Bundle Trust Board Public 5 September 2019

1 Opening Business

Nick Marsden

1.1 Staff Story

1.2 Welcome and Apologies

no apologies received
Nick Marsden

1.3 Declaration of Interests

Nick Marsden

1.4 Minutes of the previous meeting

Minutes of Part 1 (public) Trust Board Meeting held on 1st August 2019
Nick Marsden

TB 1.4 DRAFT Public Board mins 1 August 2019.docx

1.5 Matters Arising and Action Log

Nick Marsden

TB 1.5 Matters Arising Action Log.docx

1.6 Register of Attendance

Nick Marsden

Register of Attendance - Public Board 2019-20.docx

1.7 Chairman's Business

Nick Marsden

1.8 Chief Executive Report

Cara Charles-Barks
For Information

TB 1.8 CEO Board Report Sept 2019 AH sign off.docx

2 Assurance and Comittee Reports

2.1 Finance and Perofrmance Committee Report - 3 September

Paul Miller, verbal report
Assurance

2.2 Integrated Performance Report

Paul Hargreaves
Assurance

TB 2.2a Integrated Performance Report cover sheet.docx

TB 2.2b Integrated Performance Report September 2019.pdf

3 Quality and Risk

3.1 Well Led Action Plan

Fiona McNeight
Assurance

TB 3.2a Well-Led action plan update to Board September 2019.docx

TB 3.2b Well-Led action plan_revised August 2019.pdf

4 Workforce

4.1 Health and Safety Annual Report

Paul Hargreaves
For approval

TB 4.1a HandS Board cover sheet template Jan 2019 (2).docx

TB 4.1b H&S Annual report July 2019 (1).doc

TB 4.1c Appendix A18 AuditAnalysisChart.doc

TB 4.1d Appendix B 19 Compliance with safe sharp legislation.docx

TB 4.1e Appendix C 19 StaffErgonomicAssessments.docx

TB 4.1f Appendix D19 SmokingcessationpostJan1st.docx

TB 4.1g AppendixE19 EFAlertIngestionofChemicals.docx

TB 4.1h AppendixF19 Activity of Sub Groups.doc

TB 4.1i AppendixG project plan CL3 2019.docx

TB 4.1j Appendix H Final project Compliance CL3 Labs.docx

6 Closing Business

Nick Marsden

6.1 Agreement of Principle Actions and Items for Escalation

6.2 Any Other Business

6.3 Public Questions

6.4 Date of Next Meeting

Date of next Public meeting - 3 October 2019

7 Resolution

Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential

Salisbury NHS Foundation Trust

DRAFT

Minutes of the Public Trust Board meeting held at 10:00am on Thursday 1 August 2019 in The Board Room, Salisbury NHS Foundation Trust

Present:

Dr N Marsden	Chairman
Ms T Baker	Non-Executive Director
Mr P Kemp	Non-Executive Director
Mr P Miller	Non-Executive Director
Ms R Credidio	Non-Executive Director
Dr J Reid	Non-Executive Director
Mr M von Bertele	Non-Executive Director
Mrs C Charles-Barks	Chief Executive
Mr Andy Hyett	Chief Operating Officer
Dr C Blanshard	Medical Director and Deputy Chief Executive
Ms L Wilkinson	Director of Nursing

In Attendance:

Esther Provins	Director of Transformation
Fiona McNeight	Director of Corporate Governance
Glennis Toms	Deputy Director of Organisational Development and People
Mark Ellis	Deputy Director of Finance
Juliet Barker	Guardian of Safe Working (minute TB1 - 01/08/4.2)
Helen Rynne	Patient and Public Engagement Coordinator (minute TB1-01/08/1.1)
Kylie Nye	Corporate Governance Manager (minutes)
Sir R Jack	Lead Governor (observer)

ACTION

TB1 – 01/08/1 OPENING BUSINESS

TB1 – 01/08/1.1 Patient Story

L Wilkinson presented the patient story which focused on a patient who had developed Sepsis and had not been appropriately treated during her stay at the hospital. L Wilkinson noted that this particular case had occurred 3 years ago and the daughter of the patient had worked closely with the Trust to ensure learning was shared through the sepsis education sessions.

Discussion:

- N Marsden noted that the Board needed to hear stories like this one to really consider how different pressures in the Trust can affect a patient's treatment during their time in hospital. N Marsden asked L Wilkinson what key areas of learning had been shared across the Trust. L Wilkinson explained that the daughter has worked closely with the Trust to tell the story of the care her mum received as a patient. The story is used as part of training and really urges members of staff to listen to the patient's families, as too often their concerns might be dismissed yet they know the patient best.
- C Charles-Barks thanked the daughter for her continued work with the Trust and noted the benefits of feedback from family members.
- T Baker noted that the story highlighted the fact that the

daughter had not been listened to and at times this was due to busy staff who were already under pressure. T Baker asked if it was clear to families to raise their concerns to PALS if they feel they are not being listened to. L Wilkinson explained that process of reporting concerns to PALS is encouraged and the escalation process has got better.

- M Von Bertele noted the attitude of the doctors described in the presentation by the daughter. M Von Bertele noted that once an attitude is embedded amongst doctors, it is very hard to change.
- C Blanshard noted that what sometimes happens is if patients are moved to different wards during their stay, the doctors that initially meet them take their symptoms and behaviour at face value. What has been discussed with medical teams is the necessity to find out a patient's normal behavior before making assumptions on what you encounter on the day.

TB1 – 01/08/1.2 Apologies

Apologies were received from:

- Paul Hargreaves – Director of Organisational Development and People (Glennis Toms in attendance)
- Lisa Thomas – Director of Finance (Mark Ellis in attendance)
- Rachel Credidio – Non-Executive Director

TB1 – 01/08/1.3 Declarations of Interest

Members of the Board were reminded that they have a duty to declare any impairment to being Fit and Proper and of good character as well as to avoid any conflict of interest and to declare any interests arising from the discussion.

No member present declared any such interest or impairment.

TB1 – 01/08/1.4 Minutes of the Public Trust Board meeting held on 4 July 2019

The minutes of the Trust Board meeting held in public were approved as a correct record.

TB1 – 01/08/1.5 Matters Arising and Action Log

TB1 – 06/12/23 & TB1 – 23/05/04 – Clinical Strategy: C Charles-Barks noted that an electronic version of the Clinical Strategy will be completed by the end of August. J McGuinness has met with the designer. Going forward J McGuinness is working with K Humphrey, Associate Director of Strategy, to ensure there are smaller user-friendly options for the Trust's other strategies. Item closed.

TB1 0702/12 & TB1 - 06/06/06- Doctor Safer Staffing Toolkit: C Blanshard noted that medical staffing had been discussed at several forums with several actions arising in relation to weekend HSMR, concerns raised by the Hospital at Night team and the report from the Guardian of Safe Working. C Blanshard summarised the following actions from F&P and CGC and EWC:

- A paper will come to September's CGC meeting in relation to

the review of weekend HSMR. **ACTION: CB**

- A further, broader paper will also come to September's CGC meeting providing assurance that the organisation is safely staffed, particularly at weekends and out of hours. **ACTION: CB**
- A potential staffing gap has been recognised against Royal College of Physicians guidance. A paper outlining options to fill this gap will be coming to September's Workforce Committee. **ACTION: CB**

CB

The Board will have sight of the key highlights and subsequent actions via the committee escalation reports. C Charles-Barks noted that in relation to Royal College guidelines, SFT was a smaller rural hospital and suggested their staffing model may not suit the size of the organisation. C Charles-Barks noted that the Nuffield Trust and NHS Improvement were working with the acute medical team in relation to this.

TB 1- 06/06/10 - LoS/ Model Hospital – A Hyett provided an update and noted that whilst the Model Hospital does not allow consultants to monitor their own individual performance into Length of Stay, there is helpful benchmarking data that would be useful for consultants to review. Item closed.

N Marsden noted that all other actions were either on the agenda or were to come to a future Board meeting.

TB1 – 01/08/1.6 Chairman's Business

N Marsden reported that he had recently attended a system leaders' event chaired by Simon Stevens and Elizabeth Mahoney. The main focus of discussion was about the Long Term Plan and for NHS leaders in the south west to come together to discuss performance across the region. It was clear that performance across the region, in relation to specific KPIs, requires improvement. However, NM noted that SFT did perform very well against the other organisations in the region. NM noted that Simon Steven's two areas of focus are currently capital and workforce.

N Marsden and C Charles-Barks have set up monthly "Take a Break" meetings to get together with non-clinical staff to talk about their perception and experience of working in the Trust. C Charles-Barks noted that people are invited each month and are aligned to people's birthday month so a random selection of staff is invited to each meeting. NM noted what a positive and useful experience the first meeting had been. PK asked how progress against the issues raised would be reported back to those staff. C Charles-Barks explained that feedback from these meetings will link to the weekly newsletter that is emailed to all staff members via the Communications team.

TB1 – 01/08/1.7 Chief Executive's Report

C Charles Barks presented her report and highlighted the following key points:

- The Trust continues to face challenges in managing

emergency pathways. Actions are underway to try and improve patient flow across the hospital and as a result a new initiative 'Ready, Steady, Go" is focused on this and was launched in July. The initiative has already secured at least 50 champions who are taking forward actions. Progress of this initiative will be monitored via the F&P Committee. It is hoped this will also provide the capacity to respond to challenges in the community, particularly as we move into winter.

- The Trust met its Control Total in June 2019, reporting a deficit of £0.6m. This means we will receive a further £1m Provider Sustainability Funding and Financial Recovery Funding for Q1.
- At the most recent Trust induction for new staff Cara noted the large number of new starters, which is positive to see. Of the 60 new starters, 25 are newly recruited nurses from India, who are a really welcome compliment to existing staff.
- The Health and Safety Executive (HSE) recently conducted an inspection of the hospital, with a focus on ED, Maternity, Orthopaedics, Spinal, Theatres and Elderly Care. The feedback from HSE has been largely positive, with a few areas of improvement highlighted. The HSE reported that the Trust is sufficiently controlling the risks arising from violence and aggression and Musculoskeletal disorders. However, more work is required to manage asbestos, a legacy of having WWII buildings. C Charles-Barks noted that the asbestos present in our buildings poses no risk to our patients, volunteers and staff. The issues pointed out by the HSE inspectors relate to the Trust's documentation. C Charles-Barks thanked all those involved in the HSE visit for their hard work and friendly and professional attitude during the inspection.
- A small team from the hospital, including C Charles-Barks recently visited West Suffolk Hospitals, a CQC outstanding rated hospital with a similar rural geographical catchment to SFT. C Charles-Barks noted the importance of taking the time to learn from and to share experiences and best practice with other organisations.
- The recent Armed Forces weekend was an operational success due to months of careful planning and the staff who worked that weekend. The 'real' field hospital that took place on the Trust Green on Sunday was also a great success.
- The newly refurbished simulation suite re-opened in July, which has been funded by Health Education England. The suite provides an immersive training experience, so that hospital staff can train and practice different clinical scenarios in real life conditions, within a safe environment.
- On 8 July the Trust held an annual staff summer BBQ. This is a chance to say thank you to staff for all their hard work throughout the year. The turnout was great and a large number of staff took some time to attend and enjoy the setting of Horatio's Garden. C Charles-Barks extended her thanks to Horatio's garden and to the governors for their support on the day.
- C Charles-Barks provided an STP update and the future

direction of the CCG's consultation. Bath and North East Somerset, Swindon and Wiltshire CCG's are currently working cooperatively as an 'alliance'. They have recently opened a consultation to progress to formal merger. Formal merger is pending the approval of GP practices of which a majority above 50% of voting members is required. Following approval by GP members a formal application for merger will be made to NHSE in September 2019. If the merger is supported the new organisational format will commence from April 2020. Recruitment is currently underway for a Chair for BSW STP. It is expected that a new Chair will be in place by no later than Q4 of this financial year.

- A number of the board members will be attending a workshop on the 8th and 9th August to support the development of the BSW operating plan.
- C Charles-Barks informed the Board of the sad news that Councillor Jerry Wickham had recently passed away. Jerry has been a huge support for the trust in his role as lead for adult social services and more recently as STP chair. He always made a passionate contribution for improving services and will be sadly missed by many of those who worked with him.

TB1 – 01/08/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 – 01/08/2.1 Clinical Governance Committee Report – 23 July 2019

P Miller presented his report, highlighting the key areas of escalation as agreed at the CGC meeting on 23 July. The following key issues were highlighted:

- The committee received the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. The scheme is based around demonstrating the achievement of ten safety actions. If this is signed off the Trust could recover some of the CNST payment. The committee received this evidence and was content to recommend to the Trust Board that all ten safety actions had been completed.
- P Miller noted the Committee had a discussion regarding HSMR which had been discussed earlier under matters arising.
- The Committee received the Board Assurance Framework and Risk Register. After a detailed discussion FMc was provided with a risk narrative that covers the key issues of concern to be escalated to the Board.
- The Gastroenterology Review report was presented and provided assurance that the recently outsourced gastroenterology additional capacity was being appropriately monitored and managed. It was noted that there isn't currently a longer term solution and further work was required to ensure the future sustainability of the service.
- The Committee agreed that it would be reviewing the Trust's Clinical Strategy and this would take place in autumn 2019.

TB1 – 01/08/2.2 Finance and Performance Committee – 23 July 2019

P Miller presented the report, highlighting the key areas of escalation as agreed at the F&P meeting on 23 July. The following key issues were highlighted:

- The ongoing pressures in diagnostics were discussed. The year to date performance is 97.9% against a target of 99%. A concern is the number of staffing and capacity issues that are to be resolved. PM noted that there may be a requirement to discuss balancing the additional cost of further outsourced capacity, against the possible non-achievement of the 99% diagnostic target.
- The Trust is still forecasting achievement of its control total deficit of £8.9m. However key to the achievement of this financial outturn is achieving the Trusts Cost Improvement Programme and successfully managing winter pressures.
- The short term in-year transformation programme, to support the achievement of the 2019/20 financial control total, was behind plan and there was an urgent need to catch up. Just as importantly the medium/long term transformation programme for 2020/21 and beyond was judged to be in need of additional support.
- The Committee received a business case to provide additional endoscopy activity at the weekend to reduce the current backlog to an acceptable level. The cost of the business case is in excess of £600k but so is the income. Following a detailed discussion the Committee agreed to recommend this business case to the Board for approval.
  Decision: N Marsden noted that the business case had been included in the Board meeting papers and asked if they agreed to approve. The Board approved the business case.

TB1 – 01/08/2.3 Audit Committee Report – 18 July 2019

P Kemp presented the report, highlighting the key areas of escalation as agreed at the Audit Committee on 18 July. PK noted that the two key issues raised at the meeting were items on the Board agenda.

P Kemp did raise the issue relating to petty cash and cash theft cases that have been reported. This has highlighted gaps in control processes which Finance are now addressing. AH highlighted that not all of these reported thefts have been related to staff members.

TB1 – 01/08/2.4 Workforce Committee Report – 25 July 2019

M Von-Bertele presented his report, highlighting the key areas of escalation as agreed at the Workforce Committee meeting on 25 July. The following key issues were highlighted:

- The Committee discussed several risks relating to recruitment of staff and junior staffing in a number of areas. It was agreed that these should be combined into a broader risk relating to medical workforce.

- The Committee recommended approval of the Medical Revalidation and Appraisal Annual Report.
- The Committee received the Health and Safety Annual Report and the Health and Safety Executive inspection update - an action plan is due to come to the next meeting in September.
- The WDES (Workforce Disability Equality Standard) and WRES (Workforce Race Equality Service) reports were received. The reported data highlighted a diverse workforce but it was noted that the statistics are masking the complexity of work that is required to manage this workforce. Further work is required. Due to the format of the data presented M Von-Bertele noted that E Provins had reviewed the data after the meeting and confirmed it was satisfactory to submit.
- It was proposed that the Workforce Committee meet 9 times a year, similarly to the Clinical Governance Committee.

Discussion:

- AH noted that the meeting wasn't quorate and going forward a minimum of two NEDs would be in attendance.

TB1 – 01/08/2.5 Integrated Performance Report

L Wilkinson presented the Integrated Performance Report which provided the Board with the latest performance information and improvement actions across the Trust's strategic priorities. The following key points were highlighted:

- The newly revised IPR is still work in progress and there is a working group with key subject leads to ensure the correct and most appropriate data is going into the report. The progress this month is largely related to better analysis and action planning across Trust Directorates, based on service level interpretation of data and agreement of mitigating actions. The next step is rolling the structure of the report out to the Committees to ensure everyone is using the same data.
- At the end of June ED performance was 91.8% against a trajectory of 92.4%. Performance is being affected largely by higher attendances at peak periods throughout the day, affecting patient flow.
- The Trust is achieving the 92% Referral to Treatment (RTT) target and some specialities that have been struggling have shown improvement in performance in the last few months.
- The Trust met 6 out of 8 cancer standards in June and achievements of all standards in Q1 with the exception of the 62 day standard.
- The Trust failed to deliver the diagnostic waiting time standard for a third consecutive month with the key challenges in Endoscopy and Radiology.
- The Control Total was met in June, reporting a deficit of £0.6m. The £1m PSF and FRF are now achieved and payment will be received in Q2.

Discussion:

- PK noted the importance of embedding the IPR structure

throughout the Trust but asked how much resource is required to set systems up to provide the correct analysis. C Charles-Barks noted the shift in analysis and explained that there is a working group to help work through the processes and help us to understand the gap in resources.

- P Kemp noted that the DTOC information within the IPR contradicted the figures that had been reported at F&P. A Hyett explained that the figures that go to F&P are a snapshot in month, whereas the data reported to the Trust Board is an average in month. P Kemp noted that this is providing the Board with data that could be misinterpreted and that an average over the month would be a more useful indicator than a snapshot. C Charles-Barks suggested that both indicators provide useful information and asked A Hyett to record them both and triangulate in the next report. **ACTION: AH** **AH**
- C Charles-Barks queried the number of discharges before midday as this had plateaued. A Hyett noted that the Trust had launched a new initiative called Ready, Steady, Go which is a refresh of the Patient Flow Programme. Three working groups now exist with the Directorate Manager for Medicine leading. There are currently 41 initial work streams and ideas identified by groups as possible improvement ideas to take forward, with each working group having a clinical lead. A Hyett noted that the weekly Discharge PTL meeting was still underway which focused on those with a long stay who were waiting to be discharged and those who do not have a planned discharge date. P Miller referred back to the patient story and noted the importance of listening and including families when it comes to discharge plans.
- P Miller noted the fall in pressure ulcers in June compared to the spike in May and asked if this was expected. L Wilkinson noted that it wasn't expected due to the changes in how pressure ulcers are nationally reported. L Wilkinson explained that work is being planned by AMU to improve capture of skin assessment with the first admission documentation.
- C Charles Barks asked what had been the outcome of the visit from NHS England and NHS Improvement in relation to same sex accommodation. L Wilkinson noted that they were satisfied with how the Trust are managing same sex breaches and are assured by the rationale used and the Standard Operating Procedures (SOPs) in place. It was noted that the Trust are still waiting a formal response from their visit.
- C Blanshard noted that weekend HSMR was still reporting as unusually higher at the weekend than in the week. This will be addressed in the paper coming to September's committees.

TB1 – 01/08/3 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 – 01/08/3.1 Standing Financial Instructions

M Ellis presented the report, asking the Board to approve the proposed amendments to the SFIs, including changes to the delegated limits set out and updated text to accurately reflect the current decision structure of the organisation.

Discussion:

- P Kemp reported that the SFIs had been discussed at length at the Audit Committee and had been recommended to the Board for approval.

Decision:

- The Board approved the revised SFIs.

TB1 – 01/08/3.2 Collaborative Procurement Approval

M Ellis presented the report which recommended approval to change the SFIs to give F&P full power in approving procurement contract awards above £500k, rather than going to the Board as a secondary step and potentially holding up the procurement contract award process.

Discussion:

- M Ellis noted that this paper had gone to F&P to propose the SFI's were updated to reflect the change in approving procurement contract awards. As the amended SFIs had received Board approval, this paper was to note.

TB1 – 01/08/4 WORKFORCE

TB1 – 01/08/4.1 Nursing Skill Mix Review

L Wilkinson presented the report to provide assurance on nursing and midwifery workforce risks and actions and to provide an update on the impact of investment from the 2018 full skill mix review. The following key points were noted:

- The biggest risk in sustaining staffing levels is recruitment and retention. Ongoing initiatives have started to impact on vacancy levels and reduce the reliance on temporary staffing. Nurse recruitment and retention is a specific focus in the recently published Interim People Plan with opportunities identified for bringing new staff into the NHS.
- The Safer Nursing Care Tool will be rolled out across the Trust to ensure future skill mix reviews will have fully evidence-based staffing data as a triangulation point.
- There has been a change in reporting planned vs actual nursing hours to planned vs Care Hours per Patient Day (CHPPD) in line with national reporting requirements.

Discussion:

- J Reid asked if nursing students are set to increase does the Trust have enough supervisors. L Wilkinson noted that NMC standards have changed to broaden those who can supervise student nurses, therefore yes.

TB1 – 01/08/4.2 Guardian of Safe Working Annual Report (GoSW)

J Barker joined the committee to present the GoSW annual report on rota gaps and vacancies. The following key points were highlighted:

- Approximately 45% of our doctor shortfall is filled with trust grade doctors, but even with full rotas the workload is excessive and patient and doctor safety is potentially compromised.
- There are significant junior staffing issues in this trust. We are >10 WTE doctors short even after backfilling with trust grades doctors. The actual shortfall is much higher: about 18 WTE which is approximately10% of posts. This is probably still not enough doctors to do the job, even if all deanery allocated posts are full. At least 97 whole time equivalent months have been filled with trust grade doctors.
- J Barker notified the Board that she is unable to currently assure the Board that staffing in this Trust is adequate and this has been raised at the Workforce Committee. The Board noted that, as discussed under matters arising, several papers on medical staffing were coming to September's CGC/F&P and EWC meetings.

