconate in 70% Alcohol Isopropyl Wipes.
- Handling & Disposal of Linen
- MRSA Prescription Treatment & Monitoring Pathway
- Isolation policy and use of IRATs

The ICNs continue to undertake additional observational audits of staff practices within clinical areas. Feedback is provided at the time of the audit to the nurse in charge, and where non-compliance has been identified this is addressed with the individual staff member. Feedback is provided to the relevant Clinical Leader. Practice observations have included application of standard precautions, isolation nursing precautions, commode cleanliness, dirty utility room standards and linen management.

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

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

10. Innovations

The IPCWG continue to lead the review of technologies and innovations related to the reduction of HCAIs, with the involvement of key personnel across the Trust site. This has been incorporated as

a standing agenda item at the IPCWG meetings, with innovations measured against the best practice evidence/research available, which has included DH recommendations.

The IPCWG continue to strive to ensure that the Trust implements only those technologies and innovations that have been peer reviewed and appropriately approved. During quarters 1 and 2 of 2016/17, the use of the GLOSAIR 400 room decontamination system (RDS) has been undertaken and additional hydrogen peroxide vapour (HPV) machines investigated. In addition, the use of ultraviolet (UV) rays for disinfection purposes has also been explored, with feedback reported via the IPCWG.

11. Antibiotic Prescribing *(information for this section has been provided by Louise Williams, Principal Pharmacist Antibiotics)*

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

11.1 Guideline development/review

The ARG continually works to ensure policies on the Trust guidelines database are easily accessible and up to date.

Guidelines reviewed 2016/17:

- Surgery prophylactic antibiotics
- Sepsis of Unknown Origin/Septic Shock, Septic arthritis and Urinary sepsis/Pyelonephritis
- Endocarditis – prophylaxis against infective endocarditis
- Diabetic Foot
- Genito-urinary medicine (GUM)

Guidelines currently under review:

- Antifungal guidelines
- ENT antimicrobial guidelines
- Respiratory infection community acquired pneumonia (CAP)

Future guidelines for review during 2017/18:

- Respiratory infections – chronic obstructive pulmonary disease (COPD) and hospital acquired pneumonia (HAP)
- Gentamicin – conventional multiple dosing and high dose 5mg/kg daily (for adults)
- Development of new guideline for Oral and Maxillofacial

11.2 Audit

Regular Antimicrobial Stewardship Audits

The way in which antimicrobial stewardship audits are undertaken has changed significantly this year, largely due to the antimicrobial stewardship Commissioning for Quality and Innovation (CQUIN) agreed for 2016/17. The ARG took the decision that in order to ensure work is not duplicated we ceased to undertake the ‘rolling programme of audit’, instead basing our audit plan on the CQUIN requirement.

Clostridium difficile – Antibiotic treatment review and ward rounds

All cases of C.difficile are reviewed by a member of the pharmacy team, to ascertain whether past or current antibiotic treatment may have been a contributory factor. Other medications which may impact upon the patients clinical conditions are also noted and reviewed i.e. use of laxatives, antimotility drugs, proton pump inhibitors (PPIs).

A designated Senior Pharmacist attends the multidisciplinary ward rounds, when requested. This is undertaken by a Consultant Microbiologist together with the ICNs. It provides an opportunity to

review the treatment and management of inpatient C.difficile cases, and is also a forum to discuss any management issues or concerns. In addition, the group will liaise with the appropriate clinicians/nursing staff for the patient if required, and an entry is made within the healthcare records.

Antibiotic Awareness Day
An 'Antibiotic Awareness Day' campaign was held on 18th November, which proved very successful.

11.3 Risk Management
Any concerning incident reports (DATIX) relating to or involving antibiotics are highlighted at the ARG and no trends have been identified.

11.4 Defined daily doses (DDD)
As recommended in the DH document 'C.difficile – How to deal with the problem', a mechanism for capturing DDD data is in place. This is necessary to ensure cost effective use of antimicrobials and 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 Doxycycline

11.5 National Antimicrobial Commissioning for Quality & Innovation (CQUIN) 2016/17
For 2016/17, a national CQUIN around Antimicrobial Resistance and Stewardship was agreed, with standards as follows:

- **CQUIN 3a –** Reduction in antibiotic consumption (as DDDs) per 1000 admissions (3 parts)
    1: 1% or more reduction in total antibiotic consumption (DDDs per 1000 admissions)
    2: 1% or more reduction in total consumption of Carbapenems (DDDs per 1000 admissions)
    3 1% or more reduction in total consumption of Piperacillin/Tazobactam (DDDs per 1000 admissions)

All of the above must be reduced by 1% or more on the 2013/2014 baseline validated prescription data (PHE).

- **CQUIN 3b –** Empiric Review of Antibiotic prescriptions

A local audit of 50 antibiotic prescriptions per month is undertaken, to ascertain if a documented review has taken place at 72 hours. Milestones set for the CQUIN as follows: Quarter 1 = 25%; Quarter 2 = 50%; Quarter 3 = 75% and Quarter 4 = 90%.

Data has been collected and audits undertaken as per the CQUIN requirements. Awareness of this work has also been raised through the following forums: presentation at Trust Clinical Governance Core Session; discussion at F1 and F2 training sessions; presentation at the Nursing, Midwifery & Allied Health Professionals (AHPs) Forum and training sessions for Pharmacy staff. The antimicrobial stewardship team have also arranged to attend a variety of clinicians meetings going forward.

- **CQUIN 5a –** Consumption

At the end of quarter 4 of 2016/17, the results below **(Table 9)** are as follows**:**

	% change re: baseline at end of 2016/17
Piperacillin/Tazobactam	1.2
All Antibiotics	- 0.6
Carbapenems	- 33.0

The above data exhibits the following:

- Clear attainment of the 1% target for reduction in Carbapenem use.
- For Piperacillin/Tazobactam we have not met the target. However, this result should be looked at in the context of usage over the intervening years which can be seen in the table below. We have in fact elicited an 18% reduction in use since 2014/15, which is a testament to the hard work of our prescribers and wider clinical teams.
- We have also narrowly missed the target for all Antibiotic use. The table below shows that when the data sets for 2014/15 and 2015/16 are considered, it is clear that a significant reduction in total antibiotic usage has been achieved. It is of note that measures put in place to reduce Piperacillin/Tazobactam use will have had a detrimental effect on this measure.
- Piperacillin/Tazobactam prescriptions have been replaced by alternative treatments the majority of which call for the use of two or more antibiotics to elicit the same antimicrobial coverage. For example: for intra-abdominal infections, we previously recommended Piperacillin/Tazobactam (with or without Gentamicin) but our updated Trust policy calls for Cefuroxime and Metronidazole (with or without Gentamicin). Changes such as this will have had an impact on our total antibiotic usage figure (see **Table 10** below).

	% change re: baseline			
	2013/14	2014/15	2015/16	2016/17
Piperacillin/Tazobactam	0.0	19.7	14.1	1.2
All Antibiotics	0.0	10.7	5.1	- 0.6
Carbapenems	0.0	6.3	- 17.8	- 33.0

- **CQUIN 5b –** Prescription review within 72 hours

Of the prescriptions audited during quarter 4, a documented review within 72 hours, 95.3% had taken place, thus meeting the milestone for this quarter of 90%. All previous quarter's milestones have also been attained.

12. Decontamination *(information for this section has been provided by Sarah Jennings, Medical Device Safety Officer (MDSO) and Decontamination Lead (DL)*

The advent of a joint venture for the Trust with Synergy Health plc has formed Sterile Supplies Limited (SSL), which is responsible for the central decontamination and sterilisation of instrumentation and endoscopes. SSL will eventually operate from a purpose built premises on the Hospital site. A new DL has been appointed to advise the Trust and manage local decontamination within the hospital and to be a link between the Trust and SSL. The DL continues to attend and advise the Theatre Risk Group and the Emergency Preparedness Planning Group. The Trust Decontamination Working Group (DWG) has quarterly meetings, with formal feedback to the IPCC.

12.1 Progress against Decontamination Strategy

The Decontamination Strategy has been updated with regard to the 2016 Health Technical Memorandum (HTM) guidance and a review of decontamination in terms of Essential Quality Requirements (EQR) and Best Practice (BP) is ongoing. Key objectives are reviewed at DWG meetings. Risk assessments are monitored and updated when necessary.

12.2 Activity to promote compliance with decontamination arrangements

- The Decontamination Policy and Creutzfeldt Jakob Disease (CJD) Policy are current.

- Local decontamination is being reviewed and Standard Operating Procedures (SOPs) implemented to ensure consistent practice which can be monitored through training records and audit.
- Tray Tracking has been in place through SSL since September 2016. Useful data has been extrapolated which shows a decrease in fast track requests and a reduction in wet sets and damaged tray wraps.
- Instrument inventory audits have taken place to identify additional capital requirements and reviews are also capturing non CE marked instruments.
- SSL will be starting to mark individual instruments. Supplementary items will be done first to meet traceability requirements, followed by high risk CJD transmission instruments.
- SSL continues to process flexible endoscopes as per HTM 01-06. Four out of five washers are fully compliant with BS EN ISO 15883. One washer has continually shown high bacterial counts in rinse water and consequently has been out of use since November 2016. Remedial work has taken place but has not yet identified the cause of the high counts

12.3 Decontamination Audit plan

The new DL has contacted areas in addition to those already on the audit plan to discuss what procedures are in place for local decontamination. No official audits have taken place in the last 4 months, but work has been done resulting in the Respiratory Department now centrally reprocessing their CPAP masks. Dermatology Treatment Centre (DTC) are looking to source a hand held HEPA filtered vacuum to manage decontamination of their phototherapy cabins effectively. SOPs have been devised in conjunction with Laser Clinic, Ophthalmology Clinic, Spinal Pressure Clinic, community midwives and Labour Ward to provide consistency in decontamination practices. Fortnightly meetings with the IPCT will now incorporate some audit work moving forward.

12.4 Maintaining a fully complaint sterilisation facility (SSL)

SSL appointed a permanent General Manager, Stuart White, in April 2017. The DL meets with the Authorised Person (AP) for Decontamination and SSL every week to ensure that the decontamination assets that are still in use for decontamination in the current sterilisation facility are tested and working according to regulations. Once SSL are in their own premises, new decontamination equipment will be purchased and in place, as part of the joint venture.

12.5 The Decontamination Working Group

The DWG continues to have oversight of the usage of decontamination equipment around the Trust and in SSL to ensure safety and compliance is achieved. Attendees are from a variety of disciplines including Housekeeping, Estates Technical Services (ETS), Microbiology, IPCT and Theatre/ward specialities. Newly formulated SOPs have been reviewed and approved for use through the DWG and concerns including the decontamination processes for spinal wheelchairs and the reuse of Theatre tourniquets are discussed and actions put in place to risk assess and improve practice where possible. The DL has proposed changes to the Trust Declaration of Contamination Status form through the DWG.

12.6 Health Technical Memorandum (HTM) Regulations

Choice Framework Documents 01-01 and 01-06 were revised in June 2016 and are now superseded by HTM 01-01:‘Management and decontamination of surgical instruments (medical devices) used in acute care’ (Parts A-E) and HTM 01-06:‘Decontamination of flexible endoscopes’ (Parts A-E).

The new HTMs bring additional guidance and regulations for residual protein testing for surgical instruments and protein challenge tests for endoscope reprocessing. This focus aims to ensure the technical content is consistent and able to be adopted so that requirements of the Advisory Committee on Dangerous Pathogens – Transmissible Spongiform Encephalopathy (ACDP-TSE) Subgroups amended guidance can be met. The DL and SSL are working together to ensure that SSL is able to meet the guidance within the appropriate time frame.

13. Education and Training Activities

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

At the request of the Trust Board, the figures presented in Appendix 4 reflect the percentage of staff in each directorate that have completed a hand hygiene assessment at the end of each quarter and identifies the figures for the IP&C computer based learning (CBL) modules completed via the intranet site during 2016/17.

The ICNs have continues to focus on the promotion of opportunities for staff to complete their hand hygiene assessment. This has included arranging sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the musculoskeletal DMT facilitated the completion of hand hygiene assessments for staff by utilising a UV light box for rotation through the directorate areas and departments.

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

14. Water Safety Management *(information for this section has been provided by Terry Cropp, Responsible Person (RP) for Water and Head of Estates)*

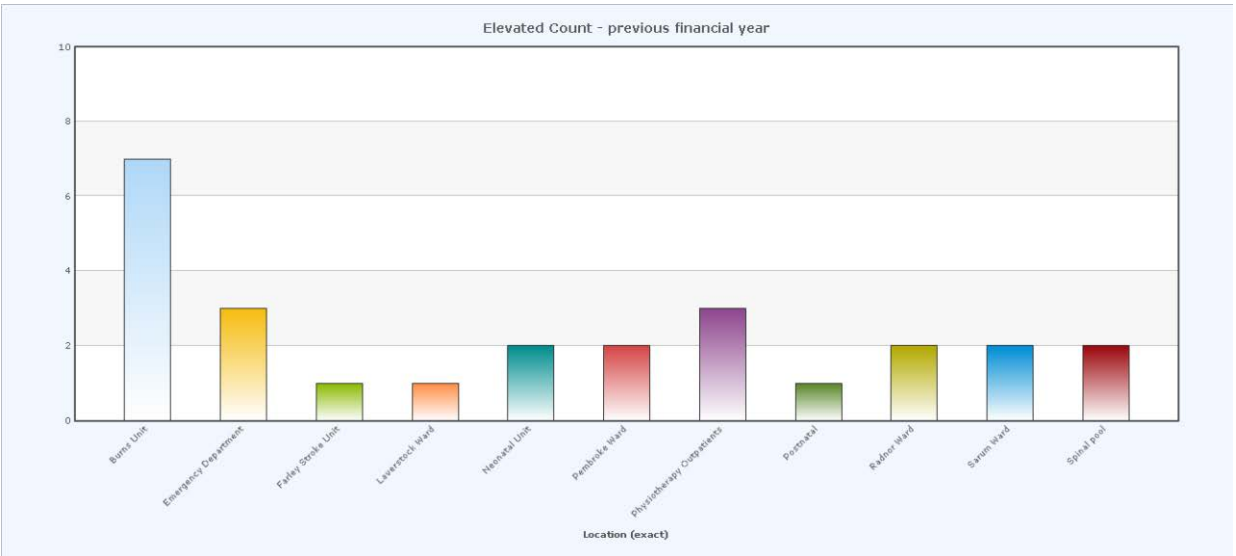
This section summarises the water safety management precautions that the Trust has taken during 2016/17. The Trust continues to monitor and manage the safety of its water systems on site in line with the Trust policy. This requires a temperature and flushing regime in the main areas with a supplementary Copper/Silver dosing system in the Spinal and Central area system. Clinical areas continue to be flushed by dedicated ETS staff. Two members of staff are engaged in providing a flushing service as part of their routine activities. Non-clinical and office areas are to be flushed and reported as such by the users.

In light of 'lessons learnt' at a neighbouring Trust, separate risk assessments (main Risk ref **1291**) have been raised for the key controls measures in respect of water safety, these are identified in the **Table 11** below, and will be reviewed at the quarterly WSG meetings.

	Risk	Risk Reference	Current Risk Score	Target Risk Score	Review Date
1	Water Safety – Flushing	4426	8	4	31-05-2017
2	Water Safety – TMV Maintenance	4427	12	4	31-05-2017
3	Water Safety – Tank & Calorifier Cleaning	4428	12	4	31-05-2017
4	Water Safety – Record keeping, drawings etc.	4429	8	4	31-05-2017
5	Water Safety – Temperature control	4430	12	4	31-05-2017
6	Water Safety – System/ Engineering RA	4431	12	4	31-05-2017
7	Water Safety – Routine sampling	4432	8	4	31-05-2017
8	Water Safety – Shower Head De-scales	4433	8	4	31-05-2017

14.1 Routine Sampling - Legionella

The routine annual sampling for Legionella commenced in September 2016, 382 outlets have been sampled. Any live counts have been managed in line with Trust policy, and where the count has exceeded 1000 cfu/l a meeting has been called and an action plan agreed to mitigate any risks to patients and staff.



The information above **(Table 12)** has been taken from DATIX, and shows the number and areas that have had elevated counts (Legionella & Pseudomonas), some of these areas may have had numerous counts but are linked to a single incident.

14.2 Routine Sampling - Pseudomonas

Routine testing continues (six monthly of 250 outlets) on NNU, Radnor Ward, Pembroke Ward, Burns Unit and part of Avon Ward. All positive samples were recorded and managed in line with policy.

14.3 Flushing

The flushing of all outlets in clinical areas across the hospital continues, with the total percentage of flushing for quarters 1 and 2 of 2016/17 at 52%. There has been significant improvement with the levels of flushing and the total percentage of flushing for quarters 3 and 4 of 2016/17 is 71.5%.

Office and support areas (non-clinical) are required in line with the amended water safety policy to self-manage the flushing regime, and report this direct to ETS. Where counts have been identified additional flushing will be carried out by ETS staff, as part of an agreed action plan.

14.4 Copper/Silver Ionisation Plant

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

14.5 Independent Advice

The Trust's Authorising Engineer (AE) is Mr Daniel Pitcher of the Water Hygiene Centre. The Trust will be extending the current contract with Water Hygiene Centre, due to end in June 2017 to June 2018 to enable some continuity with this role, and the advice/direction of the management of the Trust's water systems. The AE attends the Water Safety Group.