Discussion:

- The Board noted that further to the new junior doctor contract in 2016, further changes were impending which could have implications on being able to fill gaps with Trust locums.
- C Blanshard highlighted that whilst all the deanery FY1 posts are filled, they are the group with the highest numbers of exception reports. This suggests that there are still not enough FY1s to manage the workload.
- P Kemp asked how the Trust is managing cover in the absence of a suitable longer term plan and if there was any assurance that the Trust was providing a safe service. C Blanshard noted that the Trust's patient safety metrics and quality assurance processes provided the assurance that the Trust continued to deliver a safe service. There is a national issue of insufficient numbers of trainees and the retention of junior doctors. C Blanshard explained the current problem with retaining trainees after their FY2 year. A number of methods are used to cover the middle grade gaps caused by this but a longer term solution is required. C Charles-Barks asked what the trainees move on to do if they don't stay in the training programme. C Blanshard explained that some work overseas, some move into non-trainee posts and around 10-12% leave medicine altogether. C Blanshard reported that as part of the GMC National Survey, no immediate safety concerns were reported. J Barker noted that the issues highlighted in relation to FY2 out of hours supervision in the GMC National Survey largely related to 2 weekends, one when the bleep service was down and the other was when AMU flooded. Apart from these exceptional circumstances, no other immediate issues had been raised by staff. T Baker thanked J Barker for providing this context and asked for the wider context to be included on the front sheet of the report going forward. **ACTION: CB** **CB**
- C Blanshard noted that there is an issue of well-being for medical staff if they feel like they are working too many hours

to make up for gaps caused by vacancies. J Barker noted that the junior doctor breakfast and junior doctor forum attendance had increased and provided an opportunity for members of staff to meet each other and raise concerns. The feedback from staff highlights that the junior doctor rotas are not perfect and more staff are required.

- M Von-Bertele reminded the Board that the doctors were not only working in the Trust to provide a service to the population but SFT is also meant to deliver a certain level of training to junior doctors and maintain its reputation as providing a good training experience for medical staff.
- Paul Miller thanked J Barker for her exemplary work as Guardian of Safe Working.

TB1 – 01/08/5 GOVERNANCE

TB1 – 01/08/5.1 Board Evaluation Process

F McNeight presented the report which asked the Board to approve the recommended process for a Board Effectiveness Evaluation throughout August and September 2019. F McNeight noted that the following pieces of work inform the evaluation process:

- Facilitated 360° Review
- Board Member Questionnaire
- Board member self-assessment against the Good Governance Maturity Matrix
- Annual Report 2018/19 Overview of Performance
- Review of Board Papers.

Decision:
The Board agreed the process and content of the Board Effectiveness Evaluation.

TB1 – 01/08/5.2 Register of Seals

F McNeight presented the report which noted the entries of the Trust's Register of Seals since April 2019. It was noted that none of the signatories who had witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

Decision:
The Board approved the report.

TB1 – 01/08/5.3 Board Assurance Framework and Corporate Risk Register

F McNeight presented the report providing the Board with a refreshed BAF following the setting of new corporate objectives for 2019/20. F McNeight reported that the revised BAF had been to CGC, F&P and the Workforce Committee which has informed the summary narrative in the report.

Discussion:

- The Board noted that the risk summary correlated to the discussions that had already taken place in the meeting.
- L Wilkinson noted that the Corporate Risk Register (CRR) tracker was useful as a one page visual of risks for the organisation, particularly to highlight up and coming risks
- C Charles-Barks noted that the Board Committees should have time to consider those risks and in relation to horizon scanning, escalate these to the Board as potential future risks with the associated mitigating actions.
- JR queried the deadlines for some of the actions as several were RAG rated red for subsequent months without any indication of improvement. F McNeight explained that this is where the Committees and Board should be challenging itself and asking what has been done since the action appeared on the register. It is hoped with the newly revised BAF and increased scrutiny from Committees, better assurance can be provided that gaps in control and the associated actions are bring worked on.

TB1 – 01/08/6 APPROVAL

TB1 – 01/08/6.1 Business Case for Insourced Weekend Endoscopy Lists

The Board noted that this had been discussed as part of the F&P escalation report and had been approved.

TB1 – 01/08/7 CLOSING BUSINESS

TB1 – 01/08/7.1 Agreement of Principle Actions and Items for Escalation

N Marsden noted that the key items to note had been:

- The issues surrounding workforce and the subsequent actions relating to these.
- The requirement for the IPR format to infiltrate the Board committees to ensure everyone is receiving the same information in a consistent format.

TB1 – 01/08/7.2 Any Other Business

There were no other items of business.

TB1 – 01/08/7.3 Public Questions

There were no questions raised by the public.

TB1 – 01/08/7.4 Date of Next Meeting

Thursday 5 September 2019, 10:00 am, The Board Room, Salisbury District Hospital

TB1 – 01/08/8 RESOLUTION

Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

List of action items Trust Board Public 1 August 2019

Agenda item		Assigned to	Deadline	Status
1.4 Matters Arising and Action Log				
18.	Medical Workforce Incl. Weekend HSMR, Hospital at Night Team and GoSW	Blanshard, Christine	24/09/2019	Pending
	Explanation action item A paper will come to September's CGC meeting in relation to the review of weekend HSMR. A further, broader paper will also come to September's CGC meeting providing assurance that the organisation is safely staffed, particularly at weekends and out of hours. A potential staffing gap has been recognised against Royal College of Physicians guidance. A paper outlining options to fill this gap will be coming to September's Workforce Committee.			
2.5 Integrated Performance Report				
19.	Delayed Transfers of Care (DTOC) Data	Hyett, Andy	05/09/2019	Pending
	Explanation action item C Charles-Barks suggested that both indicators (snap shot in month and average in month) provide useful information and asked A Hyett to record them both and triangulate in the next report			
4.2 Guardian Safe Working Annual Report				
20.	Guardian of Safe Working Report	Blanshard, Christine	26/09/2019	Pending
	Explanation action item The Guardian of Safe Working report cover sheet to provide a wider context to support the content of the report.			

Register of Attendance – Public Board 2019/20

	4 April	23 May	6 June	4 July	1 August	5 September	3 October	7 November	5 December	January	February	March	% attendance rate
Nick Marsden	✓	✓	✓	✓	✓								100%
Tania Baker	✓	✓	✓	✓	✓								100%
Michael von Bertele	✓	X	✓	✓	✓								80%
Paul Kemp	✓	✓	✓	✓	✓								100%
Jane Reid	X[1]	X[1]	X[1]	X[1]	✓								20%
Rachel Credidio	✓	✓	✓	X	X								60%
Paul Miller	✓	✓	✓	✓	✓								100%
Cara Charles-Barks	✓	✓	✓	X	✓								80%
Christine Blanshard	✓	✓	X	✓	✓								80%
Lisa Thomas	✓	✓	✓	✓	X								80%
Andy Hyett	✓	X	✓	X	✓								60%
Lorna Wilkinson	✓	✓	✓	✓	✓								100%
Paul Hargreaves	✓	X	✓	X[1]	X								40%

Attended - ✓

Apologies – X

X[1] – authorised absence

Report to:	Trust Board (Public)	**Agenda item:**	**1.8**
Date of Meeting:	5 September 2019		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:				
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	None			

Recommendation:
None

Executive Summary:
This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: • **Performance –** update on current performance • **Finance –** update on our financial recovery plan • **Transformation** • **Annual General Meeting** • **Unveiling of new pharmacy robot**

Performance

Historically, July is a busy month for the hospital and this July was no different with 29 of the 31 days in July exceeding 130 attendances (the average attendances in a 'normal' day within ED). We failed to achieve our four hour wait target achieving 90.5%, against a trajectory of 95%. The Trust continued to provide good quality, safe care and had no cases of MRSA. There were three case of C.difficile in July; changes in reporting of cases, in line with national guidance, has shown an increase in the number of Trust apportioned cases, due to the inclusion of community onset healthcare associated cases in our figures.

Finance

The Trust fell short of our NHS control total in July, reporting a deficit of £0.4m when a modest surplus had been planned. As a consequent the Trust has not been able to recognise £0.5m of Provider in Sustainability Funding and Financial Recovery Funding. As this was the first month in the quarter, the Trust has August and September to recover the financial shortfall. Efforts are being made to improve the financial position, both in the short and longer term, with particular focus on the booking of theatre lists, patient flow through the hospital (Ready-Steady-Go), and the outpatient transformation project.

Workforce

Recruitment remains an ongoing challenge; there were 46 new starters, 17 of these are international nurses. However, the numbers of nurses leaving the Trust has slowed and, thus, the number of vacancies has reduced.

The Trust's overall sickness absence rate is 3.9%, which above the 3% target. This is a slight increase on last month's figure of 3.73%, with an increase in short term absences during July. We are working with ward managers to understand the spike in sickness in Medicine and support them in building resilience in the teams.

In July, as in previous months, the Trust has prepared for the UK's exit from the EU; 54 of our EU nationals staff are nurses, 45 are Estates and Ancillary, 35 are support to Nurses and AHPs, 21 are Doctors, 6 are AHPs and the rest are Scientific, Technical and Administrative staff. These figures have not changed significantly over the last year. The Trust has promoted the settled status application process and appropriately assisted staff with their settled status applications.

Transformation

The NHS long term plan is clear; as medicine advances, health needs change and society develops the NHS has to continually move forward so that in 10 years' time we have a service fit for the future. To ensure our services meet our patients needs now and in the future, the Trust is changing its approach to improvement. This means a cultural shift away from a top-down hierarchy to an environment where leaders set direction and empower staff to take action.

During September and October 2019 the Trust will be focusing on improvement with our staff, sharing some of the work taking place in outpatients, for example, and equipping staff with the tools they need to take action. Preparation for this took place in July.

Quality Improvement

The Quality Improvement Strategy is picking up pace with the tender for the provision of QI training going to selected organisations on Friday 23rd August, with the deadline for bid submissions on 18 September. This follows work in July to secure funding for training by Health Education England.

Annual General Meeting

On 30 September, the Trust will hold the Annual General Meeting for our membership and the local community. The AGM will cover the Trust's performance in 2018/19, our plans for 2019/20, and what we aim to achieve in the future. It provides the Board with a valuable opportunity to hear comments and answer any questions. There will be presentations by staff, giving AGM guests the opportunity to hear about some of the services the hospital provides direct from clinical experts. The AGM starts at 5pm on 30 September, at the Arts Centre, Salisbury.

Unveiling of new pharmacy robot

I was delighted to attend the unveiling ceremony of the pharmacy's new purpose built pharmacy dispensing robot The purpose built Rowa Vmax robot automatically stores and locates over 25,000 medicines and can dispense up to three items within 12 seconds. Added benefits include an automatic loading platform, a ward stock dispensing system and 3D barcode readers. By cutting down the amount of time pharmacy staff spend looking for medicines, this allows staff to spend more time on direct patient care and improve safety across the Trust. Following a short internal competition, the Pharmacy Team named the Robot 'Kryten' after the android from television sitcom *Red Dwarf* – welcome to the team Kryten!

Cara Charles-Barks
Chief Executive

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	05 September 2019		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Kieran Humphrey, Associate Director of Strategy Felicity Anscombe, Information Services Manager			
Executive Sponsor (presenting):	Paul Hargreaves, Director of OD and People			
Appendices (list if applicable):				

Recommendation:
The Board is requested to note the report and highlight any areas of performance where further information or assurance is required.

Executive Summary:
The Integrated Performance Report consolidates the latest performance information and improvement actions across the Trust's strategic priorities. The structure of the report is aligned with the Trust's key strategic priorities and their related (CQC based) assessment frameworks. The progress made this month in the development of the report includes a greater focus on analysis and action planning from across Trust directorates, based on a service level interpretation of data and agreement of mitigating actions. Teams are focussed on the roll out of the Integrated Performance Report format to the reporting to Board Committees and other meetings of the Trust where performance is considered. The Trust is performing positively against a number of indicators, continuing to meet the Referral to Treatment standard and the majority of Cancer diagnosis and treatment standards. Where specific action is required or risks have been identified that may affect future performance, these are set out in the commentary and analysis in the report. For key constitutional performance against the Emergency Access (4hr) and Diagnostic Standards and the Trust has mitigation actions in place to address this. Effective patient

flow and discharge remains a challenge for the Trust and wider system to address.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

September 2019

(data for July 2019)

An outstanding experience for every patient

Executive Summary

The Integrated Performance Report highlights key themes and issues across the organisation, attempting to make links between the various aspects of the Trust's business. As such it brings together themes from the: performance, quality, workforce and finance reports and seeks to set out the interlinking issues and plans to move forward the challenges faced.

Key messages – July Month 4

Overall in July activity levels were steady, they were higher than the same period last year, however were below planned levels for 2019/20. The metrics across performance and quality reflect capacity within the Trust as Delayed Transfers of Care increased in month, however bed occupancy remained at a broadly consistent level and escalation bed days were comparably low. The bed occupancy levels also reflect in the low number of non clinical breaches for mixed sex accommodation in month.

The capacity within the hospital also reflected positive workforce metrics, with no wards flagging for unfilled hours, and whilst agency spend has increased this is aligned to specific consultant posts covering vacant posts. Whilst C. Difficile rates show an increase, this reflects the change in national reporting rather than a deterioration in underlying performance.

Planned care was below expected levels, RTT performance is strong overall with some areas of specific risks outlined in the report, but income was lower than expected, which contributed to the poor financial performance in month. Whilst overall the quality and performance metrics are positive the consequence of lower activity levels on productivity and therefore the income position overall shows a disappointing financial result for month 4 .

The main risks to the Trust performance metrics as reflected in the report, include:

- Achievement of the diagnostic standard (DM01), with particular challenges in Endoscopy, whilst mitigations are in place this remains a key focus for the Executive Team.
- Weekend HSMR has increased for the 7th month (based on 12 month rolling average) detailed work is ongoing and due to present at Clinical Governance Committee in September.
- The ability to achieve the Financial plan for the year, particularly the lower than planned productivity levels in elective and day case activity, alongside lower levels of non elective activity. Recovery plans are place, and monitoring ongoing.

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NHS Foundation Trust

Structure of Report

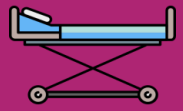
Performance against our Strategic and Enabling Objectives

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance – July 2019

Salisbury NHS Foundation Trust

There were **2,808** Non-Elective Admissions to the Trust



We provided care for a population of approximately **270,000**

17% of discharges were completed before 12:00

We delivered **22,976** outpatient attendances

RTT 18 Week Performance: **92.4%**

Total Waiting List: **17,978** ↑

Emergency (4hr) Performance **90.5%** ↓

(Target trajectory: 89.5%)

We met **4 out of 8** Cancer treatment standards

98.7% of patients received a diagnostic test within **6 weeks**

1,246 Patients arrived by Ambulance

We carried out **491** Elective Procedures & **2,391** Daycases

Our clinical income was **£69,571k** (£674k under plan)

Our overall vacancy rate was **6.22%** ↓

Reading a Statistical Process Control (SPC) Chart

The two dotted grey lines represent the boundaries of "normal"

There should always be a minimum of 24 months worth of data

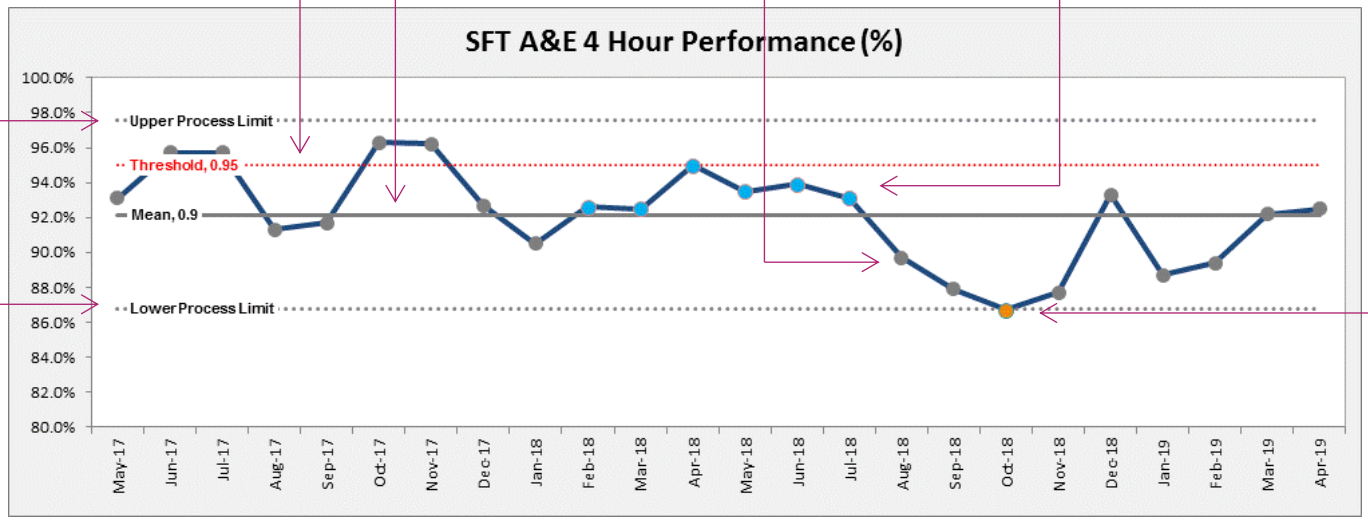
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 7 or more points above the Mean or one point greater than the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 7 or more points below the Mean or one point less than the lower limit



Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (7 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

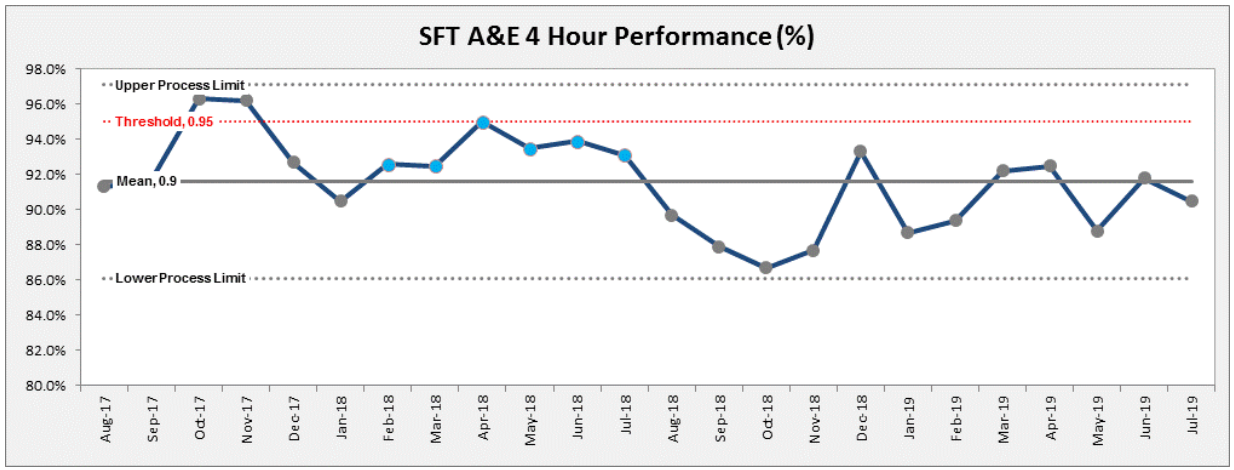
Salisbury NHS Foundation Trust

Part 1: Operational Performance

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Emergency Access (4hr) Standard Target 95% / Trajectory 89.5%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	90.5% (target 89.5%)
Attendances:	6544
12 Hour Breaches:	0
ED Conversion Rate:	25.1%

Background, what the data is telling us, and underlying issues

July has been the busiest month for attendances in 9 of the last 11 years. It is historically always higher in terms of attendances than June and, this year, saw a record day for attendances reaching 192 on the 14th of the month (Sunday). The average number of attendances within ED is 130.

29 of the 31 days in July exceeded 130 attendances.

Improvement actions planned, timescales, and when improvements will be seen

The Department has planned ahead for the remainder of the summer rotas with regards to annual leave and junior doctor rotation with any cover issues are escalated early. All Consultant gaps for M5 are covered. September rota will be more manageable once a heightened period of annual leave is concluded.

Nurse vacancies reduced to 4.19WTE from M3 (5.88WTE vacancies). This includes 2 WTE OSCE Nurses working at Band 4 level who will complete in Month 8. Recruitment advertising continues .

Dr Simon Hunter, ED deputy clinical lead has agreed to head up the "Ready" Group of Patient Flow Programme which will pick up actions from the ED action plan. Using his extensive experience and knowledge he will be redefining emergency pathways, linking closely with specialty teams, adapting the function of SSEU and maximising efficiency within the daily Consultant roles and responsibilities.

Risks to delivery and mitigations

Leadership priorities will be to focus on department morale and ensuring appropriate training, development and mentorship of new and existing staff.

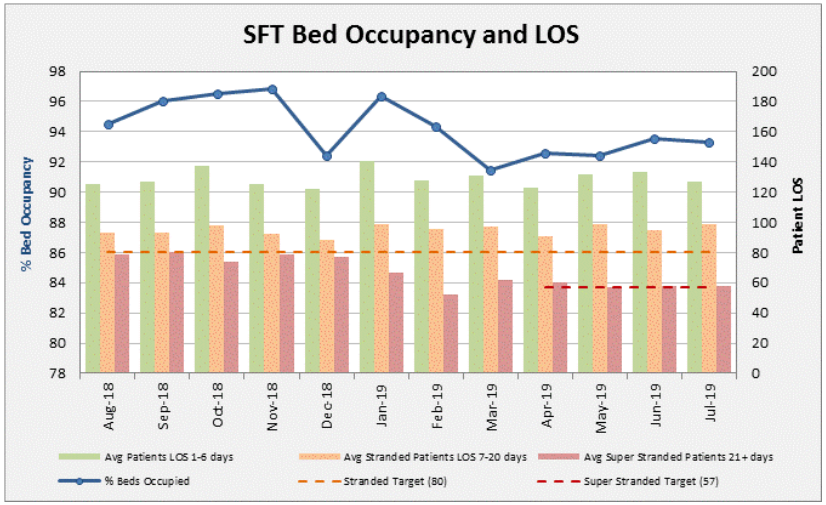
The impact of the military repatriation and difficulties following closure of Cross Plains Surgery has been assessed and will be monitored over the coming months.