14.6 Drain Blockages

There has been a significant improvement in this area. However, it is clear that the message in respect of the correct disposal of wipes and handtowels must not be lost and this is now highlighted on all 'staff induction' days.

15. Cleaning Services *(information provided by Michelle Sadler, Facilities Manager)*

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

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

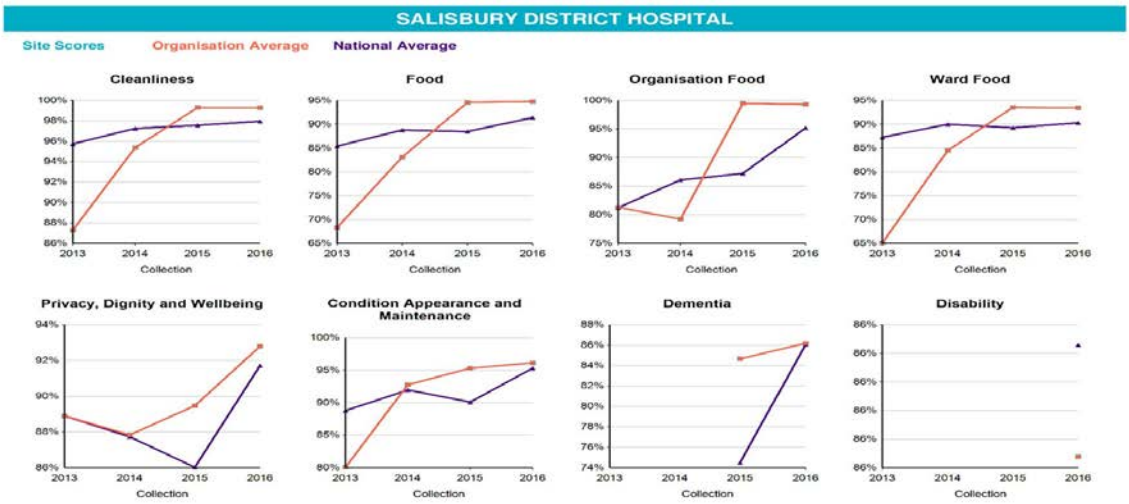
The Trust developed and implemented a programme of PLACE audits for 2016/17. We continue to achieve active engagement and good support from Governors, Volunteers and the local Health Watch representatives and undertook 54 internal PLACE 'Lite' audits between August 2016 and April 2017. Each ward produced their own action plans and reported progress via the MMG meetings.

Focus is given to themes from the ward or department and learning that can be shared with other areas. The internal PLACE 'Lite' audits have produced evidence that supports capital bids and decorating programmes so funds are appropriately allocated. The result of each assessment is submitted within the PLACE 'Lite' tool linked to the Health and Social Care Information Centre.

15.2 National PLACE

The Trust participated in the National PLACE assessment during quarter 4 of 2016/17 (March 2nd 2017). A total of 10 wards and the Emergency Department (ED) were visited, 4 food assessments undertaken, 6 outpatient areas as well as external spaces and communal areas were also assessed as required under the PLACE criteria. The provisional results reflect improvements have been made in most areas. The score for this Trust will be published in August 2017. The results from PLACE are analysed and key themes form the basis of improvement plans within the Trust.

Table 13 below shows the scores for our Trust against the national average for 2016.



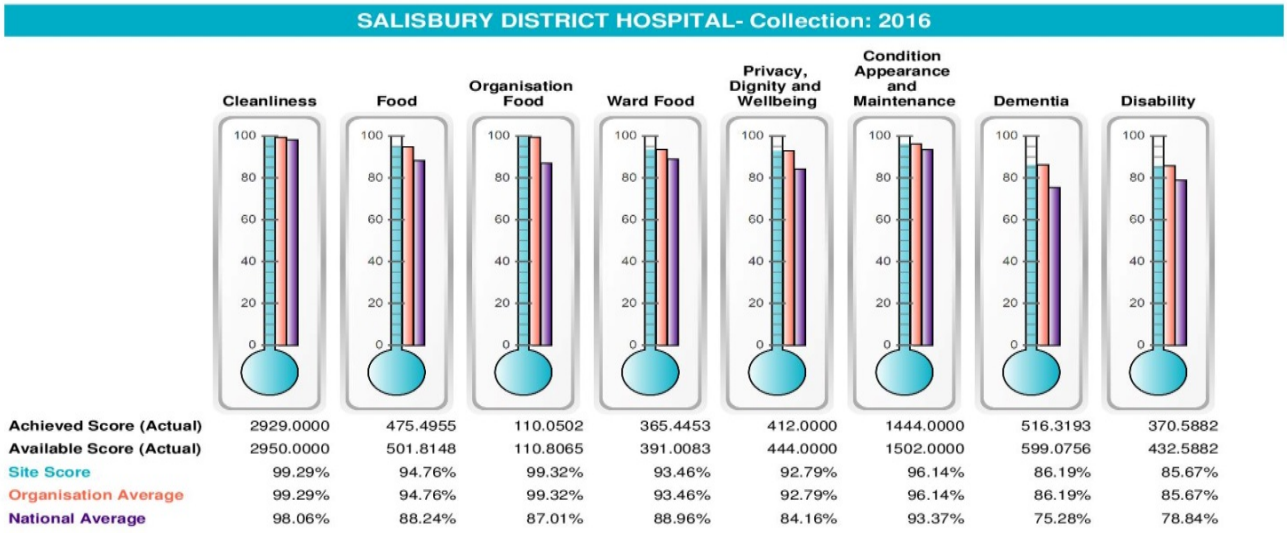


Table 14 demonstrates the additional cleaning activity arising as a result of the internal PLACE audit findings, Housekeeping audits and the requirements linked to the patients' needs on the wards.

Table 14: Additional cleaning activity

Area of Focus	Key Performance Indicator (KPI)	APR 2016	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR 2017
Departmental Data	Post infection cleans	393	363	342	**299**	380	397	411	416	**500**	476	433	365
XX –Highest **XX- Lowest**	Enhanced cleaning hours	67	63.75	**35.50**	52.75	43.75	57.75	63.25	**67.5**	64.5	52.75	55.75	52
Cleaning	Total audits	93	93	109	93	94	110	96	112	96	96	96	112
	Passes	51	47	55	48	52	63	54	59	52	47	57	57
	Qualified Passes	42	46	54	45	42	47	40	53	44	49	39	55
	Fails	0	0	0	0	0	0	0	0	0	0	0	0

15.3 Terminal, enhanced and double cleaning

Table 15 below illustrates the additional cleaning undertaken in clinical areas between April 2016 and March 2017 (excluding the deep clean programme).

Table 15: Terminal, enhanced and double cleaning

Month/Year XX –Highest XX- Lowest	2015/16 Number of terminal cleans	2015/16 Enhanced cleaning hours	2015/16 Double cleans in hours	2016/17 Number of terminal cleans	2016/17 Enhanced cleaning hours	2016/17 Double cleans in hours
April	373	109.75	47	393	67	83.50
May	471	50.75	79	363	63.75	64
June	416	34.50	103.25	342	35.50	59.75
July	367	10.25	70.5	299	52.75	63.50
August	385	26	63.25	380	43.75	120
September	457	31.75	64.25	397	57.75	69.25
October	400	49.75	86	411	63.25	90.50
November	414	44.75	81.75	416	67.5	105.5
December	374	2.5	64	500	64.5	180.25
January	384	16.75	115.50	476	52.75	185
February	395	43.75	45	433	55.75	91.25
March	530	125.75	108.25	365	52	130.25
Year to Date total	**4966**	**546.25**	**927.75**	**4775**	**676.25**	**1242.75**
Totals for Year	**6440**			**6694**		

15.4 Deep clean programme and rapid response team

The deep clean and decorating programme started in April 2016 and has now reached its conclusion. A monthly review of the progression of this plan is undertaken at the MMG and IPCWG meetings each month. Concerns were raised in December 2016 that the Housekeeping Team could not access a number of bays and sideroom facilities due to bed pressures. A plan to undertake a contingency “scrub” was implemented for those areas that a deep clean and GLOSAIR 400 RDS was not possible to better ensure areas received a level of annual deep clean.

At the end of April 2017, we were unable to complete 8 bays across the Trust (Chilmark Suite, Avon, Tamar, Breamore, Postnatal and Downton Wards). This equated to a total number of 31 outstanding bedspaces due to patient activity therefore leading to an inability to access the area. These areas will be prioritised and as they become available the deep clean and GLOSAIR 400 RDS will be completed or a contingency scrub will be undertaken. Even with the bed pressures that the Trust are facing, the number of completed areas deep cleaned or scrubbed improved by 43 bays/siderooms compared to last year (2015/16).

In addition to the deep clean programme, the demand on the GLOSAIR 400 RDS remains high and reflects the robust measures in place to ensure appropriate infection control practices.

Table 16 below reflects the activity during 2015/16 and 2016/2017.

Table 16: GLOSAIR 400 room decontamination

2016/17 MONTH	APRIL	MAY	JUNE	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
GLOSAIRS (Not including Deep Clean Plan)	64	31	21	18	22	17	28	22	35	34	23	10
Total to date	**325**											
2015/16 MONTH	**APRIL**	**MAY**	**JUNE**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**
GLOSAIRS (Not including Deep Clean Plan)	28	16	31	28	26	50	21	32	27	43	26	30
Total to date	**358**											

15.5 Housekeeping resources

The Head of Facilities presented the Housekeeping options paper (with a value of £171k) to the Executive Directors during quarter 4 of 2105/16 (January 2016) to better ensure that cleaning resources can meet the demands on the service, and ensure national cleaning standards and infection control needs are met.

The Executive Directors agreed to fund a proportion of the paper with a value of £76,582 from October 2016. This has enabled the Housekeeping Team to extend the operational hours to include 20.00hrs to 23.45hrs every day, extend the weekend cover between the hours of 12noon to 16.00hrs and recruit additional Housekeeping Supervisors to accommodate these extra operational hours. This enables the Housekeeping Team to respond to infection cleans, outbreaks and GLOSAIR 400 RDS requests to ensure the efficient turnaround of patients beds following the discharges of patients. Housekeeping Services continue to strive to work in a multi-disciplinary team way, communicate well and be responsive to the needs of our patients.

15.6 Improvement Work Projects

The Housekeeping Management Team undertook a gap analysis review to identify what actions/changes would be required to fully implement the cleaning management tool advocated by the British Standards Institute (BSI). This has now been costed and will be presented at the Joint Board of Directors (JBD) in May 2017.

A training competency document was developed and a trial implemented with new recruits within Housekeeping (identified within the BSI model), this document will be reviewed in 6 months and amendments made as required. Following this review this document may be used within other support service teams.

A capital bid has been approved for £36K to support the purchasing of new hydrogen peroxide vapour (HPV) room decontamination units. The GLOSAIR 400 RDS machines (currently in use) are reaching the end of their life expectancy and are no longer manufactured. Plans are in place to research and trial those currently on the market in order to be well placed to action an order when the current provision is condemned.

16. Summary

This annual report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust.

The report has detailed the progress against the Action Plan for 2016/17 in reducing HCAI rates for the Trust and the key priorities have included:

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

Appendix 1

Infection Prevention & Control – Annual Action Plan 2016/17

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

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

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

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

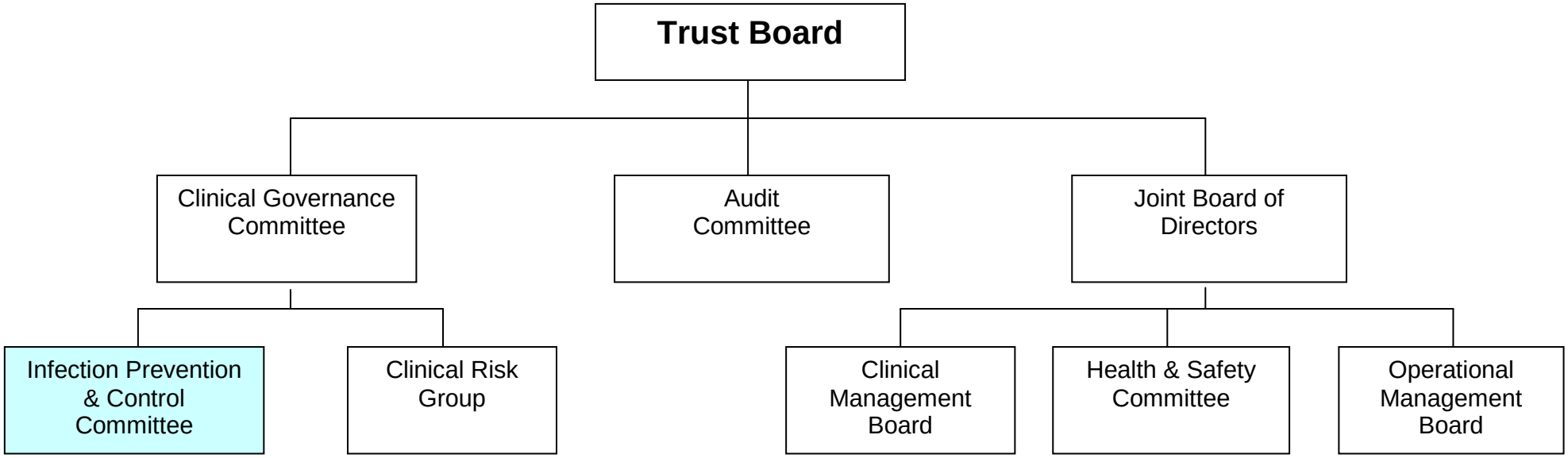
Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.		
Ensure all staff can access relevant occupational health services	AK	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	HL	Continuous
Continue the provision of infection prevention and control education at induction	IP&CT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IP&CT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	DSNs/ICNs	Continuous

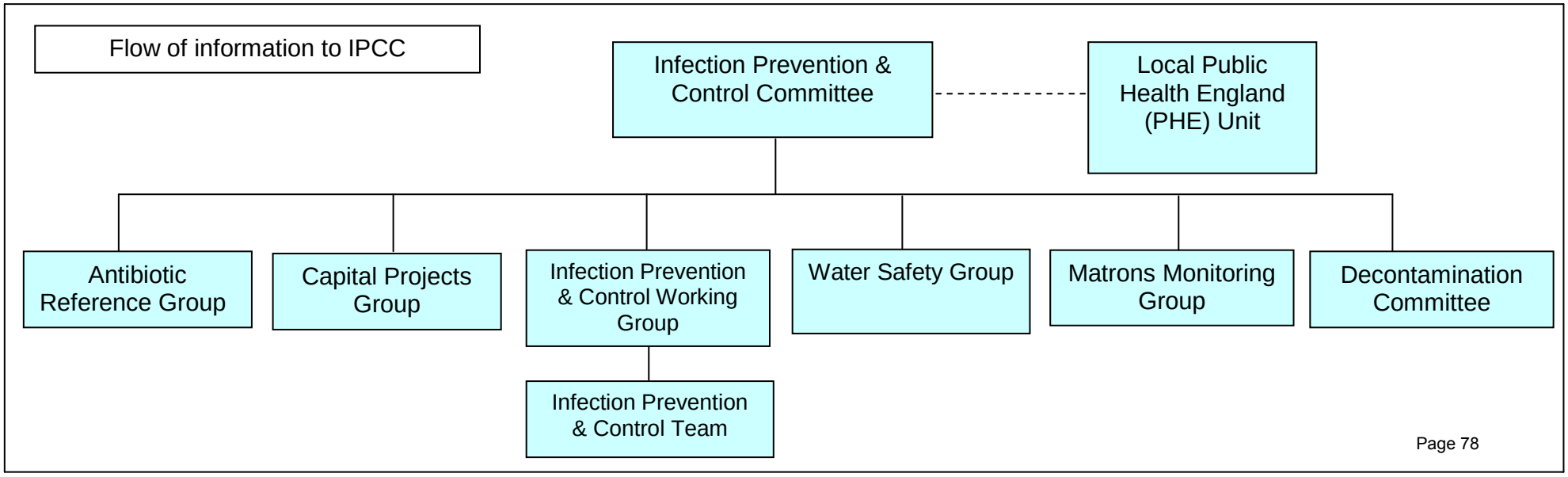
KEY INITIALS

DIPC	Lorna Wilkinson, Director of Infection Prevention & Control (DIPC)
DDIPC	Fiona Hyett & Denise Major, Deputy DIPCs
RW	Robert Warburton, Decontamination Lead & SDU Manager (up to October 2016) then Sarah Jennings (from October 2016)
JH	Julian Hemming, Consultant Microbiologist & Infection Control Doctor
SC	Stephen Cotterill, Consultant Microbiologist
PR	Paul Russell, Consultant Microbiologist & Antimicrobial Lead
IR	Ian Robinson, Head of Facilities
TC	Terry Cropp, Responsible Person for Water & Head of Estates
DSNs	Directorate Senior Nurses
JHo	Janet Hope, Head of Patient Flow
PK	Paul Knight, Health & Safety Manager, OH Department
GL	Geoff Lucas, Safety Advisor, OH Department
HL	Heidi Lewis, Manager OH Department
ET	Emma Taylor, Principal Pharmacist (up to February 2017) then Louise Williams (from February 2017)
JD	Jacqui Dalley, Neonatal Unit Sister
MF	Maria Ford, Nurse Consultant in Critical Care
PJ	Paul Jackson, Energy and Waste Manager, Facilities
AK	Alison Kingscott, Director of Human Resources
MS	Michelle Sadler, Facilities Manager

Appendix 2

Formal Trust Reporting Structure





Appendix 3

Infection Prevention & Control Annual Audit & Policy Review Programme 2016/17

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

No	Aim	Audit	When by/How	Person(s) responsible/main author
5	Prudent use of antibiotics.	Antibiotic prescribing & usage.	Action Plan agreed & monitored by the Antibiotic Reference Group (ARG).	Chief Pharmacist & Antimicrobial Pharmacist
6	Management & organisation – • Policy, guideline & information development & review programme (review dates according to ICID or SDH intranet site).	Patient information leaflet - Acinetobacter.	Review January 2018.	ICNs.
		Microbiology/Infection Control Alerts Policy.	Review February 2019.	Stephen Cotterill.
		Aseptic procedure.	Review October 2017.	ICNs.
		Central Line Policy	Review June 2019.	Sarah Clark (Radnor Ward)
		Clostridium difficile Policy.	Review February 2018.	ICD.
		Patient information leaflet - C.difficile.	Review February 2018.	ICNs.
		Contractors/Procurement information leaflet – infection prevention in hospital.	Review June 2018.	ICNs.
		Creutzfeldt Jacob Disease (CJD) Policy.	Review May 2019.	Decontamination Lead & ICD.
		Decontamination Policy.	Review April 2018.	Decontamination Lead.
		Patient information leaflet - ESBL.	Review April 2020.	ICNs.
		Glove Usage Policy & Chart.	Under review 2017.	ICNs.
		Patient information leaflet - Group A Strep (GAS).	Review February 2019.	ICNs.
		Staff information leaflet - Hand Hygiene.	Review January 2018.	ICNs.
		Infection Control Policy.	Review June 2017.	ICNs.
		Infection Prevention & Control Practice in the Operating Department.	Review September 2017.	Lucinda Pluck (Main Theatres Department)
		Inpatients with diarrhoea algorithm.	Review October 2018.	ICNs.
		Isolation Policy (including diarrhoeal infections & other alert organisms).	Review March 2019.	ICD.
		Hand Hygiene Policy.	Review June 2017.	ICNs.
		Patient information leaflet - Invasive GAS Disease.	Review February 2019.	ICNs.
		Linen Management Policy.	Review February 2020.	ICNs.
		Legionellosis Management & Water Safety Policy.	Review February 2019.	Terry Cropp.
		Clinical Management of MRSA Policy.	Review November 2018.	ICD.
		Patient information leaflet - MRSA.	Review January 2018.	ICNs.