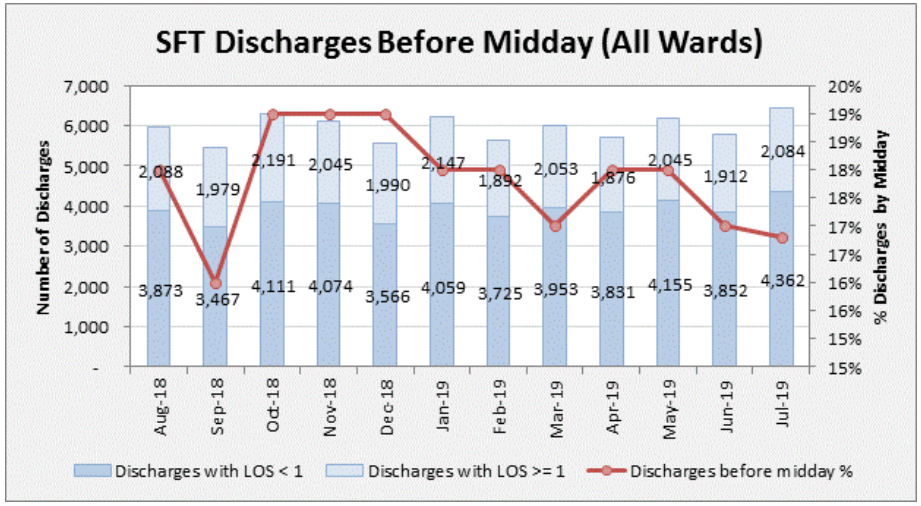
Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (7 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Patient Flow and Discharge

Are We Effective?





Background, what the data is telling us, and underlying issues

The data shows steady performance for super stranded LOS delivering the target set by NHSI for SFT. However the group of patients at 14–20 days remains steady above target despite bed occupancy reducing. This suggests that the bed days released by the improvement in super stranded performance has contributed to a positive impact on bed occupancy, but that there is further work to do in the 14-20 days group.

Discharges before midday remain a challenge at SFT and July has seen a dip in performance against the target. There have been infection control restrictions in place on some wards, which may have influenced timings of assessments of Allied Health Professionals (AHP) interventions, ward rounds and support services fulfilling discharge requirements.

Improvement actions planned

- The Expert panel now looks at all patients with a stay of 21 days+ regardless of medical fitness, giving the opportunity to clarify discharge plans earlier than previously.
- Consideration will now be given to the group 14-20 days for inclusion at expert panel to initiate impact on this number.
- The Trust is required to submit weekly a DPTL (discharge patient tracking list) coding all the patients 21+ days with a reason for their continued stay and next steps. This informs both internal and external areas of focus for teams.
- The DPTL is shared with wards and discharge teams to continue work agreed at panel.
- Advanced Nurse Practitioners have been employed in AMU, which is anticipated to support the early flow from the front door.
- The patient flow programme 'Ready Steady Go' has identified multiple areas of required improvements that is led by clinicians, and includes ward rounds, use of IT, whiteboards, communication.
- There are varying dates for completing phases and further information is available separately

Risks to delivery and mitigations

- Further infection control issues causing ward or area closure would continue to put the 12.00 target at risk.
- The ability of support services e.g. pharmacy, transport and pathology, to support a 12.00 discharge is a challenge. The ability to plan these interventions earlier would raise the question of discharge the day before,
- SFT is not yet in receipt of national data or analysis from NHSI to support future planning in this area,
- There is a large number of 14-20 days patients and it will be difficult to deliver a review of all these patients at expert panel with the time restraints currently in place,
- Ready Steady Go has identified many areas of improvement and the programme is new for July. It will be difficult to clearly identify the impact of any individual ,

Delayed Transfer of Care (DToC) Bed Days

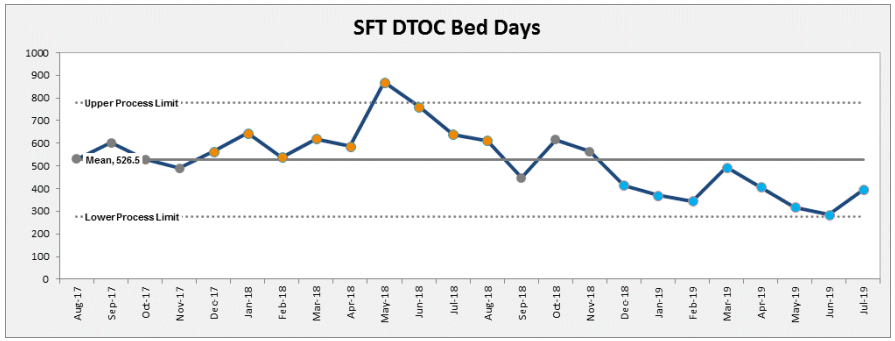
National Key Performance Indicators

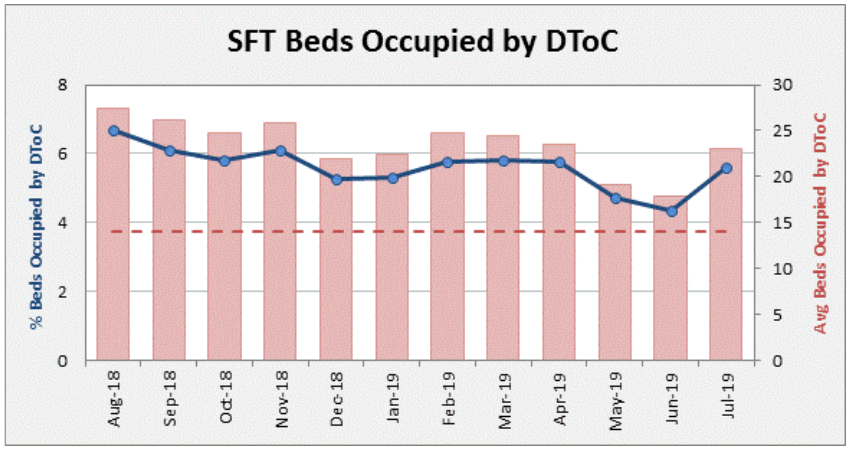
Performance Latest Month:

Data Quality Rating:

Days Lost to DToC: 153 NHS + 239 SS

DToC Patients (last Thursday of month snapshot): 21





Background, what the data is telling us, and underlying issues

The overall trend is downwards, however July saw a spike in DTOC numbers. Contributing factors to this position include commencement of the school summer holidays and its impact on care availability from both family informal support and formal from agencies and organisations. Fast track CHC processes in the hospital have been streamlined and our rate of referral has increased so this may have increased demand on domiciliary care services. Choice issues also impacted on the days delayed and although managed, the 3 cases coded contributed to 30 days in the month. July saw the demand for Care home placements in Wiltshire rise and funding process and capacity have both been the source of delays.

Improvement Action Planned

- Recruitment is underway for 3 WTE rehabilitation assistants to provide flexibility and capacity across acute and community rapid discharge services. Due for completion September 19.
- IDB review includes reporting, role development and referral processes that will ensure improved coordination and transparency of case management. Due for completion September 19.
- The results and recommendations from a choice audit undertaken in June are awaited and an action plan will follow to address any areas identified from this. Expected August 19
- The Fast Track CHC working group includes colleagues from Wiltshire CCG who understand that there would be potentially increased demand and SFT will ask them to consider their response to this when data is shared at the September meeting.

Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

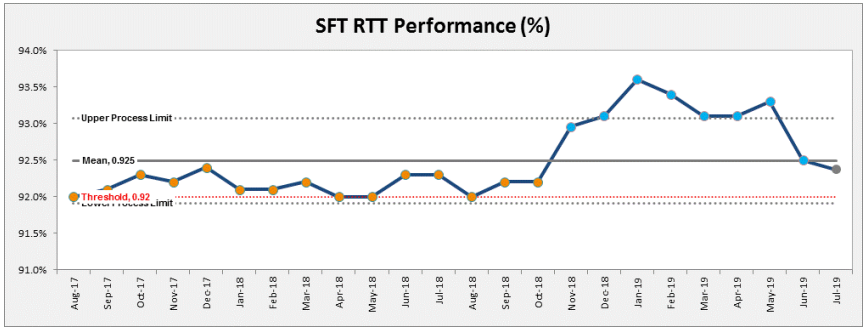
Total WL	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Dorset CCG (11J)	2,505	2,480	2,460	2,424	2,459	2,537	2,588	2,650	2,762	2,760	2,771	2,832	2,845	2,871
West Hampshire CCG (11A)	1,626	1,583	1,574	1,565	1,620	1,639	1,666	1,628	1,696	1,748	1,638	1,667	1,690	1,743
Wiltshire CCG (99N)	10,577	10,481	10,616	10,335	10,343	10,441	10,192	10,384	10,500	10,328	10,540	10,478	10,718	10,630
Other CCGs	3,138	3,135	3,016	2,989	2,834	2,526	2,411	2,180	2,105	2,113	2,083	2,323	2,498	2,732
Trust Total	**17,846**	**17,679**	**17,666**	**17,313**	**17,256**	**17,143**	**16,857**	**16,842**	**17,063**	**16,949**	**17,032**	**17,300**	**17,751**	**17,976**

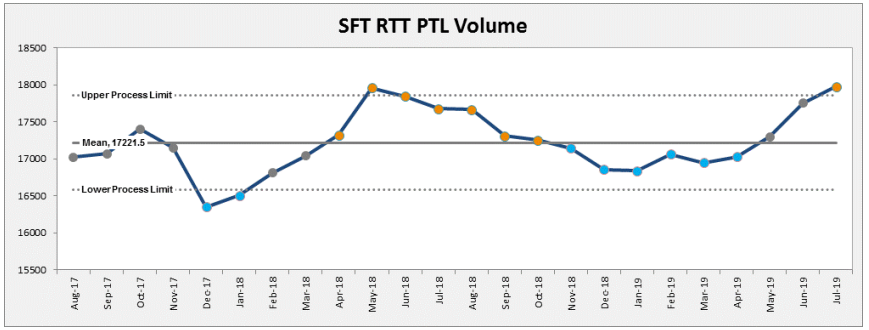
Data Quality Rating:

Performance Latest Month: 92.4%

PTL Volume: 17,976

52 Week Breaches: 0





Background, what the data is telling us, and underlying issues

Overall RTT Performance Standard achieved although there are 3 specialties raising concerns:

ENT 89.9%, booking 1st appointment Jan 2020.

Urology 82%, booking 1st appointment Feb 2020.

Dermatology 61.68%, booking 1st appointment July 2020 (52 week breach risk).

The Patient Tracking List (PTL) continues to rise from April 18 with 1st appointment booking delays being a contributory factor. The most significant rise in Others CCG's, which includes NHSE commissioned activity e.g. Military, Prison and other surrounding CCG's.

Improvement actions planned, timescales, and when improvements will be seen

ENT – Continue to move long waiting patients between consultants to reduce waiting times. Re engagement of Associate Specialist starting Sept 19.

Urology – Regular diary meetings with Consultants and Booking Team to fully utilise capacity. Consultant appointed due to commence Feb 20, with consideration to cover interim with a locum.

Dermatology – COO Intensive Support set up to initiate short, medium and long term plans to cope with significant Consultant shortfall and rising referral numbers. A workshop planned for September to review pathways and develop plans for improvement. Dermatology capacity and demand mismatch is a national and regional issue which presents a challenge and opportunity.

PTL – Further analysis of Other CCG's shows the increase is mainly attributed to an increase in Military referrals, so this will need to be triangulated with military repatriation work.

There has also been an unexpected spike of Devon CCG patients which will need to be investigated in greater detail .

Continue managed data cleansing of PTL.

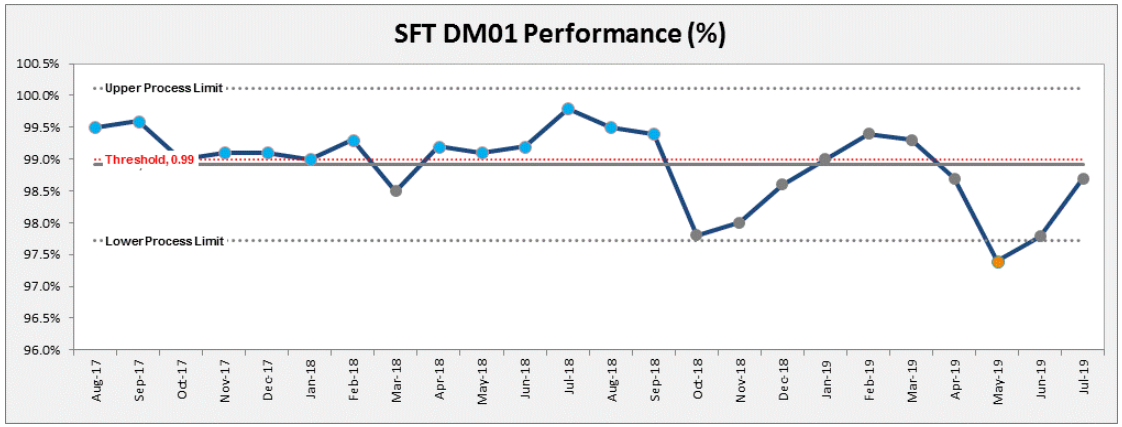
Risks to delivery and mitigations

Referral growth greater than planned and/or referral creep from neighbouring Trusts who have longer waits or have suspended some services. This will be managed through monthly Panned Access and Contract Review Meetings.

HMRC/Pension issues for Consultant workforce are reducing additional capacity across all specialties. Alternative options for managing capacity constraints are being considered on a case by case until national solution is revealed.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	98.7%
Waiting List Volume:	4,302
6 Week Breaches:	56
Diagnostics Performed:	7,907

A deep dive into diagnostics will be presented to the Finance and Performance Committee at the end of September.

Background, actions being taken and risks and mitigations

Endoscopy

34 in-month breaches. Executive approval was obtained to enable outsourcing for a further 2 weekends in endoscopy in July providing an additional 24 lists to allow some mitigation against increased breaches over and above those identified in month.

Maximum capacity in hours continues to be secured by ensuring Monday to Friday lists are fully utilised, with a focus on DNA's and active prevention by phoning patients in advance of appointments. On comparison of last year's figures we have seen a significant improvement of utilisation, for July we saw a 2.3% increase in utilised slot compared with July 2018.

In hours capacity for August remains a concern, and there is an expectation that the DM01 target will not be met for the fifth consecutive month. Executive Intensive Support continues, and a further two weekends in August have been authorised, with these lists being delivered by 18 weeks. Whilst this action will reduce the number of August in-month breaches, and improve recent performance from Endoscopy against DM01, it is not expected to enable the Trust to meet the DM01 target.

The recovery trajectory completed in June 2019 was presented to the July's Finance and Performance meeting and approval and authorisation was given commence the recovery plan. The Board approved funding for a further 15 weekends to support Insourced weekend working, to address the backlogged waiting list and recover performance targets. The procurement process is in the final stages and the contract will be awarded mid-August. The Lead Clinician for the service retired in June 2019, a business case has been approved to retain this role in the service, and the position has now been appointed.

Radiology

22 Radiology breaches

13 CT breaches were the ongoing result of a second breakdown of CT1 that occurred in July. Due to the timing of this, end of month, it was impossible to be able to recover the position fully by the end of month.

8 Ultrasound breaches occurred due to the impact of staff sickness in June and staff vacancies. The service is using agency to support the service and weekend capacity is being maximised.

1 MRI under general anaesthetic breach occurred due to an equipment issue outside of Radiology. The MRI waiting list at the end of July was 583 with the majority of patients waiting less than 6 weeks. The demand remains constant so we continue with the use of the mobile scanner for 3/4 days per week on a regular basis,. This will now continue for the remainder of the financial year. Whilst this is a significant cost, the demand and complexity of patient cohorts require additional capacity to the standard scanner which could not be met as efficiently with ad hoc arrangements.

Ultrasound staffing has become a concern owing to vacancies. A recruitment process continues and the Department are utilising temporary staffing options that are supporting the service during the summer months. Further work is ongoing to mitigate against high volumes of DNA's experienced by the service on behalf of the Admin Team. Staffing in other modalities and at Consultant level continues to be challenging; there has been a significant reduction in clinicians willing to do additional sessions and measures continue to be investigated to improve recruitment and retention of staff. We have recruited a Consultant Radiologist who will start in September.

Radiology Reporting continues to be a challenge to the service, due to additional activity being undertaken to accommodate demand and due to our current provider for outsourcing reporting notifying us that they will be reducing our capacity by 70%. This is being mitigated against by additional sessions of Reporting being undertaken by Trust Consultants, we have secured a Locum Radiologist from mid-August and a Locum Reporting Radiographer one day per week.

Cancer 2 Week Wait Performance Target 90%

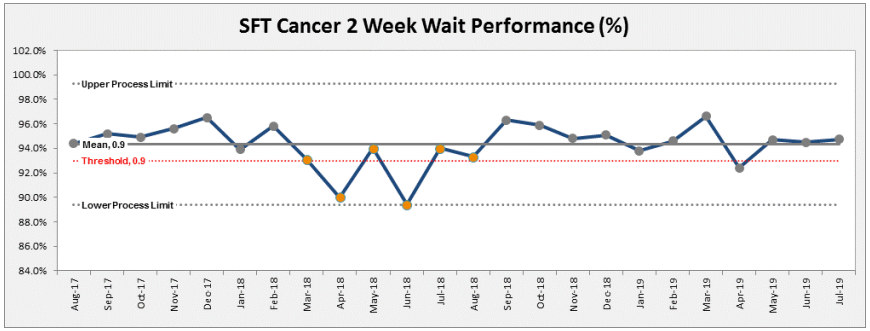
National Key Performance Indicators

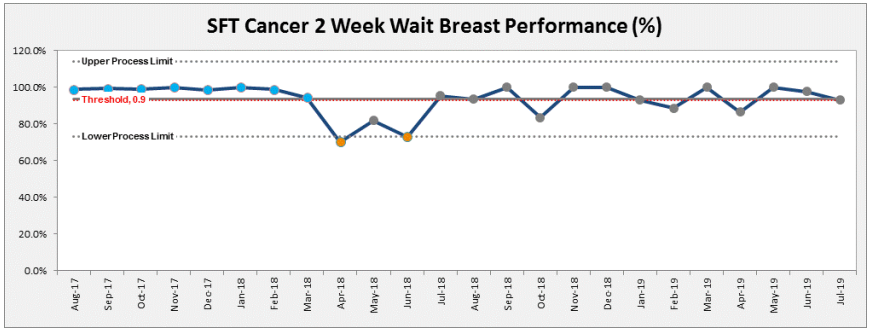
Performance Latest Month:

Data Quality Rating:

Two Week Wait Standard: 94.7%

Two Week Wait Breast Standard: 92.9%





Background, what the data is telling us, and underlying issues

For both standards, there is no significant variation in performance since September 2018.

Improvement actions planned, timescales, and when improvements will be seen

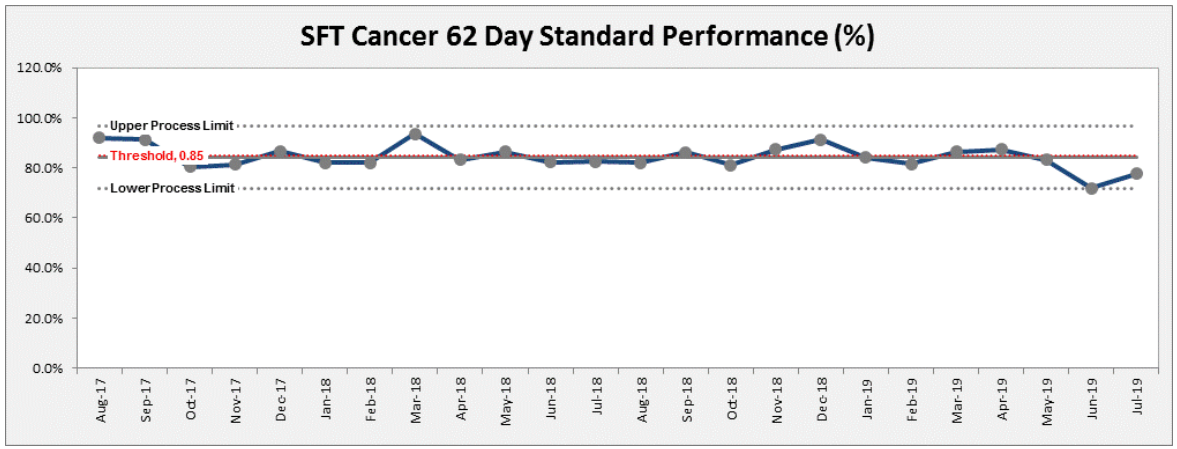
While the Trust is delivering the standard the focus will remain on looking forward to identify any risks that will potentially impact on maintaining performance in the future.

Risks to delivery and mitigations

While the Trust continues to meet the standard, there are some concerns on the current and future consultant staffing levels in Dermatology/Plastics, however recruitment activity is underway to address this. The MSK directorate are undertaking a further demand and capacity plan.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month:

62 Day Standard:	77.7%
62 Day Standard (without shared care):	75.3%
62 Day Screening:	95.7%

Risks to delivery and mitigations

Urology: There are delays at the tertiary centre for robotic treatment, often resulting in up to 12 week waits from decision to treat to treatment. One of the Consultant Urologists from SFT is increasing the number of lists he will be covering at UHS which will help to improve capacity for SFT patients (although it will take some time to reduce waits to within 31 days). The Urology Cancer Clinical Lead is planning a meeting with all Urology Consultants to review the prostate pathway in general to find improvements in time from referral to diagnosis to treatment. The Cancer Services Manager (CSM) is supporting the Clinical Lead with this work.

Endoscopy: The pressures experienced in this service area are described in the commentary for diagnostic waiting times.

Dermatology: Due to limitations within workforce there are ongoing concerns for capacity within Dermatology to meet the cancer demands on the service. Plastics are supporting with additional lists and cover where possible and, to date, there have been no breaches in compliance due to workforce or capacity issues.

Histology: Histology turnaround times have improved in M4 although it is anticipated that these will increase again during future months due to reporting delays in the outsourced service. The Cancer Services Team are providing the Histopathology Team with a weekly list of priority cases for them to expedite and this process is working well in ensuring the necessary results are being reported as quickly as possible, reducing delays in pathways.

Further actions undertaken:

Escalation Policy: The CSM has drafted an escalation policy for use by the MDT Coordinators to ensure there are clear lines of direction for when they should accept or refute delays in a patient's pathway. The escalation policy illustrates who they should escalate to and by when if tests have not been booked, if waiting times are too long or if there is a potential for patients to breach their pathway. This policy will be discussed/approved at Delivery Group before being fully implemented.

Monthly Breach Validation Meeting: The Directorate Manager for Medicine, in conjunction with the rest of the Cancer Leadership Team will be meeting once a month to review previous breaches and ensure reporting is accurate and assurance is in place regarding compliance. This meeting will also take the form of a breach review meeting whereby cause of breach can be identified and, if necessary, learning cascaded to the relevant teams to ensure some delays are not repeated for other patients.

Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (7 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (7 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Stroke & TIA Pathways

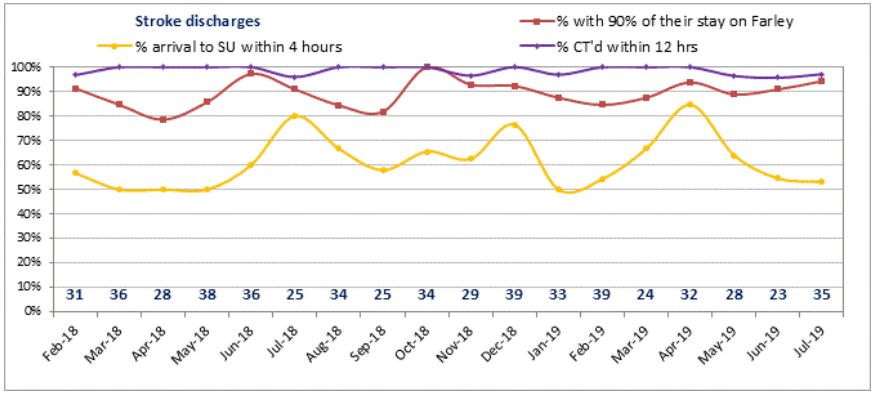
Are We Effective?

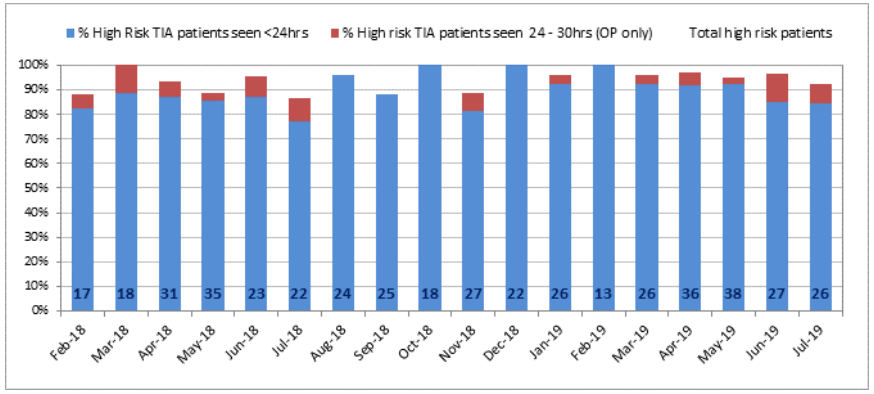
SFT SSNAP Case Ascertainment Audit Score:

Year	Q1	Q2	Q3	Q4
2018-19	B	C	B	B
2019-20				

Data Quality Rating:

% Arrival on SU <4 hours:	53.1%
% CT'd < 12 hours:	97.1%
% High Risk TIA Seen < 24 hours:	84.6%





Background, what the data is telling us, and underlying issues

Time to CT scan within 12 hours achieved for all but 1 patient (CT down time).

Time to reach the Stroke Unit within 4 hours slightly improved, with delays mainly due to first & speciality doctor assessment in ED and waiting for a stroke bed. Performance however, is still relatively good compared to national figures.

Patients spending 90% of their stay in the Stroke Unit continued to exceed the national target of 80%.

Improvement actions planned, timescales, and when improvements will be seen

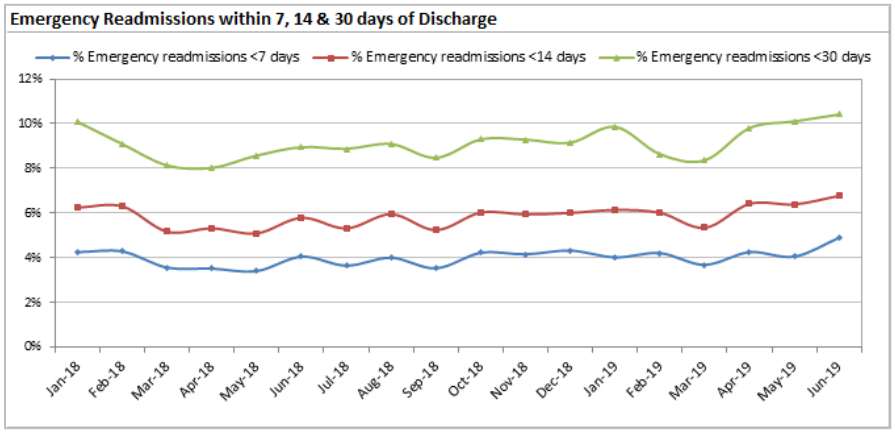
- SSNAP case ascertainment expected to improve and be sustained at 'A' once 2.0 WTE Speech and Language Therapists appointed. This will ensure patients receive the recommended input. Improvements should be seen from Q3 onwards.
- Medicine DMC part of a cross Directorate 'Ready Steady Go' project to improve down stream flow.
- Short term trial of a ANP role on Stroke Unit to assist with time to reach the Stroke Unit within 4 hours.

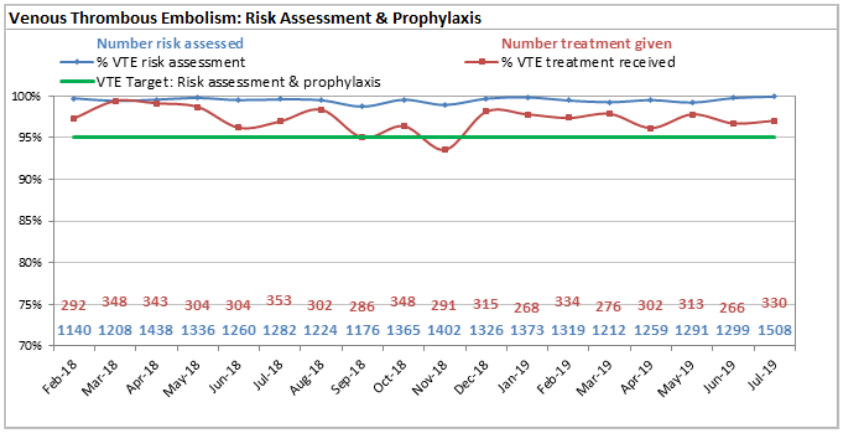
Risks to delivery and mitigations

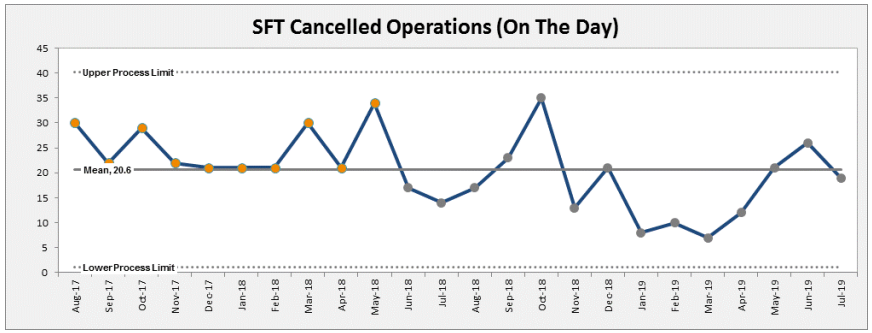
- Potential delay in recruitment of Speech Therapist and embedding new staff in practice. Mitigated by induction and ongoing support.
- Engagement with the 'Ready Steady Go' project group.

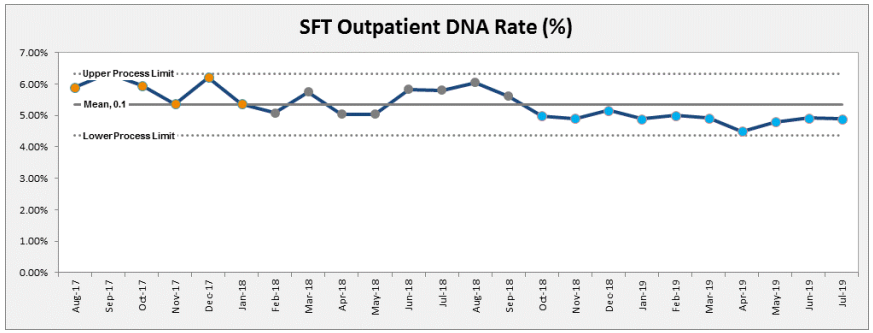
Other Measures

Are We Effective?









Salisbury NHS Foundation Trust

Part 2: Our Care

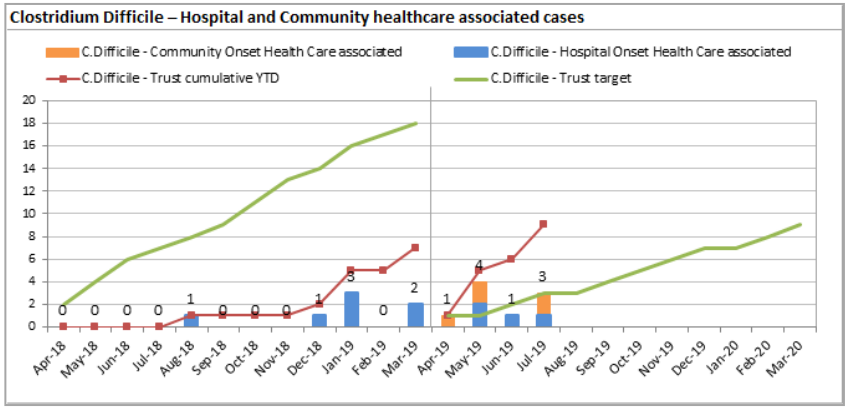
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	**Are We Safe?**	**Are We Caring?**
People	Are We Well Led?	Use of Resources
Resources		

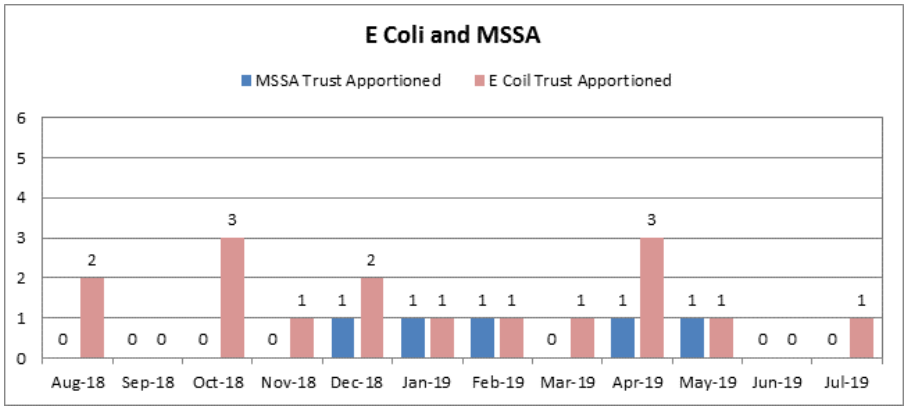
Infection Control

Are We Safe?

Year	2018-19	2019-20
MRSA (Trust Apportioned)	3	0

Data Quality Rating:





Summary and Action

A change in reporting of C. difficile cases in line with national guidance has shown an increase in the number of Trust apportioned cases. The Trust is required to count all 'healthcare associated' towards the ceiling given of 9. This now includes inclusion of community onset healthcare associated cases in the Trust figures (this includes all cases up to 4 weeks post discharge) and is a change in definition from previous years.

Board will note that this has resulted in the trajectory of 9 being met by month 4.

Action:
NHSI and the CCG are aware of the situation. All are subject to full root cause analysis review and key themes across the cases are being identified for further focus. This work continues into Q2.

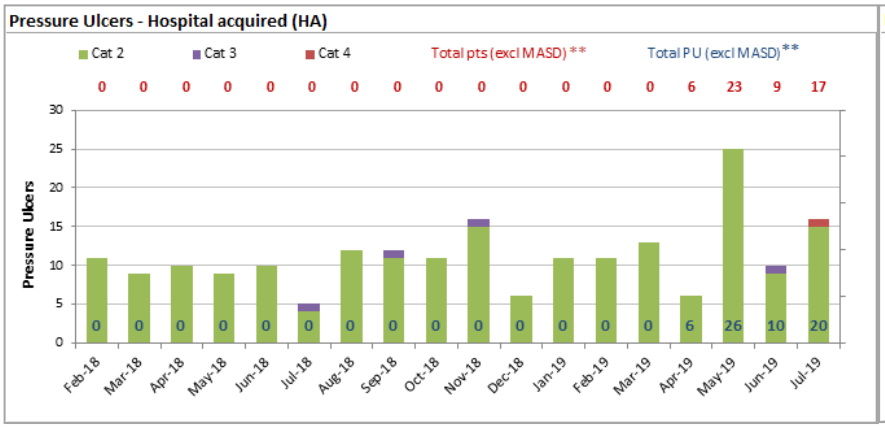
4 cases are being put forward for appeal as there is good evidence of no lapses in care – outcome should be known in September.

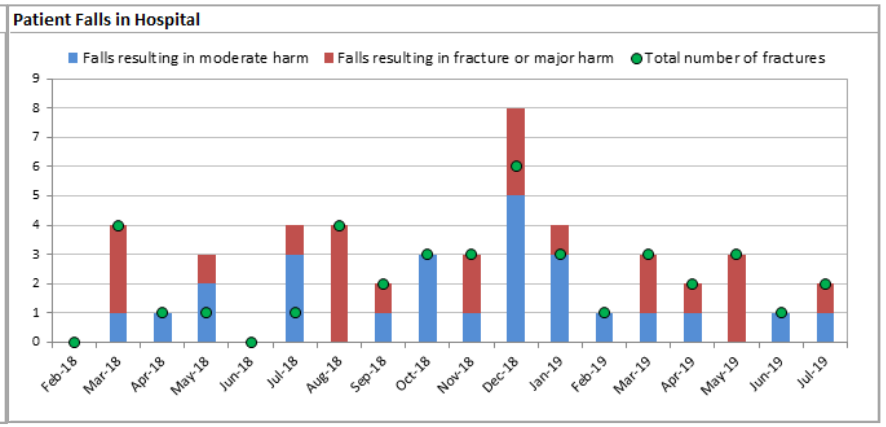
Pressure Ulcers / Falls

Are We Safe?

Per 1000 Bed Days	2018-19 Q1	2018-19 Q2	2018-19 Q3	2018-19 Q4	2019-20 Q1
Pressure Ulcers	0.71	0.68	0.79	0.88	1.05
Patient Falls	0.10	0.25	0.34	0.20	0.16

Data Quality Rating:





Summary and Action

Pressure Ulcers

National definitions regarding 'hospital acquired ' pressure ulcers changed from 1 April 2019, to include any ulcer/damage not recognised and recorded 'on admission'. This has resulted in an anticipated increase in the quarter and we continue to work with admission areas on how we improve the quality of assessment and documentation at this stage. Currently working with others across the STP to ensure alignment on how we are interpreting this definition and how we can work across boundaries better to reduce this patient harm.

One category 4 pressure ulcer, reported in July in a hospice patient and associated with metal work (SII 327 in progress).

Falls

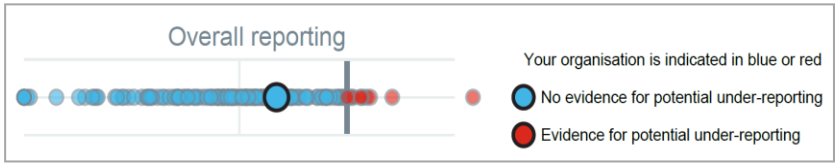
In July, 1 fall resulting in fractured hip requiring surgery, 1 fall resulting in moderate harm (fractured wrist).

A CQUIN of 3 high impact interventions to prevent hospital falls is in place, with Q1 performance achieving all 3 elements, currently at 19%. Improvement work is led by the Falls Working Group and Patient Safety Steering Group. Key intervention we are currently struggling with, and is directly contributing to this non compliance is a lying and standing blood pressure for all patients over 65 years. This is now going to be a requirement through POET e-obs with automatic reminders – due for roll out September 19.

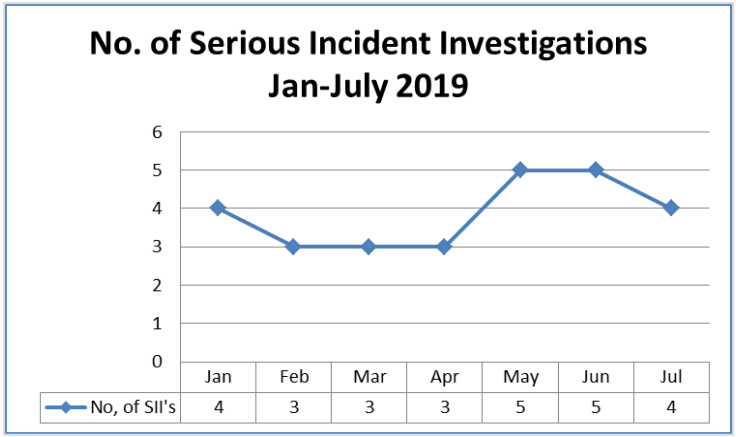
Incidents

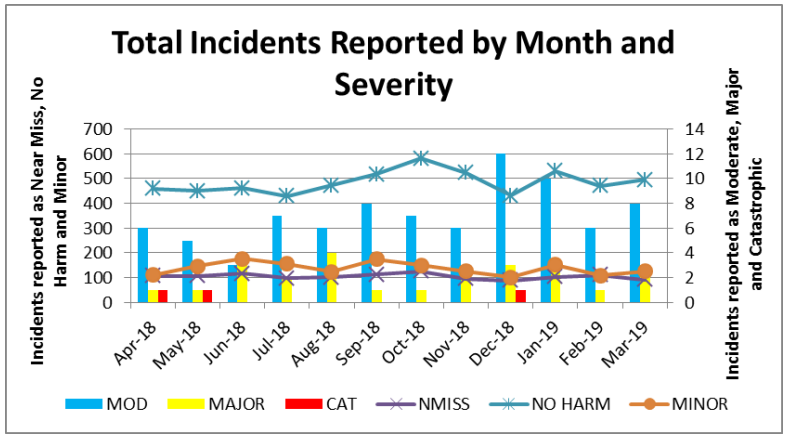
Are We Safe?

Year	2018-19	2019-20
Never Events	3	1



Information from NRLS benchmarks SFT in regard to reporting of incidents and reflects a positive reporting culture.





Summary and Action

The number of serious incident investigations (SII) did increase in 2018/19 compared to 2017/18. Analysis has shown that the overall level of harm has increased very slightly but has not increased in line with the increased number of serious incident investigations. This is due to a number of the SII's being commissioned from a process/systems perspective which resulted in near miss or low harm but has the potential to cause serious harm should it occur again.

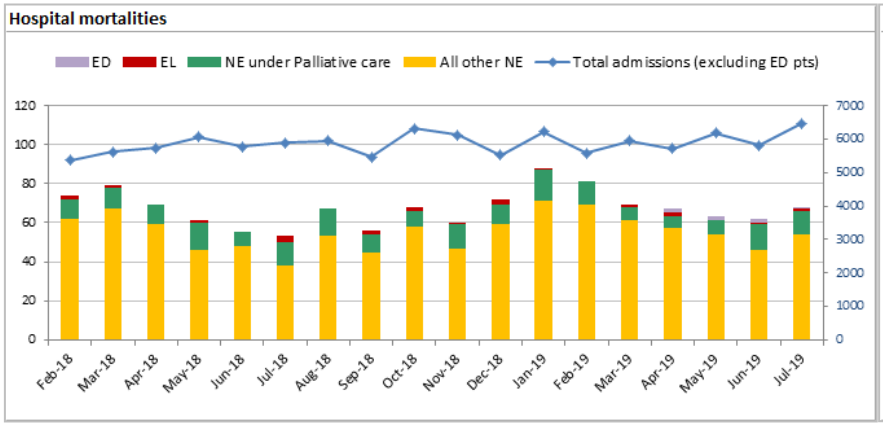
Cancer Pathways has been a recognised theme:

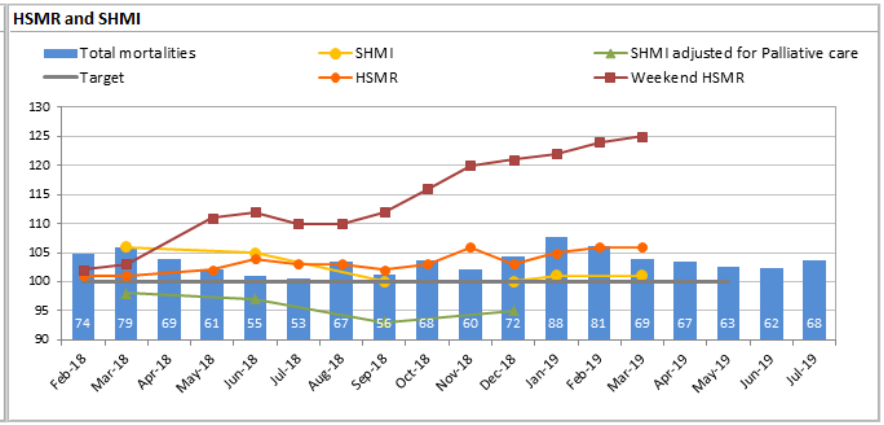
- The Trusts Risk Summit is organised for September.
- An aggregated action plan is in place to incorporate IT and administration actions which will be worked through and will be tested and challenged by Internal Audit in Autumn 2019.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

Overall, HSMR remains within expected range. HSMR to May 19 is due to be published on 22/08/19.

SHMI (and when adjusted for palliative care) within the expected range.

Weekend HSMR increased for the 7th, 12 month rolling data period and is significantly higher than expected range. A multi disciplinary case notes review involving primary care partners and based on a detailed analysis of the contributory factors has been completed. The report, findings and recommendations will be presented to the Clinical Governance Committee in September 2019.