No	Aim	Audit	When by/How	Person(s) responsible/main author
6	Continued	Patient information leaflet - MRSA Contact Bay.	Review November 2019.	ICNs.
		Patient information leaflet - MRSA Screening.	Review July 2018.	ICNs.
		Outbreak Management Policy.	Approved January 2017.	IPCT.
		Outbreak Management of Norovirus Policy.	Review June 2017.	IPCT.
		Patient information leaflet – Norovirus.	Review February 2019.	ICNs.
		Patient information leaflet – 'Now that I am in Isolation – some practical advice'.	Review November 2019.	ICNs.
		Prevention of Occupational Exposure to Blood Borne Virus Policy.	Review November 2019.	ICNs.
		Prevention of Spread of Carbapenem Resistant Organisms Policy.	Review January 2018.	ICD.
		Patient information leaflets – CPE C3 – Colonised. C4 – Carrier. C5 – Contact.	Review August 2017.	ICNs.
		Peripheral Venous Cannulation Policy.	Review November 2017.	ICNs.
		Patient information leaflet – Having a 'drip' (peripheral venous cannula)	Review February 2019.	ICNs.
		Standard Precautions Policy.	Review November 2018.	ICNs.
		Surveillance Policy.	Review January 2019.	ICNs.
		Taking Blood Cultures Policy – Adults.	Review July 2017.	IPCT.
		Tuberculosis Infection Control Policy.	Review December 2017.	ICD.
		Ebola and other Viral Haemorrhagic Fevers Policy.	Review August 2017.	ICD.
		Management of VRE Policy (New policy)	Approved April 2017.	ICD & Deputy ICD.
		Patient information leaflet – GRE.	Review September 2018.	ICNs.
		Patient information – Infection Control Advice to Patients	Review November 2018.	ICNs.
		Staff information – MERs CoV	Review September 2018.	ICD.

Appendix 4

Reports accessed from the Managed Learning Environment (MLE) on 3rd April 2017, and outlines the directorate compliance rates for Hand Hygiene Assessments and Infection Control CBL Packages completed for Quarter 4 of 2016/17

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Hand Hygiene Assessment 122014 (Quarter 4)	Balance Sheet (Direct)	3	1	4	**75%**
	Capital (Directorate)	37	2	39	**95%**
	Clinical Support & Family Services (Direct)	779	268	1047	**74%**
	Corporate Directorate (Direct)	337	85	422	**80%**
	Facilities Directorate (Direct)	267	33	300	**89%**
	Finance - Charitable Funds (Direct)	2	3	5	**40%**
	Medical Directorate (Direct)	4	3	7	**57%**
	Medicine Directorate (Direct)	390	296	686	**57%**
	Musculo-Skeletal (Direct)	313	131	444	**70%**
	Nursing & Admin Staff Bank (Direct)	0	2	2	**0%**
	Nursing Directorate (Direct)	0	1	1	**0%**
	Odstock Medical (Direct)	11	4	15	**73%**
	Quality Directorate (Direct)	254	224	478	**53%**
	Surgery (Direct)	505	174	679	**74%**
	Therapy Staff Bank (Direct)	7	44	51	**14%**
		1	2	3	**33%**
Hand Hygiene Assessment 122014		**2910**	**1273**	**4183**	**70%**

Training Title	Directorate	Number complete	Number incomplete	Number in target group	Compliance
Infection Control 122014 (Quarter 4)	Balance Sheet (Direct)	3	1	4	**75%**
	Capital (Directorate)	36	3	39	**92%**
	Clinical Support & Family Services (Direct)	885	162	1047	**85%**
	Corporate Directorate (Direct)	353	69	422	**84%**
	Facilities Directorate (Direct)	273	27	300	**91%**
	Finance - Charitable Funds (Direct)	5		5	**100%**
	Medical Directorate (Direct)	5	2	7	**71%**
	Medicine Directorate (Direct)	502	184	686	**73%**
	Musculo-Skeletal (Direct)	364	80	444	**82%**
	Nursing & Admin Staff Bank (Direct)	0	2	2	**0%**
	Nursing Directorate (Direct)	0	1	1	**0%**
	Odstock Medical (Direct)	14	1	15	**93%**
	Quality Directorate (Direct)	360	118	478	**75%**
	Surgery (Direct)	564	115	679	**83%**
	Therapy Staff Bank (Direct)	19	32	51	**37%**
		2	1	3	**67%**
Infection Control 122014		**3385**	**798**	**4183**	**81%**

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
Held on 27 March 2017

Present:	Dr N Marsden	Chairman
	Ms T Baker	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Mrs C Charles-Barks	Chief Executive
	Mr A Hyett	Chief Operating Officer
	Mr P Kemp	Non-Executive Director
	Prof J Reid	Non-Executive Director
In Attendance:	Mr M Collis	Deputy Director of Finance (for item 4)
	Mr D Seabrooke	Head of Corporate Governance
	Mrs F Hill	Head of Risk (for item 3)
	Mr R King	EPR Project Manager (for item 4)
Apologies:	Mrs K Matthews	Non-Executive Director
	Mr I Downie	Associate Non-Executive Director

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 27 FEBRUARY 2017

The minutes of the meeting of the Committee held on 27 February 2017, were agreed as a correct record.

2. MATTERS ARISING

It was noted that discussions with NHSI were continuing.

3. FINANCE AND CONTRACTING REPORT TO 28 FEBRUARY MONTH 11)

The Committee received the Finance Report. It was noted that a surplus of £120,000 represented the year to date income and expenditure position – this figure included donated income and assumed Sustainability and Transformation Funding. On this basis it was a favourable variance against the plan of £233,000 and an in month deficit of £24,000.

Achieving the 2016/17 control total continued to be discussed with NHS Improvement. It was noted that the Trust was expecting to receive £370,000 in respect of additional activity at the end of the financial year and an additional payment from Wiltshire CCG of £600,000.

Within the Trust, Medicine, Surgery and Clinical Support and Family Services Directorates were overspent although much of this information was based on estimates due to continuing problems with the data warehouse.

Concerns about under booked clinics continued to be investigated. It was noticeable that appointments were being cancelled by patients.

Contracts for 2017/18 were in place and work was continuing to finalise CQUINs.

It was noted that NHS Innovation South West would be closing and would become a non-dormant non-trading company in order to handle royalty receipts.

MC undertook to circulate to Directors information and reports about the Sterile Services Joint Venture. MC

4. FINANCIAL ESTIMATES AND CAPITAL PROGRAMME 2017/18

The Committee received the base estimates for 2017 and draft capital programme.

Base Estimates

The base estimates had been drawn up at a time of significant concern for the Trust's financial outlook. There was a forecast deficit for 2017/18 of £7m. The Board had not accepted the offer of Sustainability and Transformation Funding as the required cost savings target was not considered to be achievable.

Income assumptions were forecast outturn plus national tariff up lift and specialist services identification royalty changes with a number of further adjustments set out in the report.

For expenditure pay assumptions included national inflation of 2.1% the apprenticeship levy of £0.5m and local investment/cost pressures of £1.625m. Non-pay assumptions included the transfer out of nursery services and diabetic retinal screening. Inflation assumptions for drugs and the CNST premium. A savings target of £6.5m had been set for directorates which was considered to be the maximum likely that could be delivered.

Other factors included were changes to activity, changes to capacity and delayed transfer of care, the impact of Brexit and the impact of the Electronic Patient Record. Cash was a major concern and this represented a constraint on capital resources. A source and application of funds statement for the year was included.

In discussing the proposal it was noted that the Trust was 93% identified on Cost Improvement Programme. There was concern that the Trust's cash flow position was not sustainable. There was also an acknowledgement that there was more to do on planning staffing requirements in more depth.

Capital Programme 2017/18

The Committee received the Capital Programme 2017/18. It was noted that the draft programme had been reviewed by the Joint Board of Directors and an earlier draft by the Committee. As with previous years resources were highly constrained and a number of proposed schemes were being deferred or being considered for lease finance. High priority was given to schemes affecting health and safety. Capital resources available were based on £8m of cash generated through the depreciation in the tariff less repayment loans of £632,000. It was noted that no assumption had been made in relation to charitable support but some medical equipment items could be subject to this during the year. Some schemes currently excluded would need to be prioritised if key medical equipment was affected.

The second year of the Electronic Patient Record project was included in line with the business case and extra investment could be required if savings are to be realised. IT infrastructure schemes may transition to a managed service or lease arrangements. It was noted that there was no automatic slippage for 2016/17 schemes.

The Capital Programme would be considered by the Trust Board on 3 April 2017, together with the financial estimates.

5. OPERATIONAL PERFORMANCE – MONTH 11

AH informed the Committee that ED was at 96.5%. The expected result for month 12 was 92% and 93% for the year as a whole. The Trust had requested a resubmission for the November, December and January RTT performance as verification had taken us to over the target. It was planned to resubmit the figure of 90% for February.

Delayed Transfers of Care were at 45 and there were 77 patients assessed as 'Green to Go'. The Trust's target was to operate on a bed stock of 372 which meant 92% occupancy of the 404 commissioned beds. There 376 in patients on the day of the meeting.

Work continued to deliver the Cancer 62 Day Target in quarter 4 and similarly with the two week target. Work continued to clear the Endoscopy backlog by the end of March. MRI breaches were likely to account for all of the performance threshold allowed.

6. TRANSFORMATION AND COST IMPROVEMENT – MONTH 10

The Committee received the month 10 report. It was noted that the Trust was 93% identified for 2017/18 with quality impact assessments signed off for the programme.

7. ANY OTHER BUSINESS

8. DATE OF NEXT MEETING

The next meeting will be on Monday 24 April 2017 at 9.30 am.

SALISBURY NHS FOUNDATION TRUST

Minutes of the Finance & Performance Committee
Held on 24 April 2017

Present:	Dr N Marsden	Chairman
	Ms T Baker	Non-Executive Director
	Mr M Cassells	Director of Finance and Procurement
	Mrs C Charles-Barks	Chief Executive
	Mr A Hyett	Chief Operating Officer
	Mr P Kemp	Non-Executive Director
	Mrs K Matthews	Non-Executive Director
	Prof J Reid	Non-Executive Director
In Attendance:	Mr I Downie	Associate Non-Executive Director
	Mr D Seabrooke	Head of Corporate Governance
	Miss L Wilkinson	Director of Nursing (for item 3)
	Mrs F Hill	Head of Risk (for item 5)

1. FINANCE AND PERFORMANCE COMMITTEE MINUTES – 27 MARCH 2017

The minutes of the meeting of the Committee held on 27 March 2017, were agreed as a correct record.

2. CQUIN

The Committee received the year end CQUIN report. It was noted that £3.3m (96%) of CQUIN had been achieved. The Saving Babies Lives scheme had been very effective and brought out a significant reduction in still births. The Trust had achieved 76% on the flu vaccine. Antibiotic use had reduced by 10%.

The Spinal Outreach Service for the South West had seen 90% of new patients within 95 days of referral. For 2017/18 and 2018/19 the approach was led nationally with very little room for local negotiation.

The report described seven clinical schemes worth just over £2m and a risk reserve and STP engagement CQUIN together worth £1.2m. At this stage around 315 was considered to be at risk.

It was noted with concern that there were indications that opportunities to bid for in-year funding were being denied to the Trust because it had not accepted its control total for 2017/18.

3. FINANCE AND CONTRACTING REPORT TO 31 MARCH (MONTH 12)

The Committee received the Finance Report to 31 March 2017. It was noted that NHS Improvement were shortly to complete the final allocation of STF funding which would enable the draft accounts for 2016/17 to be finalised.

The anticipated position was a surplus of £3.3m which reflected the stock adjustment as previously discussed and the capitalisation of revenue spend on Scan4Safety. In addition any surplus above the £1.8m control total (i.e. the income and expenditure surplus) was expected to attract a bonus payment.

There was concern that outpatient attendances, particularly follow-ups reported as 10% down against plan and past year. Un-coded activity was at around 50% and in this instance average price was used and experienced showed that this was an effective temporary measure. £6.1m of Cost Improvement Programme had been delivered. 34% of this was non-recurring and would be added to the Trust's underlying deficit.

The Trust continued to discuss with West Hampshire CCG its Emergency Department performance in relation to the contract specification. It was emphasised that any action plan arising from a performance notice would need to be jointly sponsored by the CCG.

4. ASSURANCE FRAMEWORK AND RISK REGISTER

Revisions to the Assurance Framework previously agreed by the Committee were now included. There were new risks added to the Risk Register in relation to cost pressures, the control total, activity reporting and the non-delivery of CQUIN.

5. OPERATIONAL PERFORMANCE – MONTH 12

The Committee received the March 2017 report.

It was noted that Trust planned to clear the remaining diagnostics backlogs. MRI scanning capacity remained a concern for the year as capacity constraints remained.

As previously discussed the Trust had re-submitted its RTT performance for November, December and January. It would not be re-submitting the February report.

For ED Performance was 92% in March and a performance trajectory for 2017/18 had been submitted.

6. PMO REPORT – MONTH 12

The Committee received the PMO report. It was noted that the Trust was 72% identified against the £9.5m savings target for 2017/18. It was 99% identified against the £6.5m target. Monitoring and governance arrangements for CIP schemes continued to be improved. Quality Impacts Assessments had been completed – two proposals had been rejected. Surgery and IT needed to identify their savings. The corporate area had the least savings identified at this stage.

7 ACCOUNTABILITY FRAMEWORK AND FRAMEWORK FOR INTEGRATED GOVERNANCE

The Committee these two new documents for information.

8. ANY OTHER BUSINESS

The Chairman reported that he was attending a Chair's meeting with Lord Carter.

It was agreed that there should be a further seminar discussion on the long term engagement with the Sustainability and Transformation Programme. DS/CC-B

9. DATE OF NEXT MEETING

The next meeting will be on Tuesday 30 May 2017 at 9.30 am.

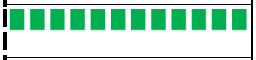
Title: Operational Performance Report Month 1

Report from: Andy Hyett, Chief Operating Officer

Executive Summary:
For Month 1 the trust successfully delivered the ED 4 hour standard, RTT 52 week, 12 hour trolley wait and Urgent operation cancelation standard. Cancer performance has been varied due to small numbers however the trust delivered 62 day target for quarter 4 and the April position is still being validated. Whilst the diagnostic standard was not delivered – performance was in line with the recovery plan.