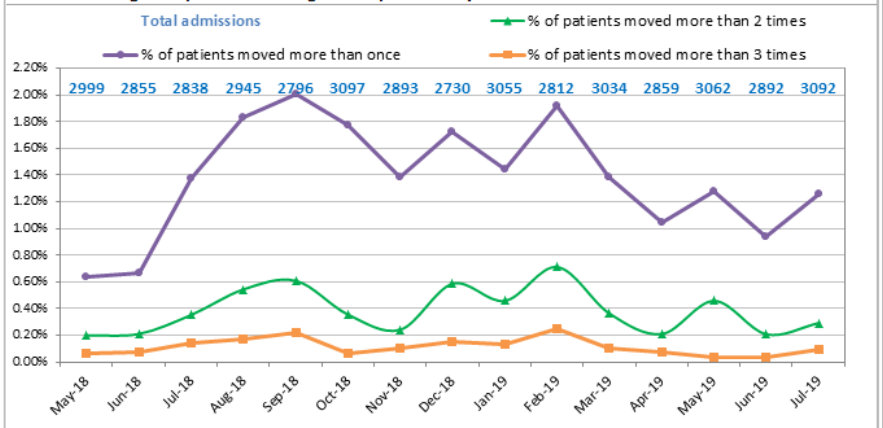
Patient Experience

Are We Safe?

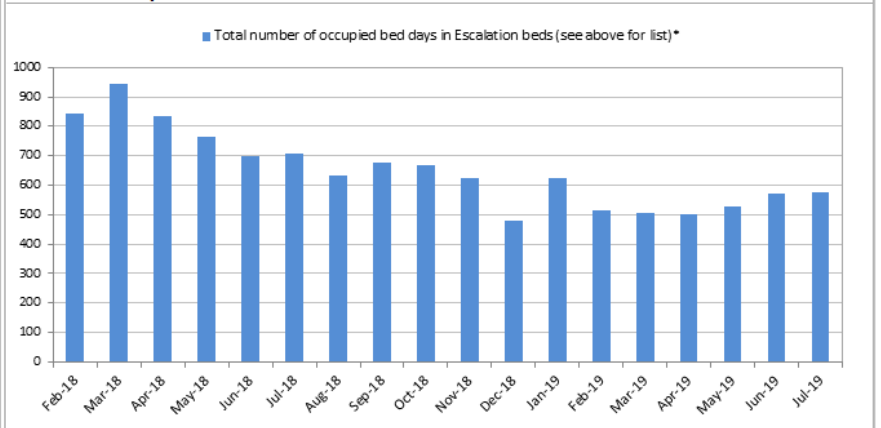
Last 12 months	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Bed Occupancy %	94.6	96.0	96.5	96.8	92.5	96.3	94.4	91.4	92.6	92.5	93.5	93.3

Data Quality Rating:

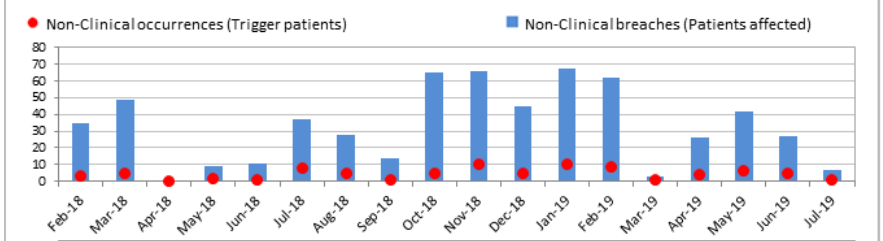
Patients moving multiple times during their Inpatient Stay



Escalation Bed Days

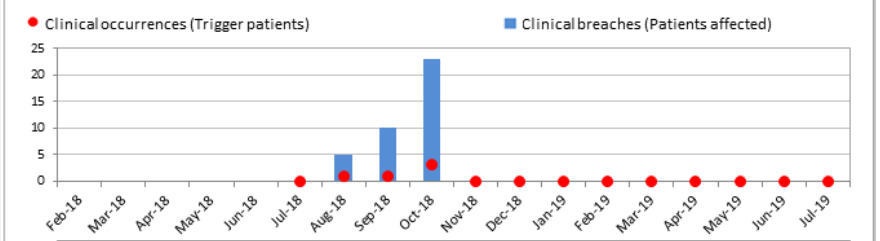


Delivering Same Sex Accommodation - Non-clinical



	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
■	35	49	0	9	11	37	28	14	65	66	45	67	62	3	26	42	27	7
●	3	5	0	2	1	8	5	1	5	10	5	10	9	1	4	6	5	1

Delivering Same Sex Accommodation - Clinical



	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
■						0	5	10	23	0	0	0	0	0	0	0	0	0
●						0	1	1	3	0	0	0	0	0	0	0	0	0

Part 3: Our People

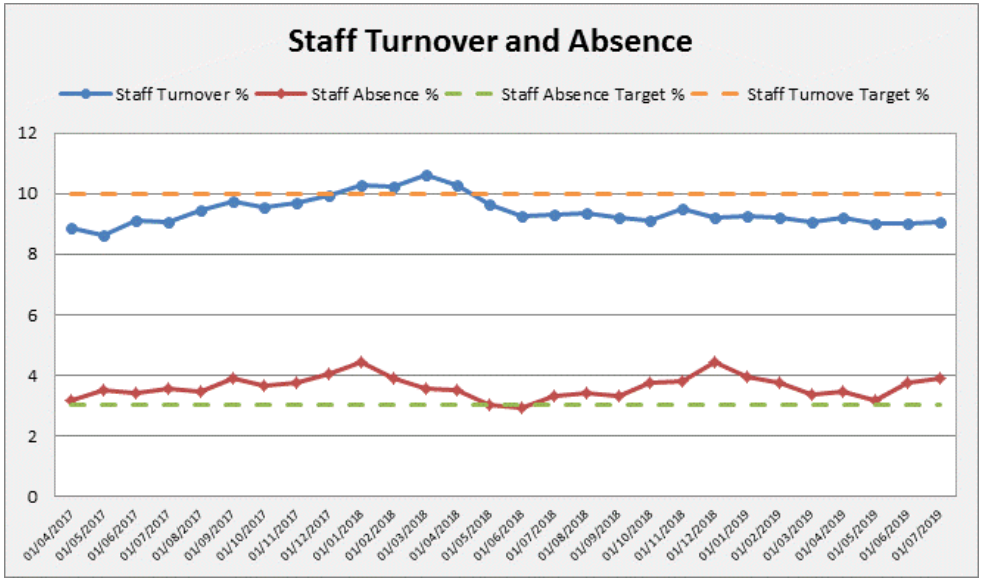
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Jul '19		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	402.6	397.2	5.4
Nursing	940.3	907.0	33.3
HCAs	405.7	529.5	(123.8)
Other Clinical Staff	609.7	611.8	(2.1)
Infrastructure Staff	1,197.7	1,189.1	8.6
TOTAL	**3,556.1**	**3,634.6**	**(78.6)**



Summary and Action

Staff Turnover: In Month 4, there were 46 starters (of which 17 were overseas nurses) and 22 leavers and turnover very slightly increased to 9.06%, although still below the target of 10%. This is set to improve over the next two months with 21 overseas nurses due to arrive in August and 29 newly qualified in September. We are working with Family Forces to support the rebasing of army families to the area which is anticipated to provide further opportunity for filling vacancies.

Absence: Sickness has continued to increase in Month 4, mainly as a result of increase in short term absences. Long term absences are being robustly managed with 3 cases of returns which were not yet recorded on ESR at time of reporting, 20 cases where returns are due imminently (September), 17 cases being dealt with through Occupational Health and 3 resignations in notice period. There was a spike in short term sickness in Medicine this month and we are working with ward managers to understand the reasons for this and support them in building resilience in the teams. The main causes of short term sickness absence are reported as colds and gastro problems; anxiety/stress/depression is not featuring heavily in this month.

Workforce – Nursing and Care

Use of Resources

% Fill of Registered Nurse/HealthCare Assistant Shifts

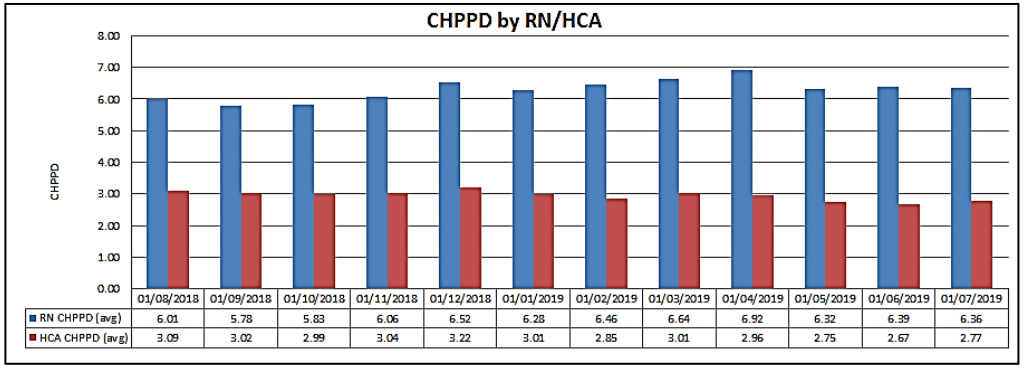
TABLE 1

Day	RN	HCA
Total Planned Hours	38444	21020
Total Actual Hours	35246	21691
Fill Rate (%)	92%	103%

Night	RN	HCA
Total Planned Hours	24802	12682
Total Actual Hours	24600	14337
Fill Rate (%)	99%	113%

Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend

TABLE 2



	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019	01/07/2019
RN CHPPD (avg)	6.01	5.78	5.83	6.06	6.52	6.28	6.46	6.64	6.92	6.32	6.39	6.36
HCA CHPPD (avg)	3.09	3.02	2.99	3.04	3.22	3.01	2.85	3.01	2.96	2.75	2.67	2.77

Summary and Action

- Table 1 shows planned vs actual hours for RNs and HCAs and table 2 shows Care Hours per Patient Day (CHPPD) by RN and HCA.
- From next month we anticipate reporting more detailed planned vs actual Care Hours per Patient Day, as per requirement for national reporting of nurse staffing. CHPPD is a simple calculation which divides the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24 hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.
- No wards are flagging red for actual unfilled hours (based on internal rag ratings).
- The skill mix of RN:HCAs remains stable for the 3rd reporting month – RN 62%:HCAs 38%.
- RN vacancies, for wards including ED/ITU, are 13% (compared to 24% same time period 2018).
- Nurse agency expenditure YTD is £650k (£800k lower than same time period 2018 – reflecting improved vacancy position).
- Nurse sensitive indicators remain stable – some anomalies in some areas such as clostridium difficile and pressure ulcers due to changes in national reporting requirements.

Workforce – Staff Training and Appraisals

Use of Resources

	Training	Appraisal	
	Mandatory Training	% Complete Medical Staff	% Complete non-medical staff
YTD Trend			
Month Trend	↓	↑	↑
Target	85.00%	90.00%	85.00%
Jan-19	91.32%	88.16%	86.30%
Feb-19	92.03%	91.46%	84.90%
Mar-19	92.09%	92.62%	86.00%
Apr-19	92.19%	90.65%	86.70%
May-19	91.99%	92.31%	85.05%
Jun-19	91.60%	92.42%	84.08%
Jul-19	90.20%	93.25%	84.59%
totals	91.63%	91.55%	85.37%

Summary and Action

Training

All Directorates are compliant, although there is a very slight dip this month. Issues reported as challenges are safeguarding, hand hygiene, and Information Governance.

Non Medical Appraisals

All Clinical Directorates and Estates & Facilities are above target in this month although the overall compliance is just under target. Some departments have acknowledged that they have work to do to improve their compliance with appraisals due.

During August we have sent out reports to managers detailing overdue appraisals by individual so that they can be checked for accuracy and booked in as necessary. It has become apparent that a common issue in completing the appraisal via the SPIDA system is for either appraisee or appraisor to forget to tick the sign off box. This results in the record showing as non-compliant even when the appraisal has actually been completed.

We would expect a return to 85%+ following this mini audit.

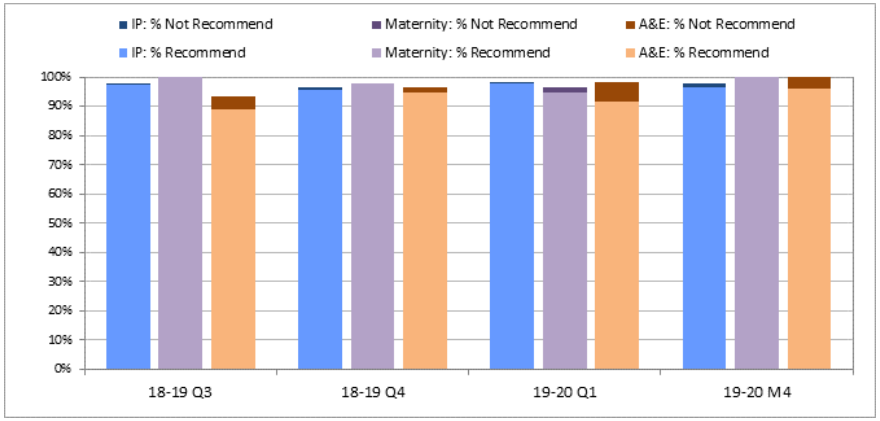
Medical Appraisals

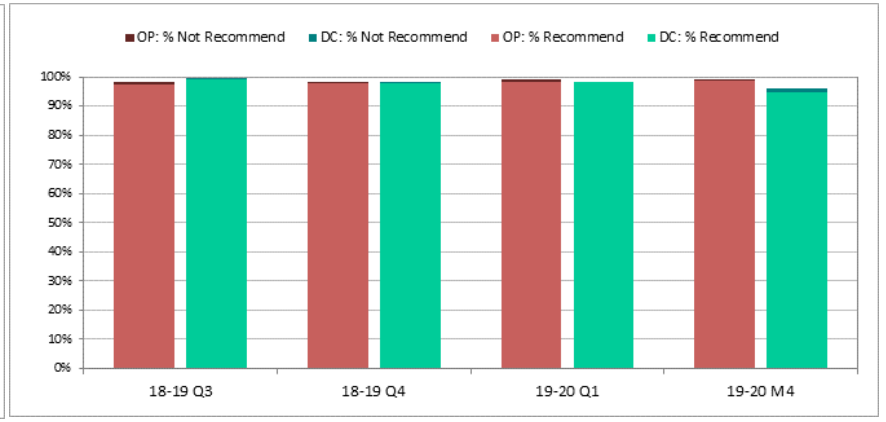
Compliant at 93.25%

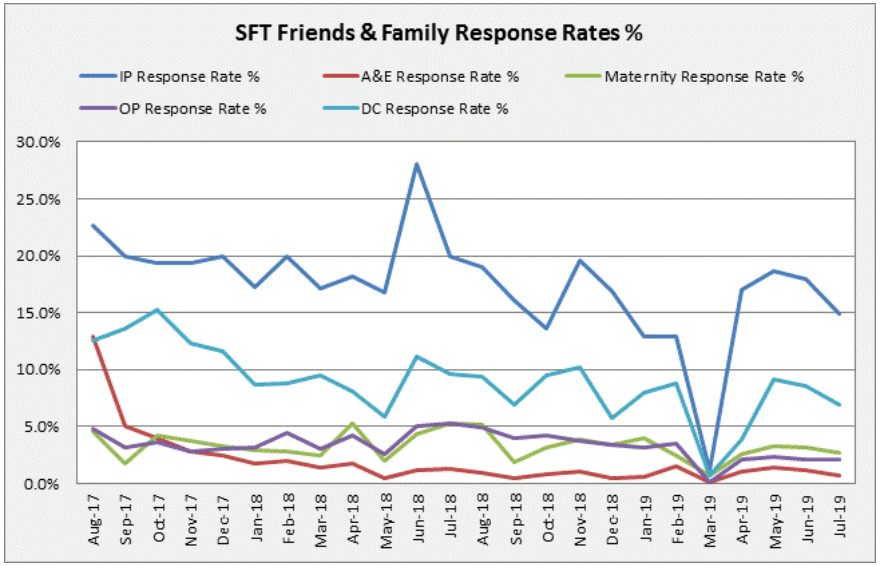
Friends and Family Test – Patients and Staff

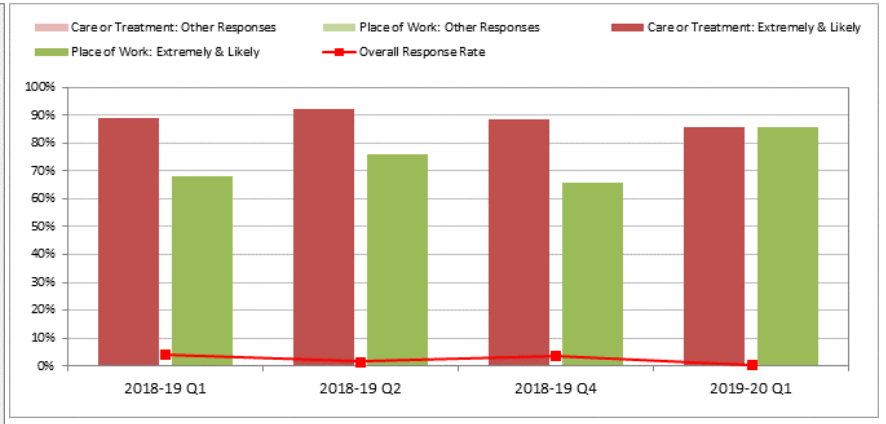
Use of Resources

SFT Friends & Family Test: Responses by Area









There was an issue in March 2019 whereby responses were input into the wrong FFT website and were unable to be retrieved, hence the low response rate for one month.

Part 4: Use of Resources

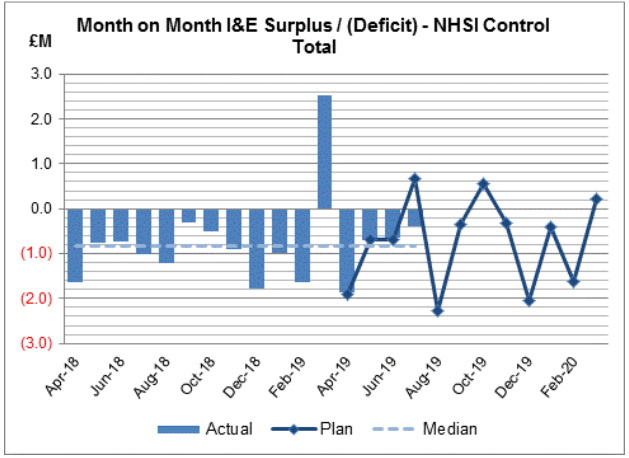
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Jul '19 In Mth			Jul '19 YTD			2019/20
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical Income	18,724	18,049	(675)	69,658	67,591	(2,067)	196,036
Other Clinical Income	778	775	(3)	3,085	3,165	80	21,449
Other Income (excl Donations)	2,350	2,434	84	9,338	9,460	122	28,307
Total income	**21,852**	**21,258**	**(594)**	**82,081**	**80,216**	**(1,865)**	**245,792**
Operating Expenditure							
Pay	(13,049)	(13,359)	(310)	(52,658)	(52,716)	(58)	(157,326)
Non Pay	(6,689)	(6,927)	(238)	(26,302)	(25,542)	760	(80,163)
Total Expenditure	**(19,738)**	**(20,286)**	**(548)**	**(78,960)**	**(78,258)**	**702**	**(237,489)**
EBITDA	**2,114**	**972**	**(1,142)**	**3,121**	**1,958**	**(1,163)**	**8,303**
Financing Costs (incl Depreciation)	(1,430)	(1,366)	64	(5,719)	(5,572)	147	(17,157)
NHSI Control Total	**684**	**(394)**	**(1,078)**	**(2,598)**	**(3,614)**	**(1,016)**	**(8,854)**
Add: impact of donated assets	*105*	*(24)*	*(129)*	*420*	*(182)*	*(602)*	*1,260*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*174*	*174*	*(0)*	*695*	*695*	*(0)*	*2,082*
Add: PSF & FRF	*451*	*(1)*	*(452)*	*1,467*	*1,190*	*(277)*	*6,772*
Surplus/(Deficit)	***1,414***	***(246)***	***(1,660)***	***(16)***	***(1,911)***	***(1,895)***	***1,260***



Variation and Action

The Trust's financial performance has dropped below that required by the NHSI Control Total in July, reporting a £394k deficit against an expectation of a £684k surplus. This planned improvement had been driven by the number of working days in the period, with an expectation that summer annual leave would predominantly affect August.

NHS clinical income of £18.0m was 10% up on that achieved in June 2019, unfortunately the plan had assumed +15% based on the working days available, so although the in-month variance against plan has reduced it remains at £675k. All points of delivery have seen activity shortfalls compared to those planned for, with planned pathway capacity continuing to be constrained by a reduction in uptake on additional sessions.

The medical pay award announced in July has been provided for in full, with £270k in cost relating to the first quarter of the year. This is compounded by and increase in medical agency cover for hard to fill vacancies.

The Trust continues to see a rise in costs associated with outsourced healthcare, driven by both increased demand (Endoscopy), and shortfall in capacity due to key hard to fill vacancies (Pathology, Radiology).

Income & Activity Delivered by Point of Delivery

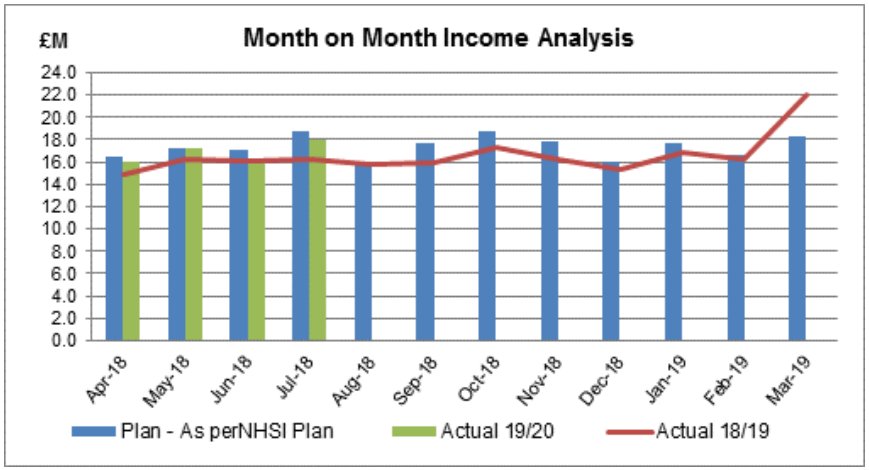
Clinical Income:

Use of Resources

Position			
Income by Point of Delivery (PoD) for all commissioners	Jul '19 YTD		
	Plan (YTD)	Actual (YTD)	Variance (YTD)
	£000s	£000s	£000s
A&E	3,041	2,964	(77)
Elective inpatients	6,491	5,984	(507)
Day Case	6,048	5,772	(276)
Non Elective inpatients	18,761	18,038	(723)
Obstetrics	3,712	3,571	(141)
Outpatients	11,405	10,801	(604)
Excluded Drugs & Devices (inc Lucentis)	5,770	5,920	150
Other	14,430	14,541	111
TOTAL	**69,658**	**67,591**	**(2,067)**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
Wiltshire CCG	37,691	37,015	(676)
Dorset CCG	8,030	8,047	17
West Hampshire CCG	5,595	5,580	(15)
Specialist Services	10,705	10,144	(561)
Other	7,637	6,805	(832)
TOTAL	**69,658**	**67,591**	**(2,067)**

Position						
Activity levels by Point of Delivery (POD)	YTD	YTD	YTD		Last Year	Variance against
	Plan	Actuals	Variance		Actuals	last year
Elective	1,830	1,666	(164)		1,744	(78)
Day case	7,671	7,581	(90)		7,535	46
Non Elective	9,291	8,743	(548)		8,612	131
Outpatients	90,648	85,768	(4,880)		83,517	2,251
A&E	23,888	23,608	(280)		23,232	376



Variation and Action

Income to date is £69,571k, £2,067k below plan and an under performance of £674k in July. Income has under performed on all points of delivery year to date with the exception of Excluded drugs and devices and Other. Cardiology Day cases are 91 cases and £146k below plan year to date resulting from a reluctance to undertake additional lists due to the impact on Pensions with an improvement in month. Elective Orthopaedics were 99 spells below the year to date plan of 436 in July which is a deterioration from the June in month performance. The Non Elective position is driven by a combination of under performance on spells and excess bed days activity mainly within Trauma and Orthopaedics and Cardiology. The Outpatients position is driven by underperformance across a range of specialties most notably in Dermatology due to Consultant vacancies with cover being provided by other specialties.

An adjustment of +£767k is included to reflect the blended approach, +£662k for Wiltshire CCG and +£105k for West Hampshire CCG, due to under performance on the non elective element of the contract. An adjustment of +£392k is included to increase income to reflect the under performance on the Dorset managed contract at Month 4. The total impact is +£1,159k.

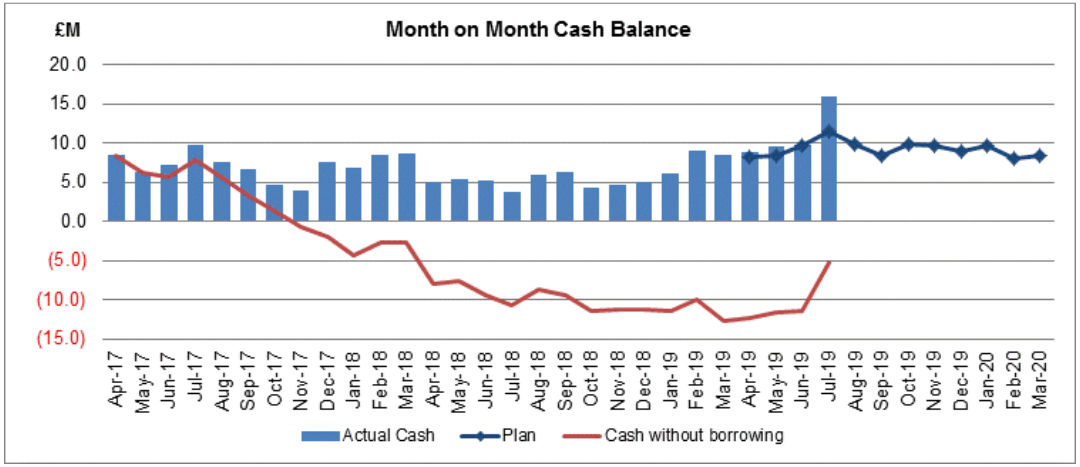
NHS England and the Trust are working towards contract signature by 31st August 2019.

Cash Position & Capital Programme

Capital Spend: 

Cash & Working: 

Use of Resources

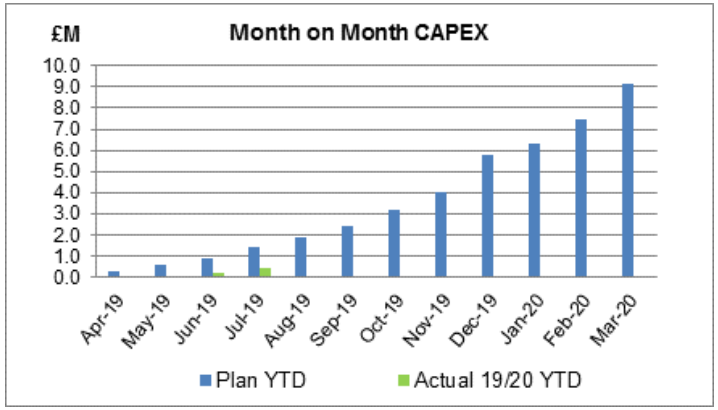


The Trust's working capital position is reasonably in line with the plan. The cash position improved during the month following the receipt of PSF funding of £4.5m earned in 2018-19.

The cash flow will continue to be closely monitored during 2019-20 to ensure funds are available when required. Although the Trust is not planning for additional borrowing in 2019-20 this will be constantly reviewed in line with the financial performance and forecast for the remainder of the year.

Capital Expenditure Position

Schemes	Annual Plan £000s	Jul '19 Plan £000s	Jul '19 Actual £000s	Jul '19 Variance £000s
Building schemes	700	0	0	0
Building projects	1,814	360	60	300
IM&T	3,540	700	82	618
Medical Equipment	2,650	200	135	65
Other	420	140	140	0
TOTAL	**9,124**	**1,400**	**417**	**983**



Summary and Action

The Trust is financing its capital spend in 2019-20 through depreciation.

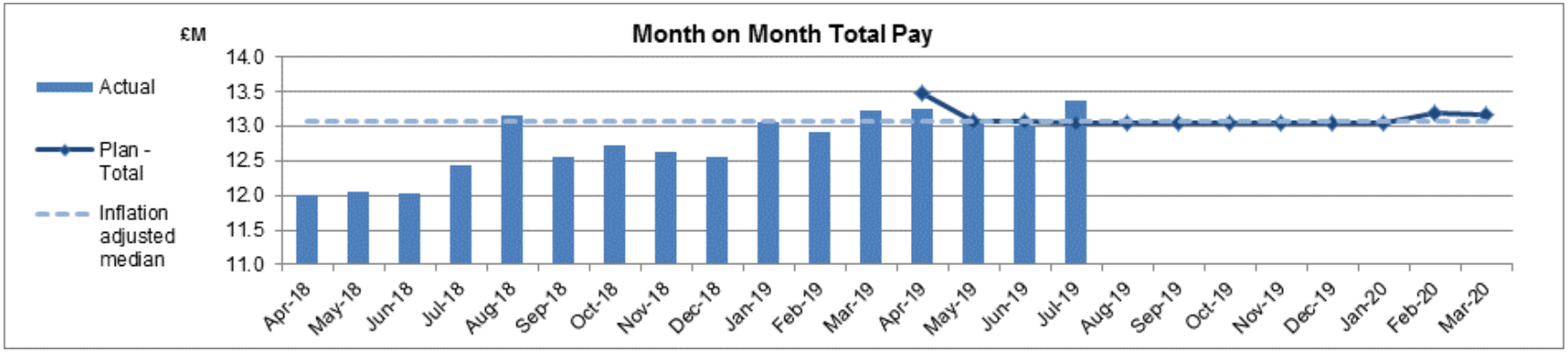
The Trust is anticipating to be behind plan for the first half of the year following a revision to the phasing of schemes within the capital programme. Expenditure is expected to come back in line with the plan later in the year with all funds fully spent by the year end. Plans are being monitored through the operational Capital Control Group which now reports into a Strategic projects group chaired by the Director of Finance.

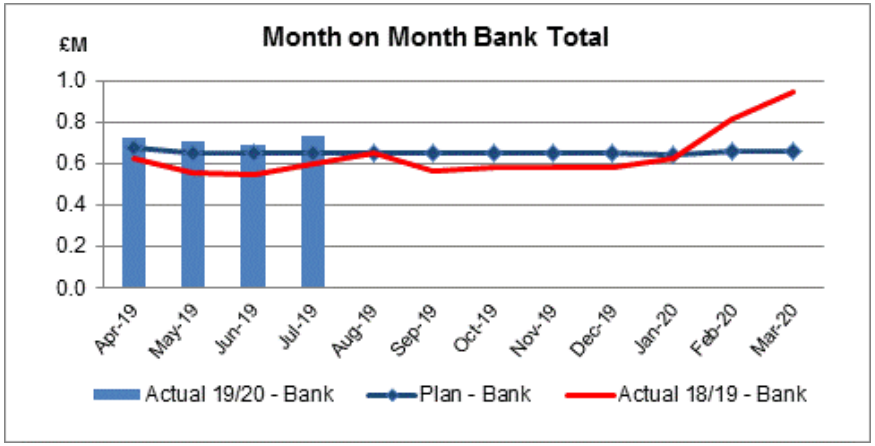
A recent announcement by NHSI initially required the Trust to reduce its capital programme by 20% for the year. Subsequent announcements have resulted in this decision now being reversed. The Trust is assessing the resulting impact on potential slippage in the programme and what steps may be required to ensure the available funds are fully utilised in 2019-20.

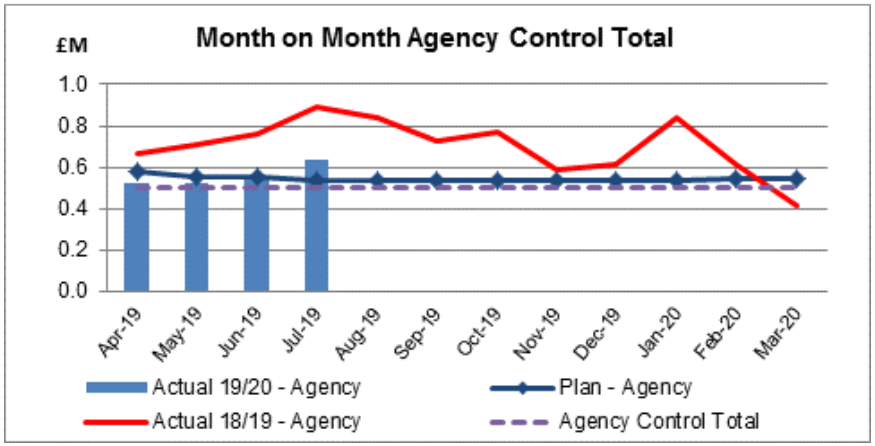
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure of £13,359k in July is £310k (2.4%) greater than planned for. The reported figures are inclusive of the 2.5% medical pay award for 2019-20 announced in July (£270k relating to Q1).

Agency costs have exceeded plan at £634k, with the month on month increase relating primarily to the consultant workforce with 11 agency locums in place during the period, and increase from 8 in June. The specialties being forced to cover Consultant vacancies through agency are: Histopathology, General Medicine, Gastroenterology, Stroke, Emergency Medicine, and Dermatology. This will reduce over the next two months or so, as new appointments take up post, eg. Histopathologist, Stroke.

The Surgery and Medicine Directorates continue to mitigate nursing vacancies with the usage of Nursing Assistants, often those in the process of obtaining full registration, as demonstrated by the WTE and financial variance swings between the staff groups.

Agency premium for the period is estimated at c£245k, roughly half of which relates to medical staffing groups due to difficulties filling vacancies and rota gaps. People Business Partners work closely with their DMTs to manage the use of this resource, create exit strategies and reduce expenditure.

Efficiency – Better Care at Lower Cost

Efficiency:

Use of Resources

Position							
	Annual	Jul '19			YTD		
Directorate	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Medicine	2,192	184	105	(80)	694	369	(325)
Musculo Skeletal	1,385	119	89	(30)	394	301	(93)
Surgery	1,728	144	112	(32)	541	332	(209)
Clinical Support & Family Services	1,965	146	131	(15)	564	417	(147)
Corporate Services	1,730	138	162	24	533	645	111
Strategic	1,000	47	79	31	22	148	126
TOTAL	**10,000**	**778**	**677**	**(101)**	**2,750**	**2,213**	**(537)**

Position							
	Annual	Jul '19			YTD		
Scheme	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Theatres	1,068	89	0	(89)	356	0	(356)
Workforce	1,001	83	86	3	333	344	10
Diagnostics	600	42	42	0	167	167	0
Patient Flow	825	69	24	(45)	275	93	(182)
Outpatients	500	56	56	0	56	56	0
Non-Pay Procurement	1,494	125	105	(19)	406	381	(25)
Medicines Optimisation - Drugs	500	0	23	23	0	92	92
Clinical Directorate Plans	2,634	206	206	0	731	539	(192)
Corporate Directorate Plans	1,378	109	134	26	426	541	115
TOTAL	**10,000**	**778**	**677**	**(101)**	**2,750**	**2,213**	**(537)**

Summary and Action

The Trust has reported CIP delivery of £677k (87%) in July 2019, this has directly contributed to the Trust's in month shortfall against plan.

Under performance is being driven by the theatres programme, scheduling software has now been procured in order to facilitate increased list utilisation, allowing focus to be shifted towards the cultural change element of the programme.

The patient flow programme has once again not met its financial target. The Trust once again managed without requiring it's escalation beds, delivering a saving of £24k but was unable to close down any of the 'core' bed base. The most notable operation KPI failure leading to this shortfall is the level of delayed transfers of care, currently running at circa 10 higher than targeted.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	05 September 2019		

Report Title:	CQC Well-Led Action Plan update			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Cara Charles-Barks, Chief Executive			
Appendices (list if applicable):	Well-Led action plan August 2019 v3			

Recommendation:
The Board are asked to note progress made against the well-led action plan and further areas for improvement.

Executive Summary:
The Trust commissioned an external review of the Well-Led Framework by Deloitte and 32 recommendations were identified in the report provided in May 2018. An action plan was subsequently implemented and a number of actions were progressed over the following 8 months, with regular oversight by the Executive Team through reports to the weekly Executive meeting. The Care Quality Commission (CQC) undertook a Well-Led inspection in December 2018 and the report findings from this provided a further focus on improvement actions required. This provided an opportune time to review the current action plan and create a new plan to progress over the next 12 months. Summary of progress is detailed within the report and themed under the key lines of enquiry (KLOE) used within the action plan. The action leads have been attending the Well-Led Steering Group to provide updates and assurance on progress. This informs the information below. Progress is being made against the well-led action plan with delivery to the agreed milestones for the majority of actions. Assurance against progress is via the CQC well-led steering group. On-going focus is required in respect of:

- Monitoring of strategy deliverables
- Effectiveness of Directorate governance meetings
- Consistency and functioning of Board Committees
- Implementation of recommendations arising from the internal review of the Executive Performance Reviews and;
- Improving the consistency of information and quality of the narrative presented to Trust Board and Board Committees.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

1 Purpose

1.1 The purpose of the report is to provide the Board with an update against progress against the Well-Led action plan.

2 Background

2.1 The Trust commissioned an external review of the Well-Led Framework by Deloitte and 32 recommendations were identified in the report provided in May 2018. An action plan was subsequently implemented and a number of actions were progressed over the following 8 months, with regular oversight by the Executive Team through reports to the weekly Executive meeting.

The Care Quality Commission (CQC) undertook a Well-Led inspection in December 2018 and the report findings from this provided a further focus on improvement actions required. This provided an opportune time to review the current action plan and create a new plan to progress over the next 12 months.

Summary of progress is detailed below and themed under the key lines of enquiry (KLOE) used within the action plan. The action leads have been attending the Well-Led Steering Group to provide updates and assurance on progress. This informs the information below.

3 Key Lines of Enquiry

3.1 KLOE 1: Leadership Capacity and Capability

There has been a continued focus on the Board development which has included individual and team coaching facilitated by NHSI for both Executives and Non-Executive Directors (NEDS). Trust Board development sessions have focussed on the Trust strategy and enabling strategies, cyber security and an NHSI facilitated session regarding use of data for Board assurance. There are forthcoming sessions in September regarding Equality and Diversity and Organisational Development and Culture.

An overarching Leadership and Management Development Strategy was agreed at the Workforce Committee in January 2019. A leadership development programme has been established with the first cohort of this commencing in March 2019 with a Clinical (medical) Leadership Programme. 40 staff have gone through the programme to date. Follow up programmes will be open to other groups, deputies and other managers responsible for people management.

Funding has been approved to support the leadership and development programme, to:

- Fund appointment of a Head of Leadership and Development
- Support purchase of leadership tools e.g. psychometric tests
- Support development of a bespoke middle management training programme including Quality Improvement modules
- Fund external inspirational speakers; Michael West speaking in November regarding compassionate leadership

To date, the leadership and development opportunities include:

- Clinical leadership programme commenced in March 2019. 40 people have attended. Includes 4 workshops. Evaluation of the programme to date. The 4th workshop (role of the clinical leader) will be replaced with a workshop including quality improvement, business cases and finance. To be implemented from September and to run bi-annually.
- Passport to progression being implemented.
- Level 3,5 and 7 apprenticeship programmes
- Senior leaders forum – this has commenced however, requires a refresh. Raised with Execs for discussion and agreement regarding the way forward. Forum to continue, starting with a motivational speaker followed by time for debate and discussion. To be Exec driven.
- Coach to lead – been on-going for 4 years. Monthly 1 day programme and access to health coaching.
- Talent management – STP developing a process and programme for talent management. The Trust work needs to align to this.

This is an on-going programme of work with oversight provided by the Workforce Committee.

3.2 KLOE 2: Clear Vision and Strategy

The Trust Strategy was refreshed for 2018-22. The Strategy Committee has been disbanded following agreement to provide focussed strategy sessions at the private Board meetings. The Associate Director of Strategy has been leading these sessions which has provided structured discussion and agreement for the way forward.

The Associate Director of Strategy is in the process of mapping the deliverables against the Trust Strategy and enabling strategies with the aim to provide the Board with assurance against these on a quarterly basis. This work will be broadened to include delivery against the corporate objectives.

There is an action with a revised deadline relating to the completion of a multi-facet survey. An external consultant is working with the Trust, reviewing the estate. A paper is going to TMC in September 2019 outlining proposals arising from the review.

3.3 KLOE 3: Culture of High Quality, Sustainable Care

The focus of actions was based on progressing the equality, diversity and inclusion (EDI) agenda and improving the Freedom to Speak Up Guardian arrangements within the Trust. A recent update was provided at the CQC well-led steering group meeting which has provided assurance of significant progress since the CQC inspection. The re-launch of the EDI Committee occurred in July.

This is an on-going programme of work with oversight provided by the Workforce Committee.

3.4 KLOE 4: Clear Roles and Systems of Accountability

The Integrated Governance Framework, including Board Committee terms of reference was updated and approved by the Board in April 2019.

All Directorates have now introduced directorate governance meetings although there is variability in frequency and approach to these. Further work with the directorates is required to fully embed these as business as usual.

There is on-going work to improve the Board assurance process and functioning of the Board Committees. Scrutiny over the agenda items for both the public and private board meetings has facilitated streamlining of reporting. Further work is required at Board Committee level over the next few months together with a more robust approach to timeliness of papers and quality of cover sheets. This will include improving the assurance process for the external reporting of data. There is recognition that the Board Committees effectiveness still requires focus and this will require the engagement of the committee Chair and lead Executive to support improvements.

An internal review of the Executive Performance Reviews by the Director of Corporate Governance has identified areas which can be further strengthened. The proposed recommendations have been agreed with the Chief Operating Officer and have been shared with the Chairman and Chief Executive as commissioners of the review. Key areas for improvement relates to the assurance and escalation process to the Trust Management Committee and the central provision of the performance packs to strengthen the consistency of presented data and support the Directorates to focus on the narrative underpinning the data.

3.5 KLOE 5: Risk Management

The key area of focus relates to undertaking of a training needs analysis which has a deadline of 30 September 2019. This will be reported as part of the next update.

3.6 KLOE 6: Accurate Information

There has been significant progress made with the revision of the Integrated Performance Report to strengthen the quality of reporting and provision of assurance. This is work in progress, being led by the Associate Director of Strategy, with the aim over the coming months to present the same data to the Board and Board Committees and improving the narrative within the reports to support identification of variances, actions to address these and forecasting of performance. With the increasing use of Statistical Control Charts (SPC), a Board seminar was held in July facilitated by NHSI called ‘Making Data Count’.

3.7 KLOE 7: Engagement

The Patient Engagement Strategy was ratified by the Clinical management Board in June 2019. The Patient Engagement Toolkit has been revised and is in the process of being uploaded to a newly developed website.

Patient and staff engagement was the focus of the August well-led steering group update and assurance gained that progress is being made to improve the consistency of approach across the organisation. It was recognised that the staff engagement programme was work in progress and that communications were required to ensure a clear narrative of progress to date was required. This would include case studies for both patient and staff engagement.

The Corporate Communication Strategy has Board approval and the focus will now be on delivery of the implementation plan. This will be reported in the next report.

3.8 KLOE 8: Continuous Improvement and Innovation

The Quality Improvement Strategy was approved by the Board in April 2019. A Trust Board seminar session is planned for September to discuss the proposed options for a 4 year programme with a view to develop and present the business case to support this in October.

4 Horizon Scanning

A review of recently published CQC reports for NHS organisations rated outstanding has identified a number of areas of particular focus going forward:

- Trust strategies aligned to the NHS 5 year forward view
- How strategy is communicated to all across the organisation with enabling strategies aligned to the Trust strategy
- Quality improvement (QI) to include evidence of sharing of QI projects and patient and carer involvement in QI
- Workforce Race Equality Standards (WRES) and the leadership development for BME staff
- Stability of the Trust Board
- Stability of ward managers and clinical leaders with evidence of leadership training and development
- Monitoring delivery of corporate objectives
- Patient and staff engagement

The above items are reflected in the work being undertaken as part of the outstanding actions within the Trust action plan.

5 Summary

4.1 Progress is being made against the well-led action plan with delivery to the agreed milestones for the majority of actions. Assurance against progress has been provided via the CQC well-led steering group. On-going focus is required in respect of:

- monitoring of strategy deliverables
- effectiveness of Directorate governance meetings
- consistency and functioning of Board Committees
- implementation of recommendations arising from the internal review of the Executive Performance Reviews and;
- improving the consistency of information and quality of the narrative presented to Trust Board and Board Committees.