Proposed Action: The board is invited to note the report

Salisbury Hospital NHS Foundation Trust Board Report April 2017

			Reporting Month		Rolling 12 months
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Apr-17**	**Patients Affected in Apr-17**	**Trend Against National Standard**
Referral to Treatment Incomplete Performance	92%	STF = 92.0%	**88.8%**	2,604	
Referral to Treatment Incomplete Specialty Compliance	16 out of 16		9 out of 16		
Zero tolerance RTT waits > 52 weeks	0	0	0	0	
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Apr-17**	**Patients Affected in Apr-17**	**Trend Against National Standard**
A&E - Time in A&E department	95%	STF = 91.2%	95.0%	205	
12 Hour Trolley Waits	0		0		
Diagnostics - Patients waiting less than 6 weeks	99%	97.0%	97.0%	3928	
Diagnostic Test Compliance***	10 out of 10		**9 out of 10**		
Urgent Ops Cancelled for 2nd time (Number)	0		0		
Mixed Sex Accommodation Breaches	0		0		
Infection control – Clostridium difficile (YTD)	19		YTD: 1	1	
Infection control - MRSA*	0		0		
Metric Name	**National Ceiling /Standard**	**Local Trajectory**	**Apr-17**	**Patients Affected in Apr-17**	**Trend Against National Standard**
All Cancer two week waits	93%		94.9%	34	
Symptomatic Breast Cancer - two week waits	93%		91.5%	10	
31 day wait standard	96%		98.8%	1	
31 day subsequent treatment : Surgery	94%		100.0%	0	
31 day subsequent treatment : Drug	98%		100.0%	0	
62 day wait standard	85%		80.0%	10	
62 day screening patients	90%		42.9%	2	

Cells with black dotted outlines indicate provisional data

*Please note: MRSA is no longer monitored by Monitor

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

***Only Diagnostic examinations carried out in the reporting month shown are counted

Supporting Information

Emergency Pathway

4 hour performance for M1 was delivered at 95.02% which was an excellent achievement. Bed pressure issues in April were less significant and there was a huge push by the department to regain 4 hour performance after a difficult Winter.

The ED Navigator pilot is now entering the second month of operation and working well. There has been a significant impact in reducing clinical risk in the ED waiting room. Initial data shows that in the first 10 days of operation 2.4% of patients were redirected either home, direct to GP or to OOH / Walk in centre.

There has been a significant focus on improving Time to Triage and Time to Treatment performance through rigorous monitoring of flow, patient by patient, through the department. Also work is ongoing to improve the consistency of escalation for specialty-related patient delays in line with the internal professional standards.

There were no ambulance handover breaches over 60 mins in April and 12 breaches less than 60 mins, 5 of which occurred on one particularly challenging day. 98.8% of total ambulance handover times were within target.

There were no 12 hour trolley waits in April.

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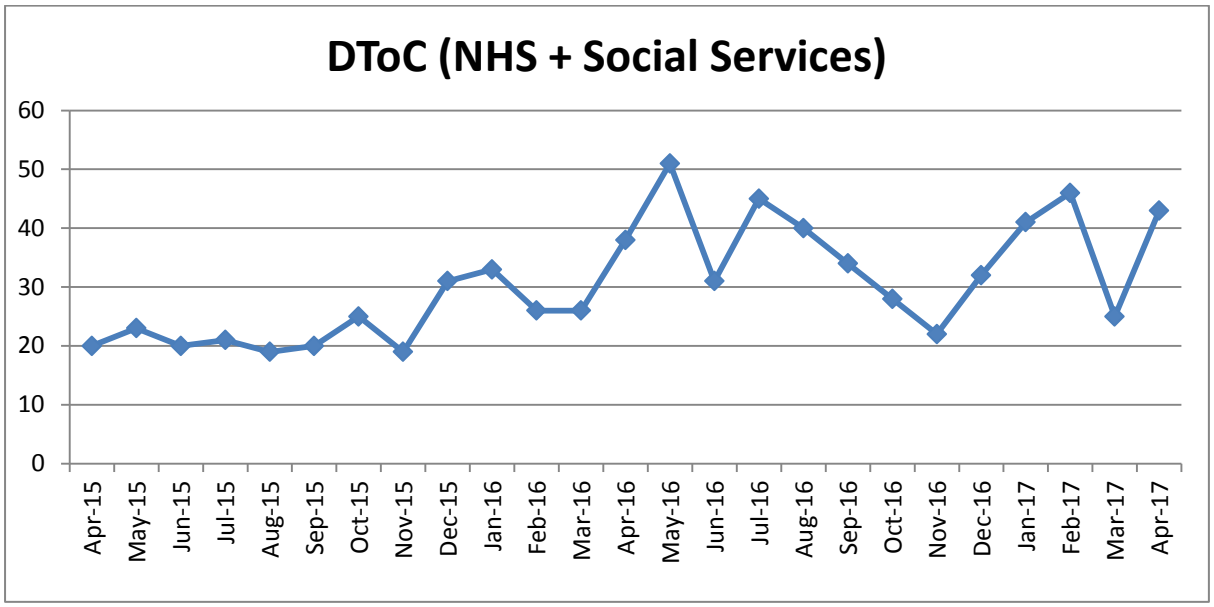
Type 1 & Type 2	Jan -17	Feb -17	Mar-17	Apr-17
Total Attendances	3832	3548	4132	4115
Total Breaches	581	543	303	205
% within 4 hours	84.84%	84.70%	92.67%	95.02%

Number of Patients with a Delayed Transfer of Care (DToCs)

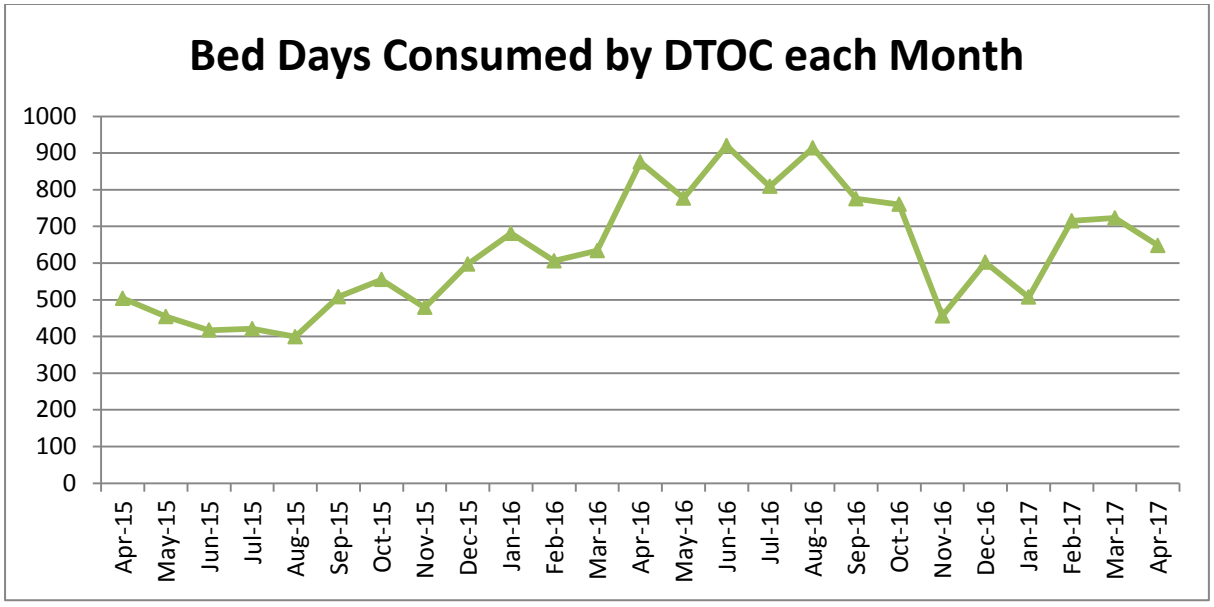
DToCs showed a dip in March but have been up again in April. The monthly snapshot position was 43, which is close to the February peak. Thus, there has been no sustained improvement in reduction of DToCs, which is an ongoing point of challenge with social services. 'Green to Go' numbers, whilst not indicated in this report, have also remained high (above 100 at one point in the month) .

Primary reasons for patient discharge delays include an ongoing shortage of community bed and domiciliary care capacity across Wiltshire, Hampshire and Dorset.



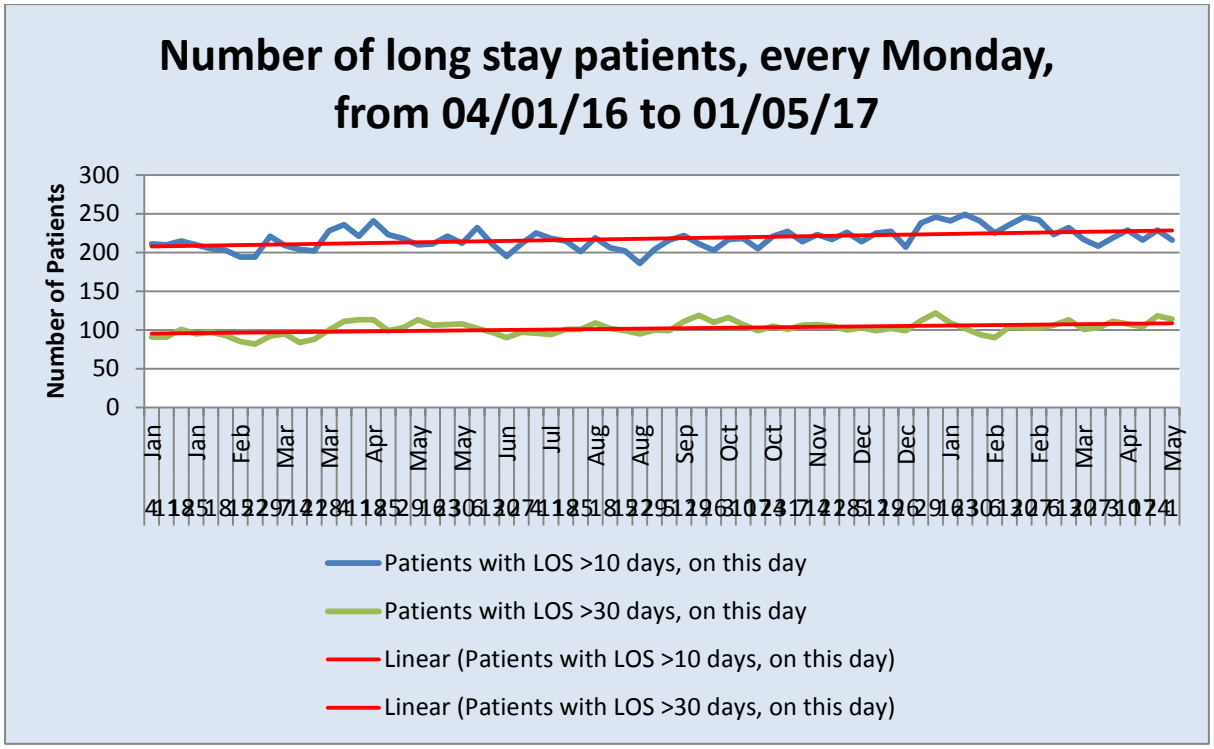
Number of lost bed days

There was a slight dip in April in number of bed-days lost due to delayed transfers of care, although numbers remained above 600.



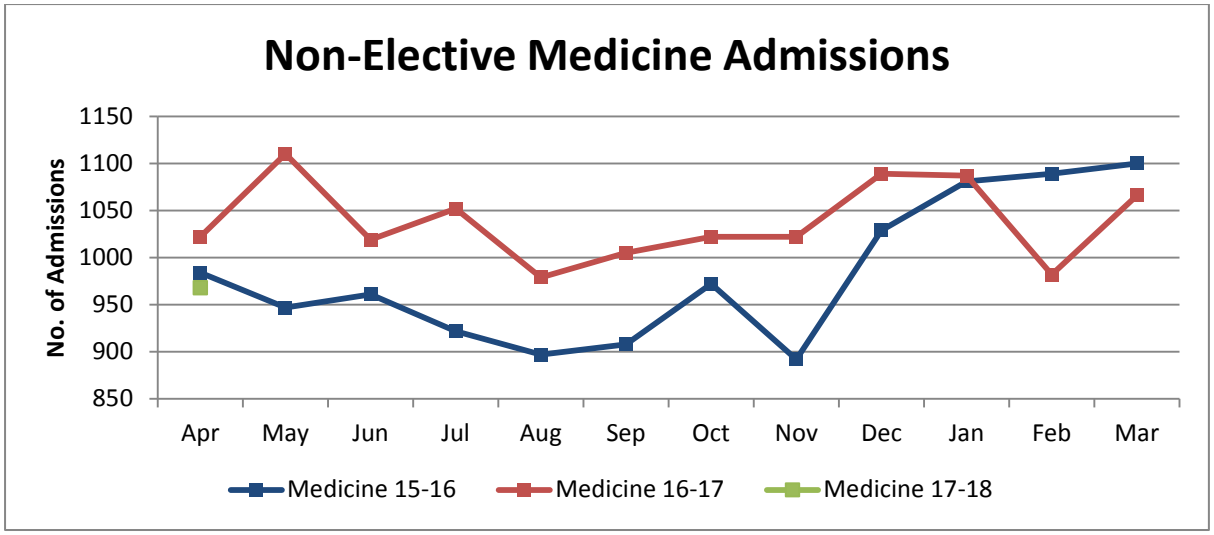
There has been no significant reduction in the number of long-staying patients in the Trust, with the overall trend being upwards.

Patients with LOS >10 days remained above 200 per day in April. Patients with LOS> 30 days remained above 100/day in April (>20% of established bed base), with no improvement on the previous month.



Medicine non-elective admissions

Medicine non-elective admissions for M1 were down on 2016-17 levels and more consistent with admission numbers seen in 2015-16. Early data for May has shown that this dip is not likely to be sustained.



Further analysis of the relationship between delayed transfers of care and ED performance is available in Appendix 2. This data shows a correlation between peaks in delayed transfers and poor ED performance. The variance in the number of delayed transfers (DTOCs, Green to Go and Stranded categories) is clearly significant.

RTT

Challenges around reporting the Trust's RTT position remain. The trust has reported 88.8% for April however validation is continuing and it is likely we will make a resubmission in the future.

The RTT standard is not being delivered in General Surgery, Gastroenterology, Oral Surgery, Trauma and Orthopaedics and Plastic surgery. In all specialties except Gastroenterology plans are in place to increase capacity to meet demand although in some areas this is dependent upon new staff starting. The gastroenterology team are working with GPs and commissioners to improve patient pathways for Wiltshire patients however this work has not yet started in West Hampshire. Unfortunately there is a national shortfall in clinicians in this area and we are currently dependent upon locum consultants.

Diagnostic

Performance in April was 97.% which whilst below the standard of 99% is exactly in line with the recovery trajectory.

1. Endoscopy

Endoscopy wait times continued to improve during April and are now at 4 weeks. The weekly weekend sessions provided by a sub contracted provider, together with the ongoing use of a gastro locum have ensured this position. There were 18 breaches in April and less than 10 breaches are expected at the end of May and

these will be for patients with special requirements who can't have procedures at weekends.

2. Radiology

The only Modality where we have seen breaches is MRI. There were 85 at end of April out of a total of 123 breaches. This caused the Trust to not achieve the Diagnostic target as the % achievement overall in April was 96.96%.

Going forward we are finalising an arrangement with a private provider for access to their new fixed scanner starting in June. Once the arrangement is in place we would expect the backlog to be cleared within 2 months and be fully compliant with the Diagnostic target by the end of that period.

3. Other issues

There were 20 other breaches in April these being in Audiology and Cardiology. The Cardiology breaches were caused by an administrative error but there could be some Audiology breaches for the next few months whilst they deal with some staffing difficulties. The numbers are likely to be small however.

Cancer

The most significant impacts on Cancer pathways have been an increase in referrals and delays in diagnostic investigations.

April Cancer Report

Report to show the monthly and quarterly Cancer Target Performance figures for the current quarter

Description	Standard	April			May			June			Q1 2017-18		
	%	In target	Total	%	In target	Total	%	In target	Total	%	In target	Total	%
All cancer Two Week wait	93	629.0	664.0	94.73	455.0	481.0	94.59	1.0	4.0	25.00	1085.0	1149.0	94.43
Symptomatic Breast Two Week wait	93	108.0	118.0	91.53	59.0	63.0	93.65	0.0	0.0	-	167.0	181.0	92.27
31 Day Standard	96	80.0	81.0	98.77	52.0	55.0	94.55	1.0	1.0	100.00	133.0	137.0	97.08
31 Day Subsequent: Drug	98	13.0	13.0	100.00	9.0	9.0	100.00	0.0	0.0	-	22.0	22.0	100.00
31 Day Subsequent: Surgery	94	15.0	15.0	100.00	10.0	10.0	100.00	0.0	0.0	-	25.0	25.0	100.00
62 Day Standard	85	35.5	44.5	79.78	34.0	39.5	86.08	1.0	1.5	66.67	70.5	85.5	82.46
62 Day Screening Patients	90	1.0	3.0	33.33	1.0	2.0	50.00	0.0	0.0	-	2.0	5.0	40.00

Currently green on four out of seven targets for April, however, a challenging month due to Easter and associated bank holidays and school holidays which have had an impact.

62 day standard currently being hampered by colorectal and urology issues:

- Colorectal experiencing admin delays over endoscopy booking
- Urology prostatectomy delays with tertiary provider

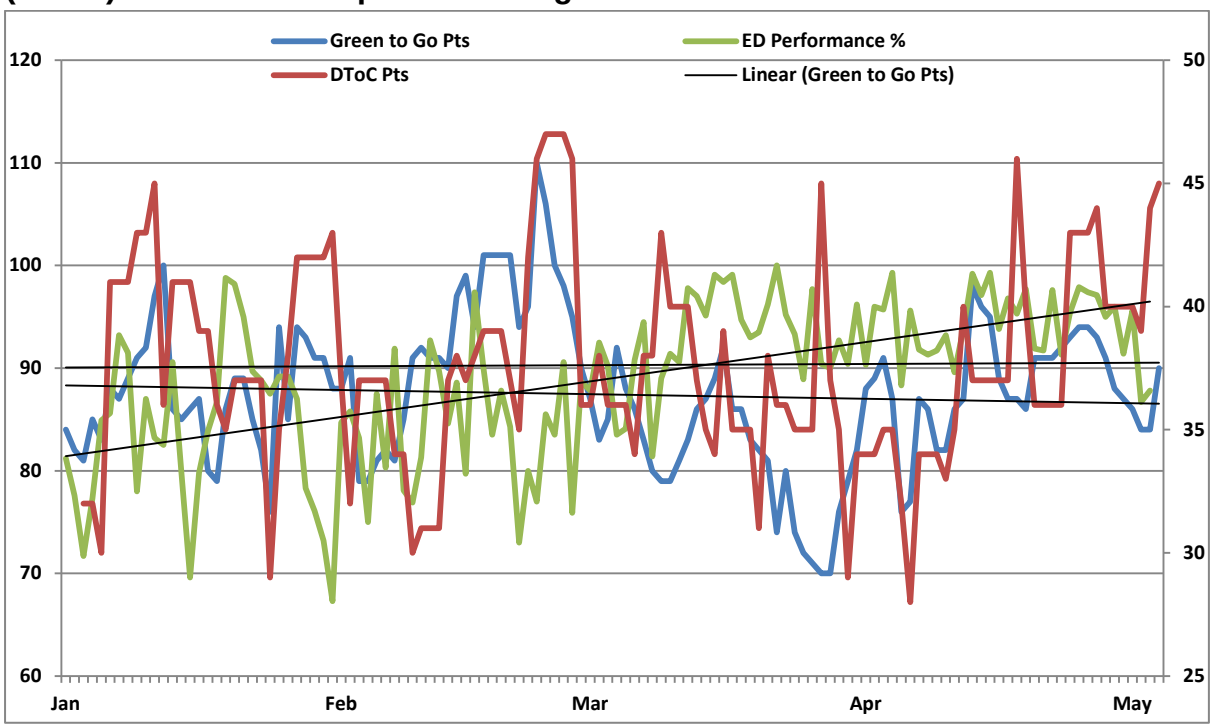
62 day screening:

- 2x breaches due to 1) complex pathway and 2) breached by **1 day** due to colorectal team

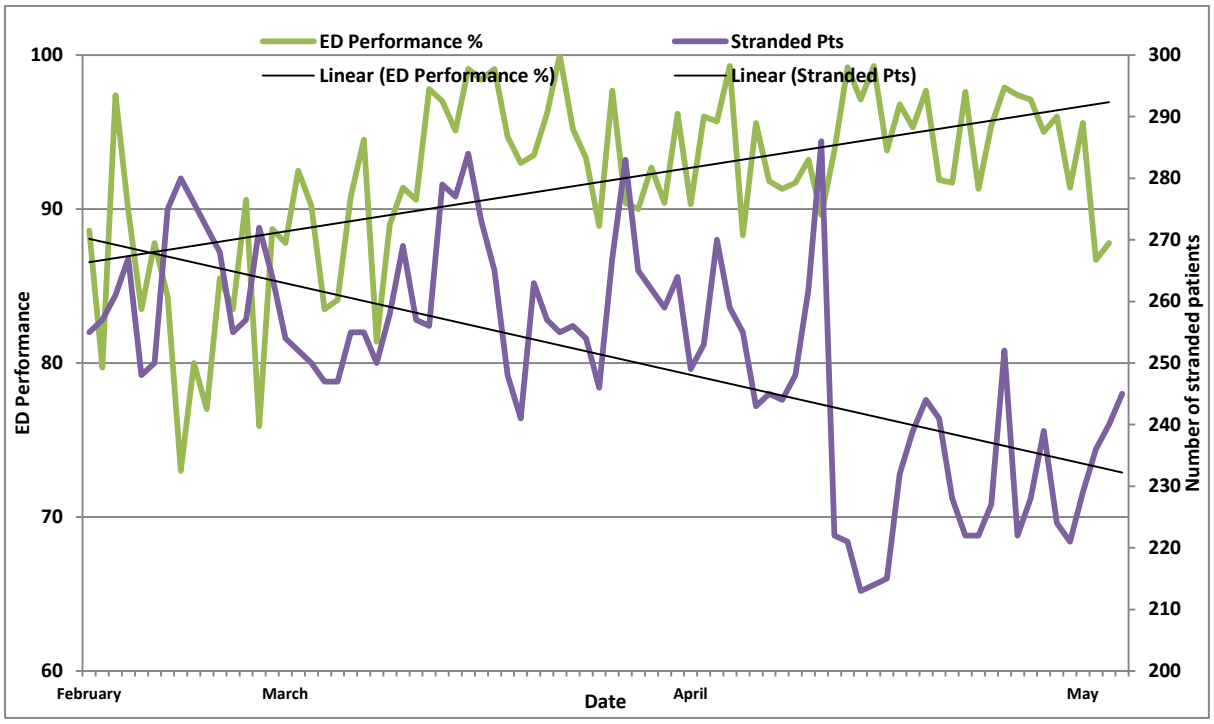
Figures will be validated by 6th June

Appendix 2. Analysis of ED Performance and Delayed Discharges

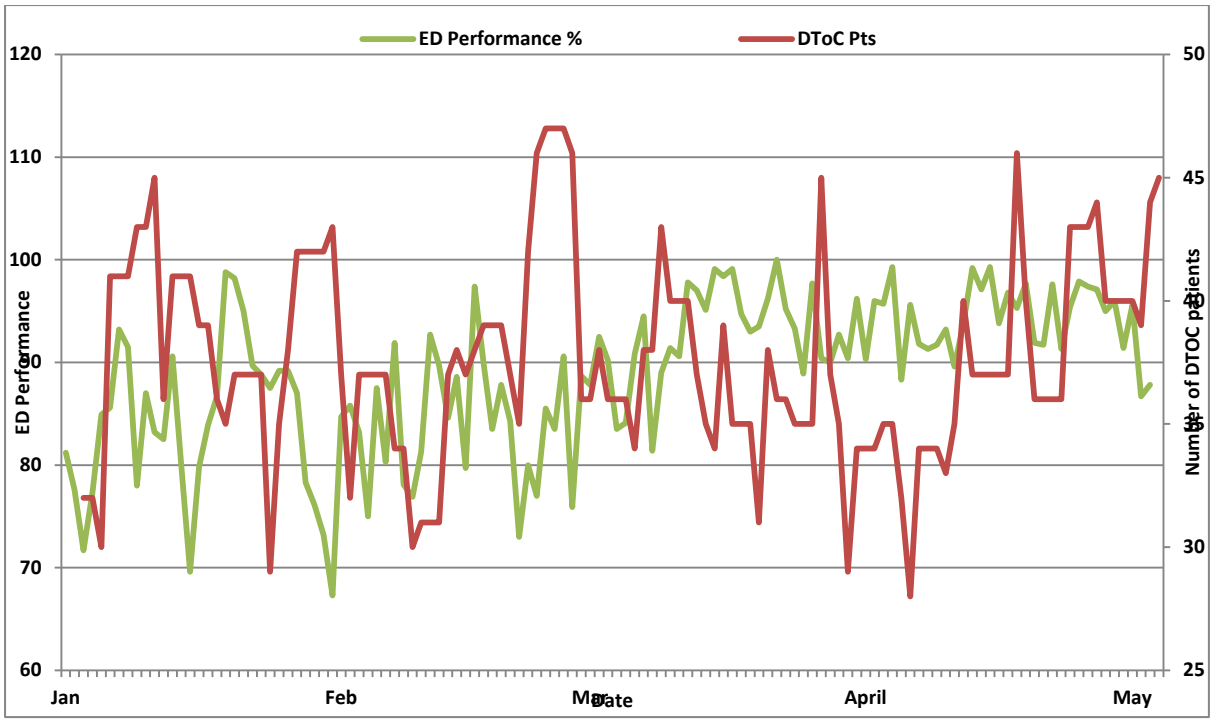
Graph 1. ED Performance, Number of Patients with a Delayed Transfer of Care (DTOC) and number of patients categorised as Green to Go



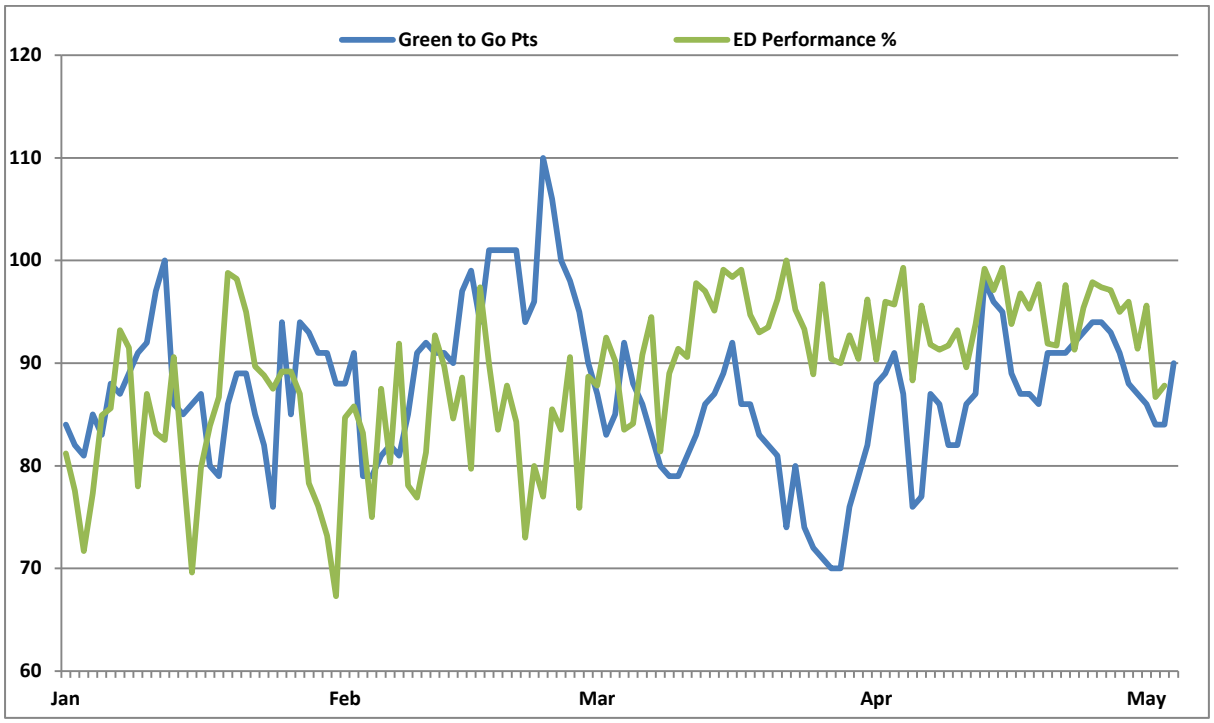
Graph 2. ED Performance versus the Number of Patients categorised as stranded patients



Graph 3. ED Performance versus the Number of Patients with a Delayed Transfer of Care (DTOC)



Graph 4. ED Performance versus the number of patients categorised as Green to Go



Major Projects Report

Date: 5 June 2017

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

Executive Summary:

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

- **IT/technology (EPR and GS1) and the adaptive impact on the organisation with Lorenzo having gone live on 30th October**
- **a joint venture to improve the responsiveness and efficiency of sterilisation services which began on 1st September, and**
- **the delivery of more integrated adult community services in Wiltshire**
- **ward reconfiguration to improve the management of emergency and planned patients**

Proposed Action:
To note the report.

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

Appendices:

Supporting Information

Introduction

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

- Electronic Patient Record
- Ward reconfiguration programme
- The GS1 Scan for Safety initiative
- Wiltshire Health and Care management of community services through a joint venture involving RUH Bath, GWH Swindon and SFT
- Joint venture to provide a sterilisation and disinfectant unit (SDU)
- Organisational development impact – a draft strategy and action plan has been discussed at Executive Workforce Committee in June and the Board in July. The action plan is being developed further with executives and senior managers. Monitoring of this action plan will be through the Executive Workforce Committee

Summary

Salisbury NHS Foundation Trust

Project	Lead	Status	Workstreams	Summary
EPR	LA	Stable at Amber	2 x green 6x amber 1 x red	Progress on system stabilisation. Data warehouse issues remain a risk.
Ward changes	AH	Green	4 x green 1x amber	Building schemes on target. Major impact for the organisation over the summer with reductions in bed numbers.
Wiltshire Health & Care	LA	Reducing at Amber	2 x green 2 x amber 1 x red	Established southern locality group to promote integrated working locally. Major focus on working with primary care on managing the frail elderly. Recruitment issues hampering progress on some key projects. CEO to be SFT representative on the Board. Will update next report with revised priorities.
Scan for Safety	MC (LW)	Stable at Green	3 x green 1 x amber	Phase 3 on target – Live in Orthopaedics for point of use scanning Further work with Theatres to increase roll out to other specialities
SDU	MC	Improving at Green	3 x green	New service well established – good feedback from clinical departments. Site demolition complete with planning permission received. Out to tender for building work by end of May

Organisational Development

- Strategy developed
- Action Plan created and monitored through Executive Workforce Committee
- Current OD projects ongoing
  - EPR implementation
  - Emergency Department future workforce review
  - Theatres workforce review
  - Spinal Unit Medical Workforce Review
  - Save 7 champions and Quality Improvement skills
  - Impact of Apprenticeship levy on workforce models
  - Lead for STP digital project
  - Lead on STP Workforce stream for Values and Culture
  - Exploration of opportunities working across Wiltshire Health and Care
  - participation in the SW Streamlining Process and STP Acute Care Collaboration'

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

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

Workstream	Status	Trend	Actions
Stabilisation Plan	Amber	Improving	• Rollout of revised outcome forms and training implemented almost complete • Themed, more in depth support and training post go live, continues based on process reviews and feedback • Reducing trend of issues being raised
Data migration	Amber	Improving	Issues with migrated data in the system now reducing through a combination of validation and system fixes
Data warehouse	Amber	Stable	Improved progress with data warehouse, Project plan in place, but slightly behind schedule. Current focus on parallel running and validation. Increased operational reporting now in place

Electronic Patient Record (EPR)

Salisbury NHS Foundation Trust

Workstream	Status	Trend	Actions
Configuration	Amber	Stable	Knowledge transfer and training to new starters underway, focus on the resolution of issues identified though process reviews and surveys
Benefits	Amber	Declining	Further analysis / review will be undertaken as part of the stabilisation activity.
Role based access	Green	Stable	Activity embedding into BAU.
Integration	Green	Stable	Testing underway for integration to Somerset Cancer record, and development for R&R and bi-directional messages for whiteboards
Phase 2 planning	Red	Stable	Phase 2 re-planning being reviewed in light of stabilisation requirements
RTT Reporting	Amber	Improving	• PTL & RTT validation exercise underway, improving trend. • Training, process & outcome forms changes also being implemented.

Ward Reconfiguration Programme

Salisbury NHS Foundation Trust

To reconfigure the wards over the summer/autumn to manage more effectively patient flow through the hospital

Work stream	Status	Trend	Actions
Create an expanded acute medical unit	Green	Stable	Out to tender by end of May Transfer Farley ward to level 2 PFI Begin building work in early August for November completion
Consolidate MSK beds into burns / orthopaedic template	Amber	Stable	Staff consultation underway, needs to be complete to allow for changes to happen which facilitate Farley moves
Open new ophthalmology facility	Green	Stable	Unit layout complete and signed off. Awaiting approval of planning (due end May) Units to arrive on site in July
Convert current eyes department to medical ward area	Green	Stable	Planning of new facility underway
Short stay surgical ward in current Braemore ward	Green	Stable	Planning underway of types of patients who will be eligible for management through short stay ward. Due to open in late November/early December

Wiltshire HEALTH AND CARE

Salisbury NHS NHS Foundation Trust

A joint venture has been established to enable SFT, together with RUH Bath and GWH Swindon Trusts, to manage adult community services to aid the integration of services across acute and community settings.

Workstream	Status	Trend	Actions
Early Supported Discharge – Stroke	Red	Reducing	Issues with recruitment. SFT formally to put a proposal together for the service to be run out of Farley.
Higher Intensity Support	Amber	Stable	• standardisation of admission avoidance processes • review of benefits to inform further development
Home First	Amber	Reducing	Additional rehabilitation support workers facilitating discharge. 70% recruited overall, but lower rate in South and evidence of staff being recruited from local care provider
Mobile working	Green	Complete	• provision of mobile hardware to c. 400 staff, to support their work • real time access and updates to clinical records
Health coaching	Green	Complete	Roll out of health coaching training to front line community staff, to ensure that every opportunity is taken to support patients, carers and their families with preventing ill health.

Scan for Safety

Salisbury NHS Foundation Trust

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

Work stream	Status	Trend	Actions
Global location numbering	Green	Stable	Physical locations at 50% completed Focus on utilisation and usage across trust – Group working on detailed use cases
Catalogue management	Green	Stable	Focus on Orthopaedic process ensuring increased level of control with regards to new products and loan and consignment sets
Patient identification	Amber	Improving	Changes to wrist band printers agreed – To be rolled out across all ward Bloodhound – Provider currently amending wrist band to allow full trust roll out Wrist Band – Still await CSC resolution – Potential alternative method scoped by trust team to be reviewed
Purchase to pay/Inventory	Green	Stable	Live in Orthopaedics – Continued support and monitoring Next areas within theatres being planned

SDU Joint Venture

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

Workstream	Status	Trend	Actions
Commercial	Green	Stable	JV agreement , leases and service contract signed mid August '16
Operational	Green	Stable	Performance continues to exceed expectation KPI's - Fast Track volumes should not exceed 9%: March = <2% KPI's – Failed trays (SSF1) target <0.25%, March = 0.19%. Turnaround time not achieved (SSF2) target < 5%, March = 2.54%. No procedures cancelled
Facility design	Green	Stable	Demolition work now complete. Planning permission received. Detailed design work progressing well and due to go out to tender imminently.