5 Recommendations

5.1 The Board are asked to note progress made against the well-led action plan and further areas for improvement.

Fiona McNeight
Director of Corporate Governance

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Theme	Action	Outcome	Deadline	Lead
Board Development	On-going development program with the organisational coach	NED and Board constructive challenge at Board	Commenced and on-going	CCB
	On-going team and individual coaching for the Executive Team		Commenced and on-going	CCB
	NED development through NHS Provider sessions		30/04/2020	FMc
Leadership development and strategy	Delivery of the Trust Leadership and Development Strategy	Strengthened leadership capability	April 2018 - March 2020	JS/PH
	Clinical Leadership Development Program		31/03/2019 Commenced. 1st cohort completed	JS/PH
	Senior Leaders Forum		28/02/2018 Commenced	PH
	Talent Management Program		31/03/2020	JS/PH

KLOE 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

Theme	Action	Outcome	Deadline	Lead
Ensure confidence in Estates Strategy	Estates Strategy to be presented at March Trust Board	Estates Strategy developed which meets all H&S requirements	31/03/2019 Presented at March Board - further changes required 01/07/2019 On July Board agenda for approval - Board approved	LA
Ensure the Trust can demonstrate and is meeting H&S requirements	NHSI self-assessment and gap analysis to be presented to Finance & Performance Committee in May 2019 and assurance to Trust Board in June 2019	Gap analysis complete and improvement plan agreed	~~30/06/2019~~ 30.09.2019 External Consultant reviewing Estates. Paper going to TMC in September outlining proposals	AH
	Delivery of action plan following NHSI self- assessment	Compliance with NHSI requirements	30/09/2019	AH
Clinical Strategy	Review clinical strategy and ensure aligned to NHS Long Term Plan and aligned to BSW clinical strategy	Clinical Strategy fully aligned to Long Term Plan and BSW Strategy	21/03/2019 Complete	CB
	Ratification by Trust Board	Ratified Strategy with monitoring of delivery through Strategy Committee	04/04/2019 Complete	CB
Strategy Committee	Ensure programme management approach to enable alignment of digital, workforce, estates and clinical strategy	All key strategies are aligned and support delivery of the Trust objectives	01/04/2019 Initial phase of work completed to align key strategies. Strategy day planned for Exec Away Day 2/5/19 followed by Board Development Day in June. Action closed and further actions to be drafted following discussions at Board	LT

KLOE 3. Is there a culture of high quality, sustainable care?

Theme	Action	Outcome	Deadline	Lead
Review of Freedom to Speak Up Guardian arrangements to reflect best practice National guidance	Development of Equality & Diversity Strategy	E&D objectives identified and programme of work implemented to deliver	31/03/2019 Agreed by Board. Included in Annual Report	PH
	Development of Freedom to Speak Up Guardian (FTSUG) proposal	FTSUG arrangements reflect best practice	31/03/2019 Agreed by Board. Included in Annual Report	PH
	Drafted Corporate Communication Strategy paper to April Board	New Corporate Communication Strategy for the Trust	~~30/04/2019~~ 31/05/2019 Presented to WFC April - further work required 06/06/2019 Board approved strategy	PH
	Exec workshop on Freedom to Speak Up Guardian/ E&D	Behaviour change to improve diversity and equality	05/09/2019	PH
Equality and Diversity	Equality and Diversity programme established initially to include BAME, EU staff, Disability and LGBTI	Cross reference EDI strategy and action plan	As per action plan Update provided to the well-led steering group in July. Good progress being made	PH
	WRES action plan and objectives to be agreed with staff			PH

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Theme	Action	Outcome	Deadline	Lead
Corporate Governance Framework	Revision of the Integrated Governance Framework to increase governance guidance to directorates and services to improve consistency while ensuring that key governance items are considered at every level. This guidance should make reference to attendees, agendas, reporting templates and approach to performance review	Consistent approach to governance across the organisation	31/03/2019 Framework revised and approved at Board April 2019	FMc
	Introduce Directorate Governance meetings	Consistency of reporting and oversight of key governance items	31/03/2019 01/07/2019 update - all committees established although require further work to fully embed	FMc /DMTs
	Internal Audit of Directorate Governance meetings (risk management focus)	External assurance	31/03/2020	FMc/Internal Audit
The Executive team should continue to review and develop the approach to EPRMs, particularly in relation to the quality of reporting, focus of meetings on key risks and ensuring that the meetings are given adequate time and prominence to cover the high risk areas in sufficient detail.	Review consistency of approach and adoption of Accountability Framework through internal audit programme	Consistent approach and compliance with the Accountability Framework	30/04/2019 Included in Internal Audit Plan	FMc
	Internal Audit review of meetings and application of Accountability Framework	External assurance of compliance	31/03/2020	FMc/Internal Audit
	Roll-out to Corporate Functions	Complete performance oversight	31/05/2019 Corporate functions now included in performance review	AH
	Performance review escalation reports to TMC require review to include assurance against actions to address identified risks and ensure RAG rating rflects the identified risks	Assurance re mitigation of risk	30/09/2019	AH
	TMC minutes to accurately reflect discussion of items for escalation and any associated actions	Improved governance and assurance	30/09/2019	KN
	Review of executive attendance at EPRs	Executive commitment to the process	31/10/2019	AH
	Review of content of EPRs to ensure consistency of provided information and the potential to move to a centrally provided information pack	Consistent approach and compliance with the Accountability Framework	31/03/2020	AH
	EPR action logs or meeting minutes to clearly identify rationale for extended deadlines	Improved governance and assurance	30/09/2019	AH
	EPR minutes to include when a person arrives late or leaves early	Improved governance and assurance	30/09/2019	AH

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Theme	Action	Outcome	Deadline	Lead
Risk management training (including serious incidents)	Undertake TNA for risk training	Tailor made training following TNA outcome	30/09/2019	LW

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Theme	Action	Outcome	Deadline	Lead
Production of an Integrated Performance Report which is sufficiently detailed, accessible and clearly identifies variations and/or a need for change or improvement	Workshop in February 2019 with data owners	Clear understanding of rationale for changes to IPR, understanding of constraints regarding information flows and capacity	28/02/2019 Complete	EP
	Proposed new IPR for review by Board members	Draft revised IPR for consultation (2 weeks)	~~12/04/2019~~ 30/06/2019 01/07/2019 Approach agreed by Private Board in June. Full revised IPR to public Board in July	EP/FMc
	Revised draft IPR to Board meeting 6th June 2019	Introduction of new IPR	~~06/06/2019~~ 31/07/2019	EP/FMc
Improving digital capability (Digital strategy) and Information Management	Present to Trust Board in March	Ratified Digital Strategy	31/03/2019 Complete	JB/EP
	Delivery of implementation plan	Strategy supporting delivery of corporate objectives	Review 31/03/2020	JB
CIP and QIA reporting to Board	Strengthening the QIA review process following go live	Oversight and assurance on scheme impact	30/09/2019	LW/L.Arnott
Production and use of data which can provide intelligent forecasting for the future and to drive commissioning decisions	Introduction of forecasting into Committees and Board reporting	Better decision making	06/06/2019 This will form part of the revised IPR which is currently developing the content (SPC and narrative)	EP
Post implementation review processes for business cases	Review of revised process effectiveness	To realise the benefits of all approved business cases	31/07/2019	ME

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality, sustainable services?

Theme	Action	Outcome	Deadline	Lead
Patient engagement	Ratification of revised Patient Engagement Strategy	Systematic approach to patient engagement	30/06/2019 Strategy ratified at CMB	KG
	Commence delivery of strategy subject to Board approval		31/03/2020	KG
	Re-write of the patient engagement toolkit		31/07/2019	KG
Staff engagement	A 'mixed economy' approach: - digital - face to face - surveys (exit/joiners) - staff led interest groups	Systematic approach to staff engagement	31/03/2020	JM/PH
Corporate communications	Corporate Communications Strategy to Trust Board in April 2019	Strategy ratified by Board	~~30/04/2019~~ 31/05/2019 Presented to WFC April - further work required approved strategy Strategy approved	JMcG
	Implementation plan to be developed	Corporate communications and engagement aligned with the Trust's objectives	**July 19 update:** business planning process underway; the results of which will determine what is included in the implementation plan and for when activities are scheduled	JMcG

KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?

Theme	Action	Outcome	Deadline	Lead
Quality improvement	QI Strategy to be developed and presented to the Trust Board in March 2019	Structured and embedded approach to quality improvement	31/03/2019 Presented and agreed at April Board	EP
	Delivery of 2019/20 implementation plan post strategy ratification		31/03/2020	EP

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	05 September 2019		

Report Title:	Health & Safety Annual Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	x
Prepared by:	Paul Knight, Health and Safety Manager			
Executive Sponsor (presenting):	Paul Hargreaves, Director of OD & People			
Appendices (list if applicable):	As per the submitted report			

Recommendation:
The Workforce Committee are recommending approval by Trust Board

Executive Summary:
This report provides all the information to the board to enable it to discharge its responsibilities under current legislation.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☐
People - We will make SFT a safe place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

SALISBURY NHS FOUNDATION TRUST

HEALTH AND SAFETY
ANNUAL REPORT FOR WORKFORCE COMMITTEE
April 1st 2018 – March 31st 2019

Executive Summary

This report details how the Trust manages and measures health and safety within the organisation. It provides assurance to the workforce committee who then provide the assurance to the board that it can honour its obligations under current and future legislation. It lists the activities of the service and how it supports staff through advice, guidance and training. It reports on the activity of the enforcing authorities (Health and Safety Executive, CQC, EA and the Local Authority), both in the Trust and in other comparable organisations. There is a section on legislative changes that have, or may in the future, impact on our operations. There is also incident trend analysis and audit results portrayed that will provide evidence for the board on health and safety compliance and performance.

Contents

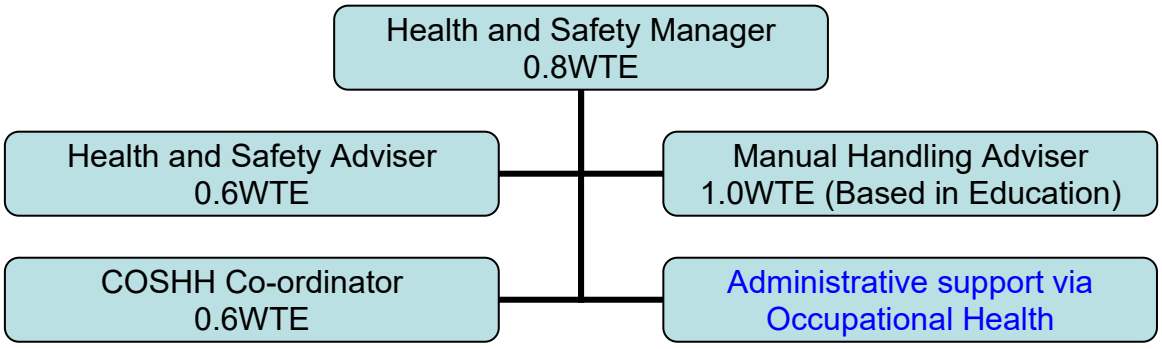
Appendices

1. Introduction

The regulatory requirements for health and safety are set out in the Trusts 'Health and Safety Policy.' Although the ultimate responsibility lies with the Chief Executive Officer, the day to day management is with the Director of Organisational Development and People. This function is delegated to the health and safety team who are based in occupational health.

2. Organisational structure and staffing levels

Staffing levels have been slightly reduced and the Health and Safety Manager reports directly to the Director of OD & People.



3. Roles and Responsibilities

Health & Safety Manager

They provide a strategic overview of the Trusts position regarding regulatory compliance. Ensure that a systematic approach to measuring health and safety and demonstrating assurance is in place. They monitor practicable safe systems of work that are in evidence and complied with throughout the organisation. They provide support for staff and committees and monitor accidents and incidents. For the last current financial year there has been support given to the management of the occupational health facility until January 2019 and the flu campaign.

Health and Safety Adviser

They support the health & safety manager in providing advice to Trust staff, inspecting areas, attend meetings and offer advice to other professionals in the organisation. They investigate Datix incidents, provide written reports, recommend actions and follow up accordingly. They provide training, both statutory and mandatory but also provide for areas on a regular basis and on demand. Together with the health and safety manager, they advise on the content of risk assessments and provide induction training. Both the manager and the adviser are solely responsible for RIDDOR reporting to the HSE. The adviser has reduced their hours by 1 day per week.

Manual Handling Adviser

They provide specialist training and expert advice on all aspects of manual handling and ergonomics as well as supporting the key trainer system undertaken in clinical and non-clinical areas. They provide managers with advice on individual functional workplace assessments including equipment training and specialised areas, this includes bariatric equipment and covers patients and staff. The increase in the Bariatric nature of our patients and the numbers presenting themselves are increasing at an alarming rate, This puts pressure on staff, equipment and the Adviser themselves in solving complex medical interventions with the added problem of weight. They develop training programmes, plan and provide training for regular and specific areas and evaluate its effectiveness. They provide guidance and support as appropriate with regard to the implementation of the moving and handling policy and guidelines. They assist with accident investigations as directed where accidents have occurred which have manual handling implications. These come either from Datix or working collaboratively with health & safety, occupational health advisers and the staff physiotherapy service. They also facilitate, by working with our insurers, our statutory obligation to tag slings/hoists and other lifting devices under the LOLER regulations.

COSHH Co-ordinator

The Department maintains COSHH assessments from the Alcumus central database. The current number of assessments, live and relevant to the Trust, is 3835 (3574) covering 1916 (1809) different products. The numbers have been reduced by removing those areas not under our control. We have also archived a lot of the assessments that do not present a 'significant risk'. These are distributed amongst the various departments in the form of 127 (123) COSHH manuals. There are 102 (105) custodians/COSHH assessors, of these manuals. A total of 3 books have been issued to new areas

Total Live Assessments	Assessments Issued Annually New + Updates	New Assessments over period	Updated Folders over this period	New COSHH Assessors Appointed
3574	71 + 77 = 148	71	28	8

Database record reviews, because of changes in details not content = 945

4. Objectives set in 2017/2018 for the 2018/19 period

The service has been engaged more and more in ergonomic assessments that are directly related to a more sedentary and aging workforce. There have been some senior middle management and senior supervisory losses accompanied by a lot of now changes in the middle management and supervisory band. These have required extra support and guidance from the team. We have made great strides in our target to reduce late reporting and be timely in the reporting of RIDDOR events to the HSE.

Delivered

- To present corporate and self-audit results to the board to enable them to assess compliance, identify weak areas, plan and implement what is needed to feed back

into the system alongside the principles of Plan, Do, Check and Act (HSG 65) contained in ***Appendix A.***

- Continue to develop and support the health and safety union representatives with regulatory updates
- Spot audits on targeted key risk areas such chemical safety on ward areas ***(Appendix E)***
- Monitor and act on CAS alerts, Safety Action Bulletins, and Field Safety Notices
- Monitoring the comprehensive investigation of serious incidents and ensuring prompt and appropriate measures are put in place to prevent recurrence
- Assess the relevant sections of the Risk Register
- Update of MLE packages where appropriate (this is still ongoing)
- Policies to be kept up to date
- Induction and voluntary sector training
- Support all the various sub-committees
- Support the drive to provide a no smoking site.

<u>Still to be delivered in full</u>

- Develop, in conjunction with Occupational Health, a strategy for identifying and then implementing health surveillance through policy
- Structure the risk assessment training into separate clinical and non-clinical courses although this has been part completed
- Provide targeted risk assessment training

<u>New Targets</u>

- Assessment of space usage under the workplace regulations

5. Health & Safety Audit System

The audit system has been completed by Catering, Medical Records, Speech and Language Therapy and the Spinal Unit. The areas were determined by the health and safety committee and completed by a responsible person from each area. It consists of 25 health and safety topics, each populated with a number of questions (Yes/No or N/A) or fields to enter data. It is a mixture of subjective and objective questions but it does give clear indication to strengths and weaknesses whether that is for individual areas, subjects or questions. The audit also requires the management to complete a short safety tour of their area which is very objective and an accurate snapshot of what is in place. The full set of results is contained within ***Appendix A***, health and safety maintains an electronic and hard copy, the area keeps its own record for evidence purposes. Four further areas will be selected at the September 2019 health and safety committee meeting.

The subjects covered were:

1. Clinical Waste	14. Manual Handling
2. COSHH	15. Medical Gases
3. Display Screen Equipment	16. New & Expectant Mothers
4. Driving at Work	17. Patient Falls
5. Fire Safety	18. Patient Handling

6. First Aid	19. Personal Protective Equipment
7. Health Surveillance	20. Security
8. Health & Safety Arrangements	21. Sharps
9. Incident Reporting	22. Skin Care
10. Infection Prevention & Control	23. Violence & Aggression
11. Information & Communication	24. Work Equipment
12. Estates	25. Young Persons
13. Lone Working	

6. Activity of the Health & Safety Committee (H&SC)

The chair of the committee is the Assistant Director of OD & People. All scheduled meetings took place and the attendance was 58% for the year compared to last year's 66%. Its main activities are:-

- Consider RIDDOR reports for the period and analyse yearly figures
- Look at the outcome of executive walk rounds
- Analyse incident trends
- Consult on and validate policies
- Ensured that the committee is fully informed of H&S activity across the south/southwest and nationally
- Updated TOR's and minutes of the committee on the intranet
- Assess and update the risk register
- Assess the impact of health & safety legislation

Ad-hoc topics include for this year include:

- Implementing 'No Smoking' across the site
- ILO International safety day, Health and Wellbeing and a healthy workforce
- Risk assessments and the risk register
- Impact of CQC under the IR(ME)R
- Impact of HSE under Biological Safety Standards
- EPRR and OH assessment of fitness for first responders
- Assessment of trust audits
- Consider compliance with the use of cleaning chemicals
- Receive the risk recording card and any relevant CAS alerts
- Consider capital bids from a health & safety aspect
- Determine any trends that need further scrutiny or investigation

Following changes to the reporting structure operated by the H&SC, the minutes of the following groups are received from the sub-committees. A summary of their activities in this period are attached as ***Appendix F***. The minutes of the Health and Safety Committee are tabled at the Workforce committee and are posted on the intranet.

- Waste management group
- LSMS and security development group (Including violence and aggression)
- Safe Sharp Steering Group
- Radiation protection committee
- Fire working party

- Medical gases group
- Central alerting system
- Risk report card
- Water safety group
- Laboratory safety group (Genetics and Pathology)

Note All these groups operate an escalation process to deal with issues. The safe sharp steering group has been replaced by an annual audit of compliance.

*Other committees that are supported are the Infection Control Committee, Smoking Cessation Steering Group, Decontamination Group, Wiltshire Smoke Free Alliance and the BNES Smoking Cessation Group..

7. Health & Safety Union Representation

Staff Side Safety Reps report 2018/19

Nancy Pallas, CSP Safety Rep

Over the past year as CSP Health & Safety Rep I have: Attended biannual union training meetings/events and collated resources for members. Continued to investigate workplace stress (via CSP 'Pinpoint the Pressure' campaign) and work closely with Stewards and Therapy Managers to address any issues found. Attended SDH Health & Safety Committee Meetings, as well as Health & Safety Rep forums. Advised members on Health & Safety-related matters, as and when contacted.

Denis Bangura, UNISON Safety Rep
Over the past year I have continued to attend the Trust's H&S meetings as often as I can, I have also helped a new Unison H&S in A&E settle into their role by being a point of contact and meeting up with him. I also had a consultation with the medical records department when they wanted to introduce lone working, and took part in the HSE visit that occurred this year. I also try and attend the safety reps open forum when I can. I was also the Staff Side rep on the Trust's No-Smoking implementation group.

Jamie Gillett, UNISON Safety Rep

Since joining UNISON as a health and safety rep in the last few months, I have attended and completed my health and safety stage 1 course, and I am currently in the process of instigating a 3 monthly health and safety inspection of the Emergency Department and will subsequently feed-back any issues to management. These inspections are due to start in May. I have also raised concerns over violence and aggression through social media which a member of staff has suffered, as a direct result of obvious identification (Name badges / trust ID) which I plan to raise at the next security committee.

Mark Wareham, UNISON Safety Rep

As Staff Side Co-Chair I take responsibility for updating lists of union safety reps at the hospital, communicating with them on matters of joint concern and updating noticeboard

lists. Over the last year I have attended almost all Trust Health and Safety Committee meetings as a UNISON rep and been an active participant in most of them (including Chairing one when management were not able to substitute), a number of the Security Management Committee meetings and have attended and organised meetings of the Staff Side Safety Reps Open Forum. One issue in particular that concerned me over the last year was the lack of Staff Side engagement with the 'Novichok' incidents and whilst I had a verbal briefing by management at one stage, and on the same day as the second admissions to hospital, in general Staff Side union reps were either ignored or frozen out of this incident. I did not invoke legal rights and press the matter, but expressed my disappointment at Trust Safety Committee meetings about the poor engagement whilst at the same time noting that thankfully no staff members appear to have suffered as a result of exposure to any nerve agent. I asked management side to reflect on improving engagement with Staff Side representation during such major incidents where staff safety is potentially at risk in future. I have also had involvement in representing groups of members on issues affecting working patterns and application of the Working Time Regulations / local agreement. Finally, I have also raised concerns about lack of cleaning in some non-clinical areas and the effect on the working environment.

8. HSE and Enforcement Visits

8.1 Activity of the Care Quality Commission (CQC) at SFT

There have been no visits over this period that are specifically Health & Safety.

8.2 Activity of the Health and Safety Executive (HSE) at SFT

The Trust was served with a statutory enforcement notice on 29/01/2019 as a result of a visit by the Health and Safety Executive (biological Safety Unit) on the 22nd of that same month. The Trust has until the 7th July to comply with the notice. A response letter was sent from the CEO to confirm out approach and its commitment to honour its responsibilities under the relevant legislation. The Microbiological Dept has delivered an action plan to the inspectorate (March 2019) which was received and accepted by the inspector. A further project plan, with committee oversight, governance arrangements and deadlines has also been produced.

The full detail is contained in the 3 documents ***Appendix G*** and the final action plan ***Appendix H.***

8.3 Activity of Local Authority (LA) at SDH

Local authorities have enforcement responsibilities for food hygiene. They inspect the kitchens for standards of hygiene, cleanliness and standards for the safe preparation and delivery of food.

- Findings following an unannounced food safety inspection on the 7th December 2018. The standards of compliance was high and the compliance with food safety legislation was suitably adequate. The catering department received on this occasion 5 stars which is the highest possible score you can achieve which indicates a very good rating. The report still shows high standards in the safe handling of food preparation, cooking, re-heating, cooling and storage.