Capital Development Report

Date: May 2017

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

Executive Summary:

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

The last few months have seen the official opening of the new Breast Unit and progress with plans for reconfiguring the ward environment further.

The EPR project continues to be a major focus in early 2017 (see major projects report). Further upgrades to two home-grown digital systems managing patient observations and discharge summaries is extending the range of clinical data recorded and transmitted electronically. In the coming year, a number of major infrastructure projects will challenge the organisation.

Proposed Action:
To note the report.

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

Appendices:

Supporting Information

PAPER: SFT 3897

CAPITAL DEVELOPMENT REPORT

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 (February 2017).

BUILDING SCHEMES:

Breast Care Unit
The new Breast Care Unit and Gynaecology OPD are now both fully operational. The official opening event for the new Breast Unit was a success and there was positive feedback received on the new facility.

Further Improvements to Phase 1 Wards – (Site Reconfiguration Project)

1. **Acute Medical Unit (AMU) Project**
   The AMU relocation project is now in full design and tenders are due to be submitted in May with building work expected to start in the former Farley template in August 17. Work will take approximately 4 months.
   In order to facilitate the above, the following ward moves are to take place in July:

   - Laverstock Ward to merge with Amesbury/Chilmark/Burns
   - Winterslow Ward to move to former Laverstock
   - Farley Ward to move to former Winterslow

2. **Ophthalmology OPD**
   The Ophthalmology OPD relocation project is now in full design. Planning approval is expected at the end of May with the new facility expected to be in place by end August 2017.

3. **Space on Level 3**
   The space vacated by Ophthalmology is planned for use by the Pembroke Ward/Suite. This is currently in the early design stage.

IT SCHEMES:

Single Sign On (SSO)
In use and well received – recent updates include:

- SynergyTrak bridge for Theatres/DSU
- EWhiteboards for the wards

Next steps:

- An SSO for Pathology labs is currently being tested

- ED are considering the implementation of an SSO build

Electronic Whiteboards
An upgrade to the system was implemented on the 25th April to enable additional functionality to support the single point, electronic referral for health and social care post discharge. A trial of the form will be led by the Integrated Discharge Team. The System Supplier was on site in support of the Perfect Week in March. A number of changes were agreed and new areas of work explored. The next phase of work will be the bi-directional messaging of information between Lorenzo and E-Whiteboards. A PID has been developed for this and work is due to start imminently.

Patient Observation and Escalation Tool (POET)
Implementation continues. The system is currently live in Laverstock, Britford, Britford SAU, Downton, Burns, Farley, Winterslow, Avon, Tamar, Chilmark and Amesbury. Training is taking place on Breamore and Pembroke. The link from POET to Review has been rolled out. Future developments include enhanced reporting and the creation of an electronic fluid balance chart.

Electronic Discharge Summaries
Implementation within DSU commended mid-March 2017. Compliance has generally been very good with DSU staff embracing the change. Support and training for consultant surgeons will continue as long as necessary.
EDS has been amended slightly to allow for the pharmacy element to be non-mandatory for patients on specific wards i.e. SSEU and SAL. These are areas that currently have no ward pharmacist and are being seen as an aid to patient flow whilst enabling the wards to utilise the EDS.

Blood Tracking – Phase 2
The pilot completed successfully. The rollout of the Bedside application has been put on hold to accommodate some changes requested by Scan for Safety.

NHSmail 2
Work will be carried out by Informatics on behalf of the Trust. All existing Microsoft Outlook accounts have to be replaced by NHSmail accounts. This will involve individuals deleting all non-essential data so that data transferred is kept to a minimum. Target is September 2017.

HSCN
The contract for N3 (the national NHS network) ended on 1 April 2017. The service is currently being run by NHS Digital who are moving us off of N3 onto HSCN. First year's funding (for the service) will come from NHS Digital, with subsequent year's funding being 75%, 50% for years 2 and 3 (beyond is currently unknown). We are working with our STP partners to ensure that we secure the best possible deal with the Salisbury Procurement Department taking the lead. Target is mid-2018.

Infrastructure Refresh
The existing infrastructure environment has been installed and running within the Trust for seven years. The hardware and software support on many of the components within this infrastructure are now reaching the end of their term. External consultancy has been engaged to advise the Trust on the alternative most cost-effective way forward. Report is due out by mid-May, tender documentation to be produced by mid/late summer 2017 with a target of June 2018 to implement the new solution.

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 2016/2017 (Appendix A to C inclusive)

Laurence Arnold
Director of Corporate Development

APPENDIX A

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

Building and Works schemes	Completion date	Budget cost incl VAT
Efficiency schemes (7703C0) Funding available to support efficiency projects with rapid payback revenue savings. Funding ring-fenced for in-year bids.		£200K (2017-18)
Road repairs and Pedestrian crossings (7020C0) Repairs to the roads on site and upgrading the pedestrian crossings to current standards – project slipped to 2017/18 and scope of works to be reviewed, and consideration made in respect of new developments on site such as the new Sterilisation Unit.	TBC	£214k (2017-18)
Accommodation upgrade (7011C0) Work completed in Avon, Bourne & Wylye House Work on-going in Langley House (Block 94)	July 2017	£150K

Rolling work programmes (multi year projects)

Building and Works schemes	Completion date	Budget cost incl VAT
Air Handling Units (7041C0) This is the fourth 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. AHU's scheduled to be replaced this financial year - Theatre 1 & 6 and 3 of the internal 'core' areas of Theatres. Work in Theatres 1 & 6 delayed due to clinical activity – date for installation being reviewed for July/August.	March 2020	£250k (2017-18)

Building and Works schemes	Completion date	Budget cost incl VAT
Nurse Call System upgrade (7202C0) Project to replace ageing nurse call systems throughout wards in the main SDH north building and maternity wards. 2nd year of 2. Work undertaken during ward refurbishments (Laverstock) and replacement of Nurse Call system in the Spinal Unit which is obsolete. Nurse call system in the Spinal to be replaced May / June 2017.	2017/18	£68K (2017-18)
Lift Refurbishment Programme (7056C0) A programme to upgrade all the lifts in Phase 1 building. Year 3 of 3. Work on lift #2 to completed by the end of May 2017.	May 2017	£66k

APPENDIX B

Information Technology schemes	Completion date	Budget cost incl VAT
PACS/RIS (7943C0) Several upgrades have taken place with the next minor upgrade to allow clinicians to search for Cardiology and Vascular ultrasound reports. Cardiology image migration is underway and is 80% complete. A proof of concept has been tested to send Endoscopy images into PACS and this has been successful.	June 2017 (XDS)	
Order Comms and Results Reporting (7942C0) **GP Tquest** Work continues on the "copy to" function of results to GPs. The LMC is assisting in determining what information GPs need to see for both pathology and radiology results. GP review has had a very successful pilot in Amesbury as reported in the last report. **Review** On-going issues with the performance of the system continue. The supplier has advised that an upgrade is required which we are attempting to schedule in.	Autumn 2017	
SAN Storage (7907CO) Complete	March 2017	£210K
Ophthalmology EPR (7934C0) The project has completed and the solution is in use throughout ophthalmology.	March 2017	£141K
Telecoms Voice Over IP (7948CO) Project largely complete	On-going roll out	£0
SpIda The 5 recommendations from the internal review of SpIda that needed changes made by the development team have been successfully deployed. These include separating the setting of objectives from the appraisal and the ability to change the Manager and the SRM via the admin page to assist with signing off an appraisal. One recommendation for the SRM to view and sign off all appraisals that are completed by their reports is still in final testing.	Late 2017 (phase 3)	N/A
CALS (7905C0) New Windows Server CALs have been purchased for the entire PC	March 2017	£200,000

Information Technology schemes	Completion date	Budget cost incl VAT
estate, this enable the use of Windows 2012 Server or Windows 2016 Server to be utilised for key background or security functions.		
Cardiology PACS (7901CO) New echocardiogram studies are now available in PACS throughout the SWASH consortium. Reports are available via CRIS and following the implementation of XDS they will be available throughout the SWASH consortium on PACS. Historical studies are being migrated to PACS and will be available at the end of May.	May 2017	
Genomics Bioinformatics software This project is to replace the existing software with software which meets the current and future requirements.	December 2017	£50,000
Gynaecology System This new software which is specifically designed for colposcopy and integrates with CRIS/PACS thus reports and images are accessible from anywhere in Hospital, avoids duplication; with real time data entry, and real time image capture, generates GP letters saving a lot of admin time and costs in long run and less time consuming in terms of training.	October 2017	£78,000
Network Maintenance To replace network hardware on the edge of the Trust's LAN, which either already have or are about to go end of support.	December 2017	£50,000
Network Security The current security environment for the Trusts connection to N3 and the internet will go end of extended support April 2020 and this project is to replace that product.	November 2017	£139,000
Partial off-line back –up of data to protect against malware The Trust's SAN storage solution has recently had an increase in storage capacity to meet the growing data needs of the Trust. The backup solution now needs to be increased in to ensure that the Trusts data is secure and available for recovery in the event of a disaster recovery situation occurring.	December 2017	£50,000

APPENDIX C

Medical Devices schemes	Completion date	Budget cost
Capital schemes		
Bed Replacement programme (7131C0) The bed replacement programme is progressing. 452 of the replacement beds have now been ordered. A capital bid has been submitted for 2017/18 to continue this scheme. 20 additional beds have been ordered to address escalation needs, this funding has been taken from the 2017/18 capital allocation.	Year 5 of a 5 year programme	£150k (2014/15) £204k (2015/16) £120k (2016/17) £55k (2017/18)
Review of Theatre Instruments (7122C0) The Trust commissioned an external review of instrumentation. The newly formed SSL will influence the future needs of the Trust and The joint SSL and SFT stakeholder group is working well and monitors and audits the emergency requirements and plans for the future needs. As a result, the total budget allocation from 20167/17 was not used and has been slipped to form the budget allocation for this project for 2017/18	Rolling programme	£300k (2014/15) £500k (2015/16) £500k (2016/17) £128k (2017/18)
General x-ray machine – Westbury (7115C0) The x-ray machine in Westbury has been replaced and is now operational.	March 2017	£181k Including enabling works
Radiology Room 2 (7157C0) The x-ray machine in Room 2 Radiology has been replaced and is now operational.	February 2017	£246k Including enabling works
Ultrasound machines (7173C0, 7177C0, 7178C0, part 7118C0) **5x ultrasound machines are being purchased as a result of successful bids in the 2017/18 capital programme. They will be used for:** • PICC line insertion – a transformational scheme being piloted by the Anaesthetics Lead ODP in conjunction with a Consultant Radiologist which requires a portable ultrasound.	May 2017	£200k

Medical Devices schemes	Completion date	Budget cost
• AAA screening – 2 machines to replace those purchased when the service was implemented. There are 4 currently in use. The other 2 machines will be replaced next year. • Ultrasound machine for cross-Trust imaging support – a review of ultrasound efficiency has been carried out and the need for a multi functional machine has been identified. • Ultrasound machine for inpatients – as part of the above review, there has been a change in practice and a dedicated inpatient room established which has proven to improve patient flow and increase throughput. This machine is needed now that the pilot is to become permanent.		
Donated Assets		
Nothing to update in this quarter.		

Title: Voluntary Services Annual Report

Report from: Jo Jarvis, Voluntary Services Manager

Executive Summary:

As at 31st March 2017, 615 volunteers were registered with the Voluntary Services Department, and volunteering within the main hospital. 117 volunteers are registered with the Hospice who are recruited and coordinated by Elaine Willman. 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.

Proposed Action:

The board is invited to note the report.

Supporting Information

Voluntary Services continues to work alongside the Human Resources Department enabling it to be involved with issues around the Trust and to keep up to date regarding changes to recruitment procedures. Josie Kennedy, Administrator has not returned to her role with Voluntary Services after her maternity leave, and therefore a vacancy is still to be filled. This role is to be filled with an apprentice who has been appointed but waiting for pre-employment checks to be completed before commencement. Jo Jarvis, Manager, has ensured that standards have been maintained during this time.

At the end of 2016 Jo Jarvis (Manager) required an operation with a 6 week recovery period. With 4 weeks' notice planning for the department to be un-manned for this period went well, with Elaine Willman at the Hospice picking up anything that was urgent and unable to wait for the New Year.

Applications. In the twelve months to 31st March 2017, 142 applicants applied to be a volunteer, 19 applicants who returned their form later changed their mind or were refused a placement due to either health checks or Disclosure & Barring checks. 98 new applicants started during the year and 25 applicants are currently completing their recruitment paperwork.

Trust Membership. All volunteers are given the opportunity to join the Foundation membership, which increases steadily year on year. The number stands currently at 218 members who are volunteers. Many volunteers have joined the membership as a member of the public rather than as a volunteer so we understand the real number of members who are also volunteers is higher.

Volunteer Governor. Pearl James provides valued support to Voluntary Services and all the volunteers. Her past year has seen her deal with some health issues but during this time she has remained in contact with Voluntary Services and the volunteers by email and telephone and continued to encourage volunteers to wear their polo shirts.

Volunteers Trust Inductions. The commencement of these inductions for Volunteers in April 2016 has been very well received. 102 volunteers having attended the 3 sessions held over the past year. They are due to be held quarterly but unfortunately due to health the date set for January 2017 needed to be cancelled.

The Volunteers Trust Inductions are session lasting 2.5 hours and includes a welcome from either the Chief Executive or Chairman, Director of Human Resources and Operation Development talking about the importance of our Trust Values and Behaviours, together with sessions on Safeguarding Adults and Children, Health & Safety, Information Governance and Infection Control to name a few.

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

Michael Beck (AKA Wally Wheelbarrow) and David Chalk were the overall winner.

Michael first started fundraising for the hospital some 13 years ago, he and David have raised over £275,000 for the hospital. The Stars Appeal Bookshop volunteers were awarded a Highly Commended as was Jo Maslen a Stars Appeal volunteer who helps organise fundraising events such as Walk for Wards.

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

We provided placements for 76 students in over 30 locations around the Trust. We would like to say 'Thank You' to all the wards and departments who agree to take Work Experience students.

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

Volunteers Day. The Volunteer's Day was held on Friday 10th June 2016. We gave volunteers the opportunity to bring a guest, whether that was their partner, friend or neighbour. Unfortunately the Volunteers Christmas Party in December was not held due to the department being unsupervised whilst the manager was on sick leave. These events give the Trust a chance to say 'Thank you' to all the volunteers and an opportunity for the volunteers to meet with other like-minded people who help us.

The next volunteer's day is to be held on Friday 7th July 2017, from 12.00noon – 2.00pm for a buffet lunch in room D, Level 5. Board members would be very welcome to attend to meet some of our volunteers.

Stay With Me Volunteers. We will be recruiting new volunteers to sit with patients to improve their mental wellbeing and to build confidence and self-esteem of patients, particularly those at risk of falls and who are confused. They will be provided with training on Dementia, helping patients with mealtime (feeding), and listening skills, and will be able to signpost carers to relevant organisations for information and support.

Main Reception Volunteers. We are working in partnership with Ian Robinson from Facilities to provide a team of volunteers to 'man' the main reception desk. Their primary role will be to answer queries such as 'where can I get …? 'Who can help me with …? They will be able to signpost the patient/visitor to the relevant people, and our hospital guides will continue to escort patients and visitors who are lost to the appropriate departments and wards as necessary.

Conclusion

Voluntary Services Department is fortunate to have the full support of the Chairman and the Board members, and we would like to thank them for their support. We would also like to thank the support of Alison Kingscott the previous Director of Human Resources and Operation Development, who has encouraged Voluntary Services to improve and re-invent itself, we wish her well for the future.

The number of volunteers currently registered with the Trust stands at 732.

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. In our challenging times we must not underestimate the support volunteers can bring to us. 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.

Please see attached list of current volunteering roles.

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, 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.

Pets as Therapy (PAT)

Pets within the hospital make a huge difference to every patient they visit. They provide, and open up channels of communication between patients. Staff and visitors also like to offer 'affection' to the pets. We currently have just 4 dogs who visit 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.

Chaplaincy Visitors

The Chaplaincy is supported by 28 volunteers who are able to offer comfort, prayers and other spiritual support to patients at their bedside.

Clinical Psychology

The Clinical Psychology department have 49 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. Sarah Homer now leads on this project and has taken over from Antoinette Broomfield.

Christmas Carols/Father Christmas

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

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

Discharge Lounge

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

Floral Societies

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

Fundraising

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

Horatio's Garden Friends

'Horatio's Garden at the Spinal Unit has 73 volunteers who 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. 117 volunteers who offer a vast array of support to patients, visitors and staff. They also support the Day Centre and fundraising events. Elaine Willman now coordinates the volunteers and has worked well with Voluntary Services to ensure their volunteers receive appropriate training specific to their needs, and that recruitment is carried out correctly in a timely manner.

Hospital Guides/Self Check-In

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

Library Services (Staff)

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

Lung Exercise and Education Programme (LEEP)

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

Pharmacy

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

Readership Panel

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

Radio Odstock

Radio Odstock have 21 volunteers providing live and recorded programmes to our patients. They are currently looking at ways of improving their listening numbers and bringing their service more up to date.