Food hygiene standards are independently inspected and supported by an external consultant who also visited the Trust in 21st May 2018. Both of these see potential future issues with equipment age, equipment suitability and meeting food hygiene requirements as a result

8.4 Activity of the Environment Agency

There has been 1 visit this year with some small remediation required around the estate. There have been no visits from the counter terrorism unit and subsequently they have downgraded the risk from this Trust and we are not of any significant interest to them for now.

8.5 Activity of the HSE and the HSE Published National Statistics

After a lull of 3 years where there weren't any planned inspections, it is envisaged that the HSE will step these up in 2019/20 as referenced in its annual report. The key areas are manual handling, violence and aggression and respiratory diseases. The income from Its FFI scheme has dropped from 15 to 14 million pounds, this will encourage the agency to be more robust in its inspection criteria.

http://www.hse.gov.uk/statistics/

8.5 HSE Notices and prosecutions served on hospitals 2017/2018

There were 4 prohibition notices served on an Acute trusts and all of these were in Estates, the rest are all improvement notices. There is a statement against each notice to provide an indication as to whether we have systems in place to mitigate any potential risk against that notice being served on us.

Year	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Notices	45	21	21	50	19	21	39

There is no detail on how many enforcement letters were distributed where the content stipulates a material breach, but it is probably where the majority of their enforcement now lies.

Improvement Notices

Subject of Notice	2018/19 No Served	2017/18 No Served	Position of the Trust
Radiation Protection	6		RPC Committee will assess
Cat 3 Systems of work	5	7	Should be in place this year
Manual Handling	5		We have an adviser
Measures on V & Aggression	4		There are suitable measures in place for the Trust
Traffic Segregation	3		Not an issue for the Trust
Competent training & H&S advice	2		Not an issue for the Trust
Bed Rail Management	2		Not an issue

Supply of appropriate RPE	1		We have supplies
Man Handling Equip Maintenance	1		
COSHH systems	1		We have a system
Exposure to X-rays IRR 2017	1	2	RPC assessing
Nuclear Medicine Management	1		Odstock Medical
Working with Biological Agents	1	2	Lab Safety Committee
Safe sharp devices	2	2	Covered in last year's audit
Management of ligature points	1		Systems and RA in place
Occupational Dermatitis	2		We have monitoring
Total	39	13 (21)	

Prohibition notices

Exposure to dangerous machinery	3		
Exposure to CO	1		Not applicable
Working at height	1		

8.6 HSE Prosecutions on Acute Hospitals

2012/13	1 prosecution	£10,000 fines
2013/14	9 prosecutions	£43,000 fines
2014/15	9 prosecutions	£499,000 fines
2015/16	9 prosecutions	£767,000 fines
2016/17	9 prosecutions	£981,000 fines
2017/18	10 prosecutions	£3,540,000 fines
2018/19	3 prosecutions	£4,100,000 fines

Costs are escalating in light of the new sentencing guidelines that came into force 2 years ago. These were tabled and explained in last year's report.

Prosecutions in Chronological Order

Trust	Fine (£k)	Costs (£k)	Cause
RUH Bath	300.0	37.45	Legionella
Oxleas	300.0	28	Violence to staff
Elycin Healthcare	500.00	67.5	Patient Fatality (vehicle)
BUPA	3,000	151.5	Patient Risk
Total	4,100	284.5	

9 RIDDOR Reports at SFT

This year there were 12 involving staff compared to last year's 21.

2011 – 2012	30
2012 – 2013	26
2013 – 2014	35
2014 – 2015	21
2015 – 2016	21
2016 – 2017	24

2017 – 2018	21
2018 – 2019	12

Date of Incident	Area	Cause
23rd May	Cardiac Suite	Coffee scald
21st June	AMU	Shoulder pain
29th June	Radiology	Upper limb pain
24th July	Main Theatres	Back pain
6th Oct	AMU	Knee dislocation
12th Oct	Obstetrics theatre	Strains/sprains
19th Nov	Medical Devices	Back pain
29th Nov	Pharmacy	Tendonitis
3rd Dec	DSU	Strain/sprains
2nd Feb 2019	Staff car park	Fracture
10th Feb	Chilmark Ward	Back pain
25th March	Car park	Fracture

Patients

14th April	ED Ramp	Fractured ankle (avulsion)
8th June	Eye clinic	Fractured ankle
26th Nov	Wessex Rehab	Sight loss one eye

1. All slips trips and falls were investigated and general advice was given to take more care.
2. All fractures were investigated but no remedial cause was found.
3. All manual handling, musculoskeletal injuries were investigated, general good practice was reinforced but no systemic failures were unearthed.
4. No needlestick injuries reported.
5. The eye injury to a patient was a freak accident in that the injured party was not in the vicinity of the machinery, all guards and precautions were in place and the machine had been validated for such protection by an external source. There was no remedial action in retrospect that could have prevented the occurrence.

There are no specific industry benchmarks available at the moment to determine whether our RIDDOR reports are high or low. Of the 7 other Acute South/South West Trusts, the average number of RIDDOR reports per 1000 staff is around 5 with some as high as 9. SDH is lower placed at 2.8 (last year 4.9).

FOI Requests

There were 2 FOI requests, 1 relating to the uptake of vaccine and the second, as part of a larger FOI concerning non-patient falls.

10. Audits and appendices

Appendix A *Corporate and Self Audit Results from the following area:*

There were 4 corporate and self-audits conducted at the departmental level.
:

- Medical Records

- SALT
- Spinal
- Catering

Summary – In general, levels of compliance were good apart from the self-audit conducted by the spinal unit. The compliance was more about the general condition of the areas which is symptomatic of its age rather than underlying safety and safe management. We will be working with the Unit in a systematic way to put together a plan of action.

Appendix B

Summary – Areas of uncertainty related to the information that should be documented in risk assessments and to the interpretation of the term 'reasonably practicable' regarding the use of safer sharps. Overall, the regulations were considered practical to implement. Issues encountered when applying the regulations in practice related to the lack of market availability of certain types of safer sharps, initial worker resistance to using them, and difficulty in using safer sharps for certain procedures due to their design.

Appendix C Ergonomic support for staff

Summary – There have been over 100 assessments, with revisits to a range of staff from consultants down to admin staff. The Trust is increasingly short on space and there are increasing time demands on employees who are regularly working extended hours without considering breaks in line with the policy. The introduction of the wider 'Lorenzo' screens and double screen systems will in time increase the number of neck strains and general wear and tear injury on the thoracic vertebrae. People in general are living more and more sedentary lifestyles and posture, when we visit, is generally unsatisfactory and the main cause of discomfort.

Appendix D Smoking cessation post January 1st

Summary – This sets out why the Trust is on a journey to make it operation smoke free. Who is responsible for that journey and where we are to date with our plans and what the reaction has been In the months that followed January 1st.

Appendix E National EFA alert on the ingestion of chemicals by patients

Summary – A paper, setting out an assessment of the problem was seen by the workforce committee, it also identified a couple of high and medium risk areas and a set of proposals to reduce risks in these areas and across other clinical areas. These proposals were adjudicated on viability at the matrons meeting.

Appendix F Summary of the Sub Groups

Summary – All of the subgroups have met on a regular basis.

11. International Labour Organisation

Every year the ILO focuses on one element of Safety and Health, this year its focus is 'the future of work' which took place on 28th April 2019.

Inspired by the ILO centenary anniversary and discussions on the future of work, the world day this year attempts to take stock of a 100 years of work in improving occupational safety and health and looks to the future for continuing these efforts through major changes such as technology, demographics, sustainable development including climate change and changes in work organization.

The official World Day on 28 April 2019 will only be the beginning of worldwide events and activities to continue throughout the rest of the year, around the theme of safety and health and the future of work, celebrating and building on the wealth of knowledge and action accumulated over 100 years as we get ready to face and appreciate the changes brought forward by the future of work we want.

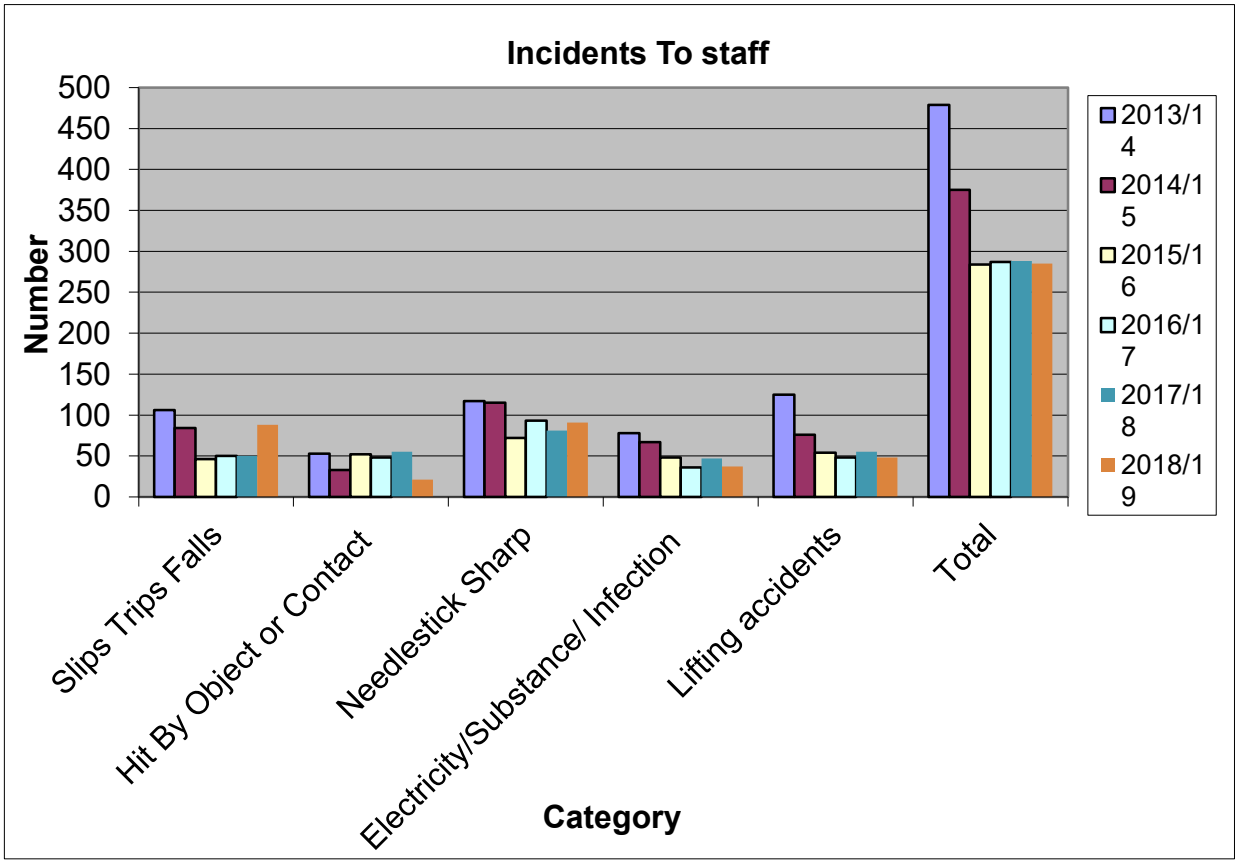
The ILO will launch a global report to that effect, sharing the story of 100 years in saving lives and promoting safe and healthy working environments. The report attempts to capture the evolution of safety and health from before the inception of the ILO in 1919 to date, going through the major turning points that have influenced this field and have influenced the way ILO has contributed to improving safety and health at work.

More importantly, the global report will touch upon the changes in work arrangements, technology (digitalisation and ICT, platform work, automation and robotics), demographics, globalisation, climate change, and other drivers that are affecting the dynamics of safety and health and the nature of professions in this area, notwithstanding the persistent traditional and re-emerging risks and variations across developing and developed countries.

12 Incident reporting and trend analysis

This year there was a total of 248 staff accidents and incidents; this is showing a very stable situation over the past 4 years and a significant reduction from the levels between 2013/15. This is a positive trend in light of the increased activity of the Trust, external high profile events, the increased use of bank and agency staff and the operational pressure of ward and other area moves internally. There has been a slight uplift of slips, trips and falls but handling injuries are down in numbers but the time off accordingly, still tends to be a long term event. The previous year's reduction of violence and aggression numbers which directly correlates to the introduction of security on site has now also risen significantly. However, these numbers have been skewed by a couple of very difficult patients who have generated a significant number of events on their own.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Slips Trips Falls	106	84	46	50	50	80
Hit By Object or Contact	53	33	52	48	55	21
Needlestick Sharp	117	115	72	93	81	81
Electricity/Substance/ Infection	78	67	48	36	47	27
Lifting accidents	125	76	54	48	55	39
Total	479	375	284	287	288	248



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Verbal Violence & Aggression	215	180	66	58	38	54
Physical Assault Violence Weapon	109	81	61	59	58	91
Those above resulting in injury			32	36	38	
Total	324	261	127	117	96	145

Note The above figures may differ slightly from the data returned by the LSMS. It only reflects data on what has happened to staff, it does not include information on racial or sexual abuse as these are dealt with by other acts of parliament.

Risk Profile

The following information is based on the 'risks open' and the 'risks closed' currently held on the Datix database. The search criterion was on 'organisational risks' as these are, in the main, health and safety related.

Category	Total	Average	Range
New Risks	2 (3)	6.0 (8.1)	4 – 8 (6 – 10)
Open Risks	38 (29)	5.8 (5.6)	2 – 12 (2 – 10)
Closed Risks	101 (88)	4.5 (4.7)	0 – 12 (0 – 12)

*Last year's figures in brackets

Summary of significant open risks

These risks events have been generated by individuals in the organisation; the RAG rating below is my assessment of the potential, the PPM risk is still in place and deteriorating as is the nature of the risk. There has been a reduction from the provision of lead gowns as an assessment has been conducted and funding made available. This is still there because we haven't moved to a managed system, which is the preferred option. There have been no changes to the ratings but 2 new risks are in play.

Last year

Risk Score 3	Compliance with the electricity at work regulations	Acceptable with continued rotational 5 year funding to a programme to test the Trusts infrastructure
Risk Score 4	Fire Door wear and tear	Acceptable with programme of replacement and modification on an annual basis
Risk Score 6	Fire Dampers PFI	No funding required as it is excessive compared to the risk and revolves around the reset ability
Risk Score 9	Fire Alarm Tone	No funding required as it is excessive compared to the risk, an emergency tone is still being generated
Risk Score 9	Capacity of Medical Records	This is a risk that will continue to grow with time in the short term but may alleviate with digitalisation
Risk Score 9 up to 10	Planned Preventative Maintenance resources	This is a risk that carries the greatest potential in that the outcomes are many and unknown
Risk Score 9 down to 8	Provision of Lead Gowns (PPE)	This is a risk that will continue to grow as gowns continue to grow older, there has been 1 off capital input

This year

Risk Score 9	Provision of manual handling advice	There is growing pressure on the MHA as clinical input on bariatric patients increases, there is no cover for this role and the provision of this service is being evaluated
Risk Score 6	Provision of a Radiation Protection Adviser	Trusts are being put under pressure by the HSE (more inspectors recruited by HSE and CQC) and there needs to be a contingency plan for this role as again, it is a single point of failure.

13. Changes in Legislation, the HSE and the Brexit effect

There have been a significant number of variations issued on H&S legislation but none that adversely affect the Trust and its day to day operations apart from IR(ME)R. There has been some movement because of and determining a pathway as a result of Brexit.

- Exit regulations 2018
- Health & Safety (Miscellaneous Amendments) EU
- The Chemical (Health & Safety) Genetically Modified Organisms (contained use) EU Exit Regulations
- The Justification Decision Power (Amendments) (EU Exit) Regulations
- REACH etc (Amendments etc) (EU Exit) regulations 2019
- Ionisation Radiation Regulations (as amended) 2019
- The Justification of Use Radiation Powers (Regulations)
- Radiation (Emergency Preparedness) and Public Information Regulations
- IR(ME)R
- PPE Regulations
- Gas Safety Installation and Use Regulations
- Community Drivers Hours (Offences)
- Gas Appliance Regulations
- IET Wiring Regulations (18th Edition)
- Workers Exposure Limits
- Sentencing Guidelines
- Drone Regulations (Consultation 15th Feb 2019)
- Poisons Act
- Weights and Measures 2019 Miscellaneous Provisions
- Blood Safety and Quality Amendments

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The HSE continues to concentrate on the health, rather than the safety element of its title. Our Helping Great Britain work well strategy sets the direction for further improvements. This year has seen further commitments, engagement and ownership of the challenges ahead from partners across industry, unions, and the many others with an interest in our work. Our first annual conference in September 2017 was a particular highlight. In addition, we have also been pleased to see our sustained focus on the Health and Work programme bearing fruit as we raise awareness of occupational lung disease, musculoskeletal disorders and work-related stress, and how to manage associated risks.

The impact of the Sentencing Council guideline will continue to be closely followed in 2019. But it's worth noting the FFI charges by which HSE supports its own activities have increased from £129 to £154 per hour.

2019 will continue to bring questions around Brexit and what it means for occupational health and safety. Most UK health and safety laws derived from EU directives have been in place for many years and are embedded in companies' policies, management systems and working practices. The most pragmatic approach the UK can adopt is to "grandfather" all legislation derived from EU directives when we exit, and then review it piecemeal. The legislation to do this is now being put in place.

It is also wort noting that the HSE received a 'Crown Censure' regarding an incident whereby one of its own staff members was injured in 2016. Which proves that however

much we regulate, audit assess and support the process, we cannot guarantee a risk free environment.

14. Policies

Policies updated and validated this year through the Health and Safety Committee are:-

- Health & Safety Policy
- Bariatric Policy
- Violence and Aggression
- Psychological Wellbeing and effectiveness at Work Policy (Pending Extension)
- Staff working in another organisation
- Low Voltage
- Waste
- Security (modifications)
- No Smoking Policy

Up and coming policies are:-

- COSHH
- DSE

15. Health and Safety Awareness at Induction

The Health and Safety Adviser conducts a monthly awareness session for new staff as part of the induction process.

Monthly Induction Booked	Attended	DNA	Year
459	393	66	2014/15
499	358	141	2015/16
416	353	63	2016/17
354	309	45	2017/18
246	305	52	2018/19

There has been some discussion in the Trust and through the health & safety committee regarding Risk Assessment training. This was conducted in conjunction with Risk and comprised of 6 risk assessment training sessions per year. The Risk Department has now opted to train users on a one to one basis on the Datix system. This means that the training on the legal aspects will be picked up by health & safety. This will be rolled out in the coming year unless comments are made by the HSE.

17. Conclusion

Over the past 5 years, we have steadily improved on our safety management systems. However, over the last year there have been significant changes in the structure of the Trust in both higher management and the committee system.

It is now fully apparent that timely investigation and subsequent intervention into accidents, incidents and near misses has seen a stabilising of accident statistics, this is

particularly meaningful considering the increased activity in all areas of service delivery. Plus, the influx of a number of our middle management team means more input from us in day to day issues.

We have rectified most of the problems in getting staff to recognise over 7 day injuries and are now rarely reporting late under RIDDOR.
After the drop in musculoskeletal injuries over the past few years and having a stabilised base, this year has seen another significant drop in harm. Again, this is seen to be good news in light of increased activity and a significant increase in bariatric patients. The headline figure is that handling injuries have gone down a further 29% this year

I feel we are managing health and safety in light of significant organisational and operational changes within the Trust.

Violent incidents have gone up markedly, this is almost certainly been down to a core of problem patients generating a lot of reports, again the headline is that the numbers of staff injured as a result have been almost the same as last year.

Major achievements are:

- Continuing to build on the audit system as a key tool for the Trust. It also provides evidence for regulators and defence strategies for claims and litigation. We have now completed 12 areas as we add another 4 this year.
- We are now compliant in all major areas on needlesafe devices and this has been checked through audit.
- Putting through a significant number of policies and SOP's.
- Successfully rectifying the issues in the CL3 Laboratory and providing the evidence to the Executive that we have trained staff and robust management systems

Managing health and safety in a healthcare setting is a challenge to us all and therefore mindful that we still need to:-

- Continue our work and effort into radiation protection, specifically the role of 'radiation protection supervisers' (RPS's). This is an area where the regulators are 'growing into it'.
- Monitor closely and learn from statutory enforcement notices, this gives us a sound base when hosting a regulatory visit.
- We still network comprehensively with other Trusts especially around the activity of the regulators; we are an integral part of the south and south west healthcare groups and we know that inspection time tables are being ramped up by the HSE.
- Be creative with our space utilisation, many of our services are growing and the pressure on administrative areas is not immune to potentially overcrowd.
- Have better coverage for manual handling induction training and advice whilst still operating on a single point of failure when it comes to professional manual handling advice. A re-look at the role and a case for more resources is long overdue.

The Dept continue to be vigilant and proactive in that we inform and audit the Trust on a risk based principle. We still have to react to day to day issues which seem to be growing whilst still trying to be strategic and sensibly steer the Trust and its staff forward.

Audit Results 2018/2019 Period

Corporate Audit There are 25 sections over a wide range of subjects and a total of 202 questions. Some of the questions are very define whilst others are more nebulous and designed to stimulate thought and precipitate actions. The analysis of the results was based on the 3 test system, compliant (100%) part compliant (50%) and non compliant (0%). Not all of the questions would have been answered in all of the sections as some may not have been relevant to the particular speciality.
Self Audit This is a simple safety tour of the area on the day and completed whilst walking around and observing. There are 57 questions and these are designed to be simply Yes/No or N/A answers with the compliance calculated numerically on this basis.

Area	Spinal	SALT	Med Records	Catering	Avge
Out of 25 Sections Those Relevant	22	21	11	20	
Out of 202 Questions Those Relevant	166	144	69	152	
Percentage Compliance Corporate Audit	92.6	80.0	75.8	90.7	84.8
Percentage Compliance Self Audit	56.0	96.0	62.5	83.3	76.0

Corporately, we scored reasonably well and there were very high scores for spinal and catering. Overall, clinical waste, COSHH, water safety, fire safety, work equipment, PPE, security incident reporting and infection prevention and control were high. Low scores did not show any specific pattern. Self audit low scores are commented on below, but individual issues are addressed as a result of this exercise.

Scoring Action Plan

76-100% No action needed and the area has the correct approach to health & safety
51-75% Management