Recycling

A team of 19 volunteers collect all unwanted furniture, equipment and office sundries such as desks, filing cabinets, folders, and box files. They repair some items to enable them to be reused; items that are beyond repair are dismantled, parts which have a scrap value are sold rather than being disposed of.

Salisbury Hospital League of Friends (LoF)

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

Schools in the Community Volunteers

We received applications from sixth form students from various public and private schools within our local area who wish to volunteer. Many of the pupils have expressed a wish to pursue a career in healthcare, and attend once a week during term time to gain experience working within

our Trust. Pupils are always polite and committed to their placement, staff and patients are always pleased to have their company.

Spinal Unit

There is a close working team of 39 volunteers who provide an integral service to the patients and staff on the Unit. Volunteers very often become a befriender to patients as they can be some distance from their home and their relatives, and provide an important service at mealtimes feeding patients or preparing/cutting their food.

Trade Unions & Staff Associations

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

Ward Helpers

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

Wessex Rehabilitation Unit

Wessex Rehab has 10 volunteers who help patients using the workshop. They create a number of products which they sell, and are able to produce wine racks, house name/number plaques and stools, and engraving to a range of materials. They are also able to produce specially commissioned items, and have produced a number of staff badges and door signs for the Trust.

SALISBURY NHS FOUNDATION TRUST
Minutes of the Audit Committee
Held on: Monday 13 March 2017

Present: Mr P Kemp (Chairman and Non-Executive Director)
Mrs K Matthews (Non-Executive Director)
Mr M von Bertele (Non-Executive Director)

In Attendance: Mr R Batley (KPMG)
Mr M Stabb (TIAA)
Mr A Morley (Local Counter Fraud Specialist, TIAA)
Ms H Cobb, (Local Counter Fraud Specialist, TIAA)
Mr M Cassells (Director of Finance & Procurement)
Mr D Seabrooke (Head of Corporate Governance)
Mrs F Hill (Head of Risk Management, for item 4)
Mr S Bleakley (Head of Pharmacy, for item 7)
Mrs C Charles-Barks (Chief Executive, from item 6 onwards)

ACTION

1. MINUTES – 17 OCTOBER 2016

The minutes of the meeting of the Committee held on 17 October 2016 were agreed as a correct record.

2. MATTERS ARISING

Staffing agency checks – this would be picked up later in the meeting.

It was also noted that work continued to improve on staff exit procedures together with improvements to processes for the management of ID badges and the location/ownership of trust mobile phones.

3. EXTERNAL AUDIT

The Committee received the External Audit Report comprising the Progress Report and Technical Update, External Audit Plan and Interim Audit Findings.

It was noted that KPMG had finalised the Trust's charitable funds audit and the interim audit for 2016/17 had been completed.

KPMG were looking at the performance indicators to be reviewed as part of the quality report requirements.

It was noted that a small number of off-payroll workers were potentially affected by the changes to rules for engaging this type of worker. Compliance with these proposals was being discussed with the individuals concerned. Executive to confirm to the committee when the Trust is fully compliant with the new requirements **MC**

Under the External Audit Plan, principal risk factors of income recognition, management override of controls, evaluation of land and building assets were highlighted. No issues had arisen from the testing carried out on ED wait times information in respect of April – December 2016. The final audit would see a test run from January to March 2017 data. There were some gaps noted in TIAA data as the time the patient was first seen by the referrer was not always recorded in a timely way.

The Committee noted the reports.

4. HALF YEAR REVIEW OF THE ASSURANCE FRAMEWORK

The Committee received the report of the Head of Risk evidencing the conduct of the process carried out by the three assuring committees between October 2016 and January 2017.

The Committee also received for information the March 2017 Assurance Framework and Risk Register extract together with details of the proposals presented and agreed as part of the annual Trust Board Review of the content of the Assurance Framework. For clarity, the Audit Committee is currently only asked to review the adequacy of the overall assurance process and not to comment on the findings from the other assuring committees.

It was noted that the risks managed by the Finance and Performance Committee had been reviewed at its February meeting and were not recorded in this update. It was agreed that the committee regarded this as positive evidence of the working of the process, in as much as a risk framework that was agreed to be out of date due to environmental circumstances was being actively addressed, by the relevant assuring committee.

Proposals were being discussed that would bring the proposed new Workforce Committee forward as an assuring committee and this would assume some of the assuring duties undertaken currently by the Joint Board of Directors with the remaining duties passed to the Finance and Performance Committee. It was noted that executives were introducing a strengthened process to ensure the regular review of assurance framework actions. The Trust Board would be reviewing the Assurance Framework again at its June meeting. **FHi**

5. INTERNAL AUDIT

The Committee received the progress report including follow up on outstanding audit actions and the Draft Audit Plan for 2017/18.

Audits completed since the last report were as follows:

Nurse revalidation - substantial assurance
Payroll - substantial assurance
Overseas visitor income - reasonable assurance.
Capital Programme - substantial assurance
OML - reasonable assurance
Cash Collection - substantial assurance
Financial accounting - reasonable assurance
IG Toolkit - reasonable assurance
Procurement - substantial assurance

Members of the Committee were congratulated the Executives as five of the nine audit reports presented were rated as substantial assurance.

In relation to overseas visitor income MS agreed to pull together further benchmarking in support of assessing the strength of the Trust's processes for identifying and collecting income. It was noted that the Trust was

strengthening the controls over signatories and authorisers for procurement card spending. MS reported that TIAA were on track to complete the remaining audit by the year end. **MS**

There was however concern about the number of items identified for follow up dating from the 2015/16 year. An update had been received from the Director of Corporate Development which set out a satisfactory route to addressing the outstanding issues. The management plan in relation to the outstanding Medical Devices findings required further thought and the Chief Operating Officer would be reporting to the next meeting of the Committee on this. **AH – May meeting**

It was noted that on the IT firewall, progress was being made on hardware replacements and training was put in place to improve resilience on data protection. Although there had been no planned disaster recovery exercise for EPR, unplanned outages had tested these systems.

It was requested that the executive develop a formal process to close or modify recommendations if it was not proving appropriate to implement them. TIAA offered to offer input on this. **MC**

The Audit plan for 2017/18 comprised 300 days, plus 26 days carried over from the previous year and would be deployed flexibly. Audits of Medical Devices, medicine safety/security and actions arising from the Lorenzo implementation were highlighted.

MC

Executive Directors would review the audit programme to ensure the areas they were responsible for were suitably prepared.

The committee formally approved the plan

6. COUNTER FRAUD UPDATE

The Committee received the Counter Fraud Progress Report 2016/17 and 2017/18 Plan. AM highlighted a successful prosecution of a member of the public who had fraudulently claimed for taxi fares. He highlighted recent intelligence alerts received in relation to cyber fraud.

It was noted that the Counter Fraud Standards had been updated in respect of requirements under the Bribery Act 2010 and in relation to the condition 5.9 of the NHS Standard Contract in regard to the carrying out of pre-employment checks. Counter fraud had carried out a review of nurse agency staff pre-employment checks and the findings were enclosed with the report.

Under the supply contracts which were let through a lead provider there was a requirement for contractors to have in place processes for checking agency workers before deploying them. It was however the responsibility of the client trust to ensure that anyone working on their site had been checked. Formal contracts were in place with all of the framework agencies used by the Trust. One other agency did not have a contract but this had been visited by the Local Counter Fraud Specialist who had found on a dip sample that pre-employment checks were of a high standard. The Committee did not wish to see the contractor agencies' work duplicated for example through systematic local checks but it was felt that additional assurance on this point was required.

LW –

Mark Stabb undertook to consider this further and it was requested that the Director of Nursing be requested to attend the next meeting to discuss this further. **May meeting**

The Counter Fraud Work Plan was received, using a risk based approach and the indicative number of days was 58 to complete the programme. The committee formally approved the plan

7. MEDICINE CABINET SECURITY REVIEW

Following the initial discussions at the October 2016 meeting the Committee received a report setting out the results of a series of ward visits conducted in December 2016 and early February 2017.

It was noted that, although the storage of drugs formally classified as "controlled" was consistently compliant, there were a disappointing number of non-compliance findings for other drugs that were required to be closely managed by qualified staff. There were some upgrades to the physical storage facility required that were in hand in the PFI building as a result of the review. Nursing and Pharmacy teams were involved in addressing this issue.

Members of the Committee were concerned that following the discussion of this in October that issues continued to be found and it was requested that a solution and closure to this issue be identified for the 19 May meeting of the Committee. **LW/SB**

8. LOSSES AND COMPENSATION REGISTER

The Committee reviewed and signed the Losses and Compensation Register.

9. DATE OF NEXT MEETING

The next meeting of the Audit Committee will be held on Friday 19 May 2017 at 10 am.

Further Meetings 2017

Monday 18 September at 10 am
Monday 11 December at 10 am

SALISBURY NHS FOUNDATION TRUST
CLINICAL GOVERNANCE COMMITTEE
Thursday 23rd March 2017, 10am-12pm
Boardroom, Salisbury District Hospital

MINUTES

CHAIR – PROFESSOR JANE REID

Present:

Professor Jane Reid – (Chair) Non-Executive Director
Dr Michael Marsh – Non-Executive Director
Dr Christine Blanshard - Medical Director
Lorna Wilkinson - Director of Nursing
Steve Bleakley – Chief Pharmacist
Ian Downie - Non-Executive Director
Tania Baker – Non-Executive Director
Michael Von Bertele – Non Executive Director

In attendance:

Kate Williams	Minute taker
Jan Sanders	Governor
Fenella Hill – Head of Risk Management	CGC031716

CGC031701 Apologies:

Cara Charles-Barks – Chief Executive Officer
Claire Gorzanski – Head of Clinical Effectiveness
Fiona Hyett - Deputy Director of Nursing
Hazel Hardyman – Head of Customer Care
Andy Hyett – Chief Operating Officer
Steve Long - Non-Executive Director
Mark Stabb – Head of TIAA
Dr Samuel Williams – F1

CGC031702 – Any Urgent Business

1. LW reported that there were concerns about the overall numbers of falls resulting in harm. Historical aggregated reviews have revealed changing themes. There is currently a 90 day challenge focusing on falls risk assessment, safety briefs and initiatives. There is encouragement for staff to think differently and get new ideas to address this issue. Louise Roe has been recruited to the Risk Team and is taking the lead on falls. JR suggested using the strong volunteer service to pilot a scheme for observers on wards to aid navigation.

This item is to come back to the Clinical Governance Committee to report on the results of the 90 day challenge. **LW**

2. CB reported that a recent external meeting regarding future mortality reporting raised concerns that, going forward, investigations will be required in respect of all deaths in hospital. This reporting would be subjective due to the definition of 'avoidable' and would be based on notes review with large inter and intra-observer variation - there would be potential for 'league tables' to be produced from the statistics. It would be more appropriate to complete a structured judgement review process which would generate a detailed review only where there is cause to do so. SFT will be required to publish a policy regarding investigations into deaths. It is suggested that there needs to be more effective

engagement of bereaved families in the process, who will be able to choose if they wish to become involved. There is potential for learning to arise from this, and staff will be asked to identify how the Trust has changed following a review. A medical examiner role will be funded from 2019 to aid in reporting. TB noted that pilot schemes suggest that this role does add value, and suggested that this work is undertaken within a broader scheme. JR commented that it may be possible to access processes already in place.

CB reported that a detailed mortality report is produced annually but it is not currently possible to collect data regarding cause of death from the death certificate. MM commented that University Hospital Southampton secured additional funding to collect this data. CB noted that the new mortality reporting would take place on a quarterly basis in the next financial year, with policy and processes set by 1st September 2017. The reports will go to the public board.

3. LW reported that there were ongoing challenges with medicines storage. Improvements are being made with safety crosses attached to drug cupboards as a visual aid and to provide a daily reminder to staff. Audits are being run every 6 weeks to gain assurance. Staff are struggling with some of the replacement locks in the PFI, these need to be checked and additional ones fitted where necessary.

The committee asked that this come back to the Clinical Governance Committee as a hot topic. **LW**

GC031703 – Minutes of the meeting held on 26th January 2017

After clarification of several points, the minutes were approved by the committee.

CGC031704 – Action Tracker

All items were agreed.

CGC031705 – Matters Arising – Medication safety verbal Exception Report (deferred from Feb 16) – Steve Bleakley

SB reported that Louise Williams is the new medication safety officer. There is a need to improve time on the wards to investigate incidents. There are approximately 20 incidents per month and the team write to the medics involved. There is currently a theme relating to IV paracetamol doses. There are ongoing rolling audits in respect of controlled drugs. An audit completed with NHS Counter Fraud gave challenging results regarding the storage of controlled drugs. Work has been undertaken and improvements are being made. A repeat audit will be completed in April 2017.

CGC031706 – Matters Arising – Results of the investigation into referrals between SFT and New Hall Hospital – Dr Christine Blanshard

CB reported that investigations were carried out to assess the processes between SFT and New Hall Hospital, which are different for private and NHS patients. In the incident which prompted the investigation the correct processes had been followed but there had been human error which had led to delays.

CGC031706A – Matters Arising – Major Issues report – committee to decide if this report is required to come to the CGC meeting in the future – Committee

The committee discussed this report and a decision was taken that this should not come to the Clinical Governance Committee meeting in the future. The report will go to the Trust Board meeting in the future to allow access for all non-executive directors.

STRATEGY

CGC031707 – Core Service presentation – Medicine with a focus on care of the elderly – Diran Padiachy

This item did not take place.

ASSURING A QUALITY PATIENT EXPERIENCE

CGC031708 – CQC inspection action plan verbal update – Lorna Wilkinson

LW reported that the steering group continues to meet. There is a monthly meeting with the CQC and a good relationship with the local and regional manager, who have given positive feedback. An exception report is provided to them on a monthly basis. JR asked if the CQC members have shared their view on challenges faced with flow / outpatients to which LW responded that they are acknowledging the challenges but are both very positive with the plans in place, and impressed with the longer term strategies. They have been very complimentary as to the response made to the spinal warning notice. The CQC meet regularly with NHSI. LW confirmed that peer reviews are planned with RUH and Royal Berks.

LW reported that all extra capacity beds had been closed down in the previous week.

CGC031709 - Dementia Strategy end of year report 16/17 and measures – Dr Carmen Carroll and Sandy Woodbridge

This item was deferred to May 17.

CGC031710 - End of Life end of year report 16/17 – for information only – Dr Pippa Baker

Significant progress has been made over the last 12 months, this has been validated both by the "Good" rating from CQC and the significant improvement in the National Care of the Dying audit results. The recent development of an EOLC Strategy and work plan will help prioritise and manage future EOL developments. There has been a clear benefit from having a motivated EOL team and 7 day working specialist palliative care service. However, there have been significant staffing issues which continue within the EOLC team. These staffing issues have meant EOL education sessions have had to be cancelled and minimal support has been available for the wards, which in turn, may have led to a reduction in the use of the PCF. A business case was submitted in 2016 for further CNS support for the EOL team to help realise the EOL Strategy, and the EOL steering group will need to review the work plan and prioritise work depending on the staffing and future of the EOL team. CQC commented on the lack of mandatory EOL training and it was agreed at CMB to propose targeted mandatory EOL training for new staff to the Trust alongside the ongoing education programme. During the last year both hospice at home and the 72 hour service have started, supporting patients in their own home. Other areas that need resolving are the lack of an effective EPaCCs (Electronic Palliative Care Communication System) and planning the future role of TEP forms within the acute Trust, particularly in view of the recent launch of "ReSPECT" (Recommended Summary Plan for Emergency Care and Treatment) by the Resuscitation Council.

CGC031711 – Q3 Customer Care report – Lorna Wilkinson

62 complaints were received in Q3 compared to 99 complaints in Q2 and 66 complaints for the same period in the previous year. The activity from comments, concerns and enquiries has decreased from 437 in Q3 last year to 427 in Q3 this year.

The main issues from complaints are:

- Clinical treatment (28), 4 less than Q2 (32) - sub-themes were 9 unsatisfactory treatment across 8 different areas, 8 further complications, 5 correct diagnosis not made, 3 delay in receiving treatment, 2 treatment unavailable and 1 inappropriate treatment. Orthopaedics received 8 complaints about clinical treatment with 3 related to correct diagnosis not being made, 2 further complications and 1 each for delay in treatment, treatment unavailable and unsatisfactory treatment.
- Staff attitude (11), 3 less than Q2 (14) – 6 related to medical staff, 3 other staff and 2 to nursing staff across 10 different areas.
- Appointments (9), 6 less than Q2 (15) – sub-themes were 4 appointment date required, 3 appointment system delays, 1 each for appointment cancelled and unsatisfactory outcome, across
- 6 different specialties.

The main issues from concerns were appointments (27), clinical treatment (17), communication (8) and attitude of staff (7). The main specialties for appointments across concerns and complaints were Plastic Surgery (6), Central Booking (5) and 4 each for Orthopaedics and Oral Surgery.

There were no new requests for independent review by the Parliamentary and Health Service Ombudsman and one closed case that was partially upheld.

A total of 315 inpatients were surveyed in the quarter. They made 189 positive and 167 negative comments. The main areas of concern were food and nutrition on the ward and noise.

The responses to the Friends and Family Test remain overwhelmingly positive and the numbers are too low to identify any main area of concern.

There have been 2 new project requests in Quarter 3, 1 National Patient Survey and 1 completed project. NHS Choices received 14 comments in Q3 with 10 positive and 4 negative comments relating to 10 different areas.

LW reported that there were disappointing results in terms of timeliness. We have learned that personalisation of the complaints process is beneficial, using evidence, action plans and timeliness.

JR noted that the NHSLA will be re-named as NHS Resolution from April 17 and will be focusing on mediation.

CGC031712 – Learning Disabilities end of year report 16/17 – Gill Cobham

This item was deferred to May 17.

ASSURING CLINICAL EFFECTIVENESS

CGC031713 – Quality Indicator including DSSA – tabled only – Dr Christine Blanshard

- No cases of C.difficile. One MSSA bacteraemia currently being investigated.

- A decrease in the crude mortality rate. SHMI decreased from 106 (June 16) to 104 (September 16) and is as expected and 103 when adjusted for palliative care (June 16). HSMR increased to 119.5 in November 16 and is higher than expected. No new CUSUM alerts. A detailed briefing paper on mortality governance and improvement actions was presented to the CGC and our commissioners in February 17.

- An increase in the number of grade 2 pressure ulcers. Share and learn meetings continue to drive improvements.

- There were no falls resulting in fractures, moderate or major harm in February 17.

- In February all stroke patients had a CT scan within 12 hours and patients spending 90% of their time on the stroke unit increased. Those that did not spend 90% of their time on the unit were patients admitted to AMU due to unavailability of a stroke bed (1), not admitted to the stroke unit at all (1), a patient transferred to another ward to make way for an acute stroke patient (1) and a short length of stay (1). Patients arriving on the unit within 4 hours significantly reduced due to waiting for a bed (6). A bed escalation framework for clinical site decisions is in draft. This will include any decision to put a non-stroke patient into the take bed on the unit will only be authorised by the Executive Director on call or the Chief Operating Officer in the day.

- An increase in high risk TIA patients being seen within 24 hours. 10 patients were not seen within the timeframe due to no available morning clinic and no available clinic capacity. Improvement work led through the Stroke Strategy Group.

- An increase in the number of complaints but a decrease in the number of re-opened complaints and concerns.

- The same high numbers of escalation beds were open as in January. There were 5 non-clinical mixed sex accommodation breaches affecting 29 patients, the majority on AMU (4) and SSEU (1) all resolved within 24 - 48 hours.

- The mean score of patients rating the quality of their care improved. The Friends and Family test of patients who would recommend ED, wards, the maternity service and care as a day case and outpatients was sustained.

CB noted that there were data issues with regard to stroke patients and readmission rates. MM questioned if the reasons are known for the ward moves which are taking place through the night. LW responded that the majority are from assessment areas onto wards. MM sought clarification of the moves which do not fall into this category. LW to review how this information is captured. **LW**

LW reported that from April 17 this information will be presented differently so that there is more clarity as to where differences are being made. The CCG has understood the pressures involved in

recent mixed sex breaches and there have been no fines.

TB observed that clinical audit information included in a separate report could be added to this report as it would prove useful to view the information together.

CGC031714 – Draft Quality Account 16/17 – for discussion – Dr Christine Blanshard

- Overall, the Trust has made progress in improving the quality of care in 2016/17 but there is still work to do. The report describes progress with this year's improvement priorities: keeping patients safe from avoidable harm; ensuring patients have an outstanding experience of care; working with our partners and patients to prevent ill health; providing patients with high quality care seven days a week and co-ordinated care across the whole health community.

- Five quality priorities have been selected for 2017/18 following a consultation. To sustain and embed good practice the five priorities are the same as last year but the work streams with each are different:

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

- The draft quality account has been reviewed by six members of the Readership Panel and two have commented. One said '' As I worked my way through this report I couldn't help but be impressed by the stunningly good statistics achieved by SDH. I count myself fortunate indeed to be in the catchment area of such an effective and highly motivated hospital. Happy that all who need to hear this do so''. The other commented '' Its sheer comprehensiveness and its ability to enlighten one''.

- The quality account will be subject to external audit by KPMG on the content, 2 mandated indicators and 1 local indicator. 1) Referral to treatment (RTT) incomplete pathways. 2) The Emergency Department 4 hour wait standard. 3) Local indicator selected by the governors – high risk TIA patients seen within 24 hours of referral.

CB noted that this report is not yet complete, it has been to CMB and a readership panel, and reviewed by external stakeholders.

The committee commented that factual reporting is desirable in this report and that in some areas a change of tone would be appropriate. The CEO's report was considered and it was suggested that a summary would be useful due to the length of the document. JR asked if there was 100% compliance with the WHO checklist, to which CB responded that it was audited at 100%. JR noted that there are new Freedom to Speak Up guardians and asked that the position be checked regarding the need for a named non-executive director to perform this role. TB commented that she would have expected to see 'outcomes' under 'priorities for 17/18. This report will come back to the committee in May.

CGC031715 – National Clinical Audit update – Dr Christine Blanshard

21 reports were published within the reporting period. Action plans are/will be agreed by the Clinical Management Board and are monitored by the clinical teams and Directorates to ensure improvements in care pathways and completion of action plans.

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

MM sought assurance for adherence to cardiologists seeing patients, as numbers had fallen below the national average in the NICOR audit. CB confirmed that this was due to the loss of a heart failure nurse resulting in a patient flow issue. There is now a new consultant Cardiologist. MM commented that the work being completed gave confidence that the situation was improving.

MM asked who is responsible for the actions resulting from the neonatal audit to which CB responded that it is Jim Baird and one other member of the team. Shirley Kinsey manages the neonatal unit. The matters are considered at directorate performance meetings.

CB reported that the national joint registry data has been reviewed at CMB, the figures include

those from historical metal on metal hip joints which required a high level of revision. New Hall shows the same levels. The GIRFT (Getting It Right First Time) programme being led by the national director for clinical effectiveness has produced useful benchmarking data, and the visits we have had – to orthopaedics, spinal surgery and urology, have been useful in generating ideas to improve effectiveness and productivity.

MM suggested that the Board need to consider smoking cessation on site within a year and it was agreed that this action would be raised with the Board.

CB confirmed that there is almost 100% participation in most national audits. There had been an issue with data collection in the inflammatory bowel disease audit, but these have now been resolved.

CGC031716 - External Enquiries and Externa Agency Visits biannual report – Dr Christine Blanshard

National Reviews

Two reports were published between August 2016 and January 2017.

- Nursing and Midwifery Council: Amendments to Modernise Midwifery Regulation and Improve the Effectiveness and Efficiency of Fitness to Practise Processes (January 2017)
- Care Quality Commission: Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (December 2016)

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

National Confidential Enquiries

One report was published between August 2016 and January 2017.

- Treat as One: Bridging the gap between mental and physical healthcare in general hospitals (January 2017)

Work is continuing on recommendations from five reports published in previous reporting periods.

External Visits

A total of 13 visits and inspections took place between August 2016 and January 2017.

- Deanery and other training issues
- South Western Ambulance Service NHS Trust (SWAST) (January 2016)
- IR(ME)R CQC (January 2017)
- NHS England: Higher Level Responsible Office Quality Review (HLROQR) [Medical Revalidation] (January 2017)
- NHS England Specialist Commissioning Peer Review of Spinal Cord Injury Services (December 2016)
- British Parking Association (November 2016)
- HFEA Fertility Centre unannounced visit (November 2016)
- Local Supervising Authority Audit of Supervision of Midwives (November 2016)
- DVLA (November 2016)
- CCG: Joint targeted area inspection Domestic Abuse (October 2016)
- EHO: Unannounced visit to Catering Department (September 2016)
- Audit of Unlicensed Aseptic Dispensing Units in accordance with EL(97)52 Salisbury District Hospital (August 2016)
- HTA - Post Mortems (August 2016)

Work is continuing on actions from five visits which took place in previous reporting periods.

- Wessex School of Surgery
- Environment Agency Inspection of Areas using Radioactive Material
- Care Quality Commission Inspection
- QA Diabetic Eye Screening Programme (DESP)
- QA visit for the Bath, Swindon & Wiltshire Bowel Cancer Screening Programme

CB confirmed that following the IRMER visit standard operating procedures (SOPs) are now written down and these have been ratified. Issues with clinical leadership identified at the spinal peer review are being addressed.

ASSURING SAFETY

CGC031716 – Assurance Framework – Fenella Hill

The Assurance Framework must be reviewed and updated quarterly by the delegated Assurance Committees to ensure that scrutiny is applied to assure the Board that the Trust's principal risks are being managed and controlled effectively in order for the corporate objectives to be achieved.

A Trust Board reporting template was circulated to committee members identifying key changes since the last meeting. The Trust Risk Register (extract of clinical risks scoring 12 and above) was also submitted for reference.

The committee is receiving regular updates regarding mortality. CB confirmed that there is ongoing HSMR work as part of reviews within the Mortality Surveillance Group meetings. LW confirmed that the Trust is on target for 90% compliance regarding safeguarding training; and that the Board assurance framework is being reviewed as part of the governance reviews and will be passed by internal audit. LW confirmed that she will refresh the nurse staffing data against the 17/18 objectives.

JR noted that nursing recruitment is very low and is likely to cause issues – this is a national issue, complicated by the withdrawal of bursaries.

PAPERS FOR NOTING

CGC031718	Clinical Management Board meeting minutes (February 2017)	Unavailable
CGC031719	Clinical Risk Group meeting minutes (January 2017)	Noted
CGC031720	Information Governance Group meeting minutes (January 2017)	Noted
CGC031721	Children and Young People's Quality and Safety Board meeting minutes (December 2016)	Noted

The committee requested that this item become 'Reports from Boards or Committees by Exception'. **KW (Action completed)**

ANY OTHER BUSINESS

LW/CB

TB asked if reviews were made at Trust Board with regard to Wiltshire Health and Care assurances. LW and CB will follow this up.

ID asked for assurance regarding avoidable readmissions. CB confirmed that there are some coding issues, and that there is a theme of completely unrelated conditions being shown as a readmission.

MM asked that the Dementia paper which is due to come to the committee in May 17 show clearly the improvements made in dementia care. MM further asked that the information regarding the level of psychotropic drugs being used is stated in the summary. LW confirmed that this would be passed on to Carmen Carroll. **LW**

JS requested information regarding Major Incident volunteers and their need for action cards, which have not been issued. LW will take this to AH and this will go to the Board. **LW (action completed)**

NEXT MEETING

2017 dates will be Thursdays, 10am-12pm in the Boardroom – 18th May, 22nd June, 27th July, 28th September, 26th October, 23rd November. No meetings in April, August or December.

SALISBURY NHS FOUNDATION TRUST

Minutes of the Council of Governors Meeting – Part 1
At Salisbury District Hospital
Held on Monday 15 May 2017

Present:	Nick Marsden (Chairman)		
Governors Present:	Ross Britton	**Apologies:**	Pearl James
	Mary Clunie		Nick Alward
	Shaun Fountain		Jonathan Wright
	Lucinda Herklots		Jenny Lisle
	Raymond Jack		Chris Horwood
	Alastair Lack (Lead Governor)		
	John Mangan		
	Colette Martindale		
	Isabel McLellan		
	Rob Polkinghorne		
	Beth Robertson		
	Jan Sanders		
	Lynn Taylor		

In Attendance: Paul Kemp (Non-Executive Director)
Tania Baker (Non-Executive Director)
Michael von Bertele (Non-Executive Director)
Hazel Hardyman, Head of Customer Care (for item 5)
Malcolm Cassells (Director of Finance and Procurement) for item 4

ACTION

Governors joined the Chairman in holding a minute's silence in memory of Michael Mounde who had represented the West Wiltshire Constituency and had died in March.

1. MINUTES

The minutes of the meeting held on 20 February 2017, were agreed as a correct record.

2. MATTERS ARISING

Item 7 – The Chairman reported that the Governor Advisory Panel had discussed the issues raised and had undertaken to do further work on membership engagement and NM would circulate anything that arose from this. NM

Item 9, Military Governor – The Chairman reported that it did not appear likely that a military governor would restart attendance at Council of Governor meetings. It was agreed to leave the post vacant for the time being.

Ethics Committee – There was no further information about a meeting of the Clinical Ethics Committee.

Nursery Tender – it was noted that a new provider was in the process of taking on the service and MC described the transition arrangements put in place in this regard.

3. TRUST PERFORMANCE TO 31 MARCH 2017

The Council received the Governor's report. The Trust was facing challenges in relation to two week breast cancer waits and with the A&E four hour target which was due to delayed transfers of care in the hospital. The target had been met for April. There were congratulations on the achievement of 13 attributed C-Diff cases against the ceiling of 19.

The Council noted the Performance Report.

4. FINANCE REPORT AND CONTRACTING REPORT TO 31 MARCH 2017

The Council received the Finance and Contracting Report. MC reminded the Council that under its 2016/17 control total the Trust had a target of £1.8m and had, with the one-off support available from the Sustainability and Transformation Fund generated a surplus of £4.5m that would be off-set against the Trust's underlying deficit. It was noted that the Trust had achieved the control total and had received additional bonus payments for doing so.

For 2017/18 the Trust was planning for a year end deficit of £7m.

In terms of activity it was noted that high levels of non-elective patients had affected elective activity. Cost improvement for 2016/17 had delivered £6.1m through the directorates against t target of £6.5m. Discussions were continuing with commissioners about obtaining the full range of income available to the Trust. A performance notice had been received from West Hampshire CCG and there was concern about the relationship between this commissioner and the Trust.

As the Trust had not accepted the 2017/18 control total it was becoming evident that it was being denied access to in year funding allocations for initiatives such as Emergency Department streaming, for which a good business case was available and also IT resilience support.

The Finance Directorate continued to estimate much of April's activity figures because of problems with the data warehouse.

The Council noted the Finance and Contracting Report.

5. CUSTOMER CARE REPORT – QUARTER 3

The Chairman welcomed Hazel Hardyman, Head of Customer Care and the Council received the quarterly report. The principal causes for complaints were clinical treatment and staff attitude. There had been no new Parliamentary and Health Service Ombudsman cases and an action plan on a past case had recently been submitted. There had been a good RTF survey response. There had been 14 NHS Choices comments submitted in the quarter and Alastair Lack complimented the improvement in the way that the Trust's responses were written.

The Council noted the Quarter 3 Customer Care Report.

6. MAKE-UP OF CAROUSELS FOR APPOINTMENTS

The Council approved a protocol for the selection of Governors to serve on appointments carousels for nominations Committees and associated carousel interviews.

7. CONFIRMATORY VOTE FOR LEAD GOVERNOR – STANDING ORDER 16.2.B

The Chairman invited Governors to confirm the succession of Raymond Jack as Lead Governor and Alastair Lack as Deputy Lead Governor from 1 June 2017.

The vote was carried unanimously.

8. FEEDBACK – SALISBURY CITY CONSTITUENCY MEETING

The Council received for information the notes of the 21 March constituency meeting held at Salisbury Methodist Church.

9. GOVERNOR QUERY – MOBILE CHEMOTHERAPY PROVISION

The Council received for information the response from the Trust to a query from Lynn Taylor about the mobile chemotherapy truck.

10. COMMITTEE/WOKING GROUP REPORTS

The Council received for information the minutes of the Membership and Communications Committee 28 February. The editor of the membership newsletter gave an update on the work of the editorial board in producing this. He requested governors to suggest ideas for future topics.

The End of Life Steering Group had been discussing arrangements for out of hours mortuary viewings. Colette Martindale emphasised that any viewing needed to be arranged appropriately to ensure families had the required support.

An oral update on the work of the Dementia Steering Group was given by John Mangan.

The notes of the Strategy Committee held on 27 March were received and this had discussed the proposal to update the Trust's 2014/19 Strategy and had received information about the Board's reconfiguration to emergency and elective pathways which was underway in summer 2017, in readiness for winter 2017/18. It was noted that a review of the Trust's estate had recently been commissioned.

11. DATES OF COUNCIL OF GOVERNORS MEETINGS IN 2017

Details were provided of the next meeting of the Council of Governors which was 17 July and the next informal meeting with the Chairman and NEDs on 12 June. The 6 June Medicine for Member's session was unlikely to proceed as no speaker had been found for this.

12. ANY OTHER BUSINESS

Major Incident Plan

Jan Sanders had a contact with the Emergency Planning and Resilience Team and had attended a recent table top exercise which had proven to be very interesting and it was understood that the Emergency Planning team would be addressing a Council of Governors Development Day.

Cyber Attack

It was noted that the Trust had not been directly affected by the recent worldwide cyber-attack. The Trust's resilience plans had worked and the IT Department had done a good job at this critical time.

Salisbury NHS Foundation Trust Board - 5 June 2017

SFT 3902

Title: Quarterly Review of Assurance Framework by Joint Board of Directors

Report from: Joint Board of Directors **Presented by :** Cara Charles-Barks, Chief Executive

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

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

Proposed Action: the Board is asked to NOTE the minutes extract of the minutes of the Joint Board of Directors for 19 April 2017

Supporting Information

Minute extract from 19 April 2017

There were newly identified gaps in control and assurance in relation to risk 1.1 (delivery of key performance targets) and relating to on-going manual validation of waiting lists. Waiting times increasing in Orthopaedics and plastics and there were remedial actions for expanding Orthopaedics and adding trauma capacity. A gap had arisen in relation to monitoring reports not working due to issues with the data warehouse which would continue to be monitored at executive level. The launch of the Integrated Governance and Accountability Frameworks was a remedial action in relation to on-going assurance from directorates.

No new positive assurances had been identified.

On the Risk Register the re-configuration of genetics services had been escalated to JBD and scored as a 12 and a risk in Maternity in relation to staffing had been increased due to sickness levels. An earlier review date of the risk in relation to demand from non-elective patients needed an earlier review than 31 October 2017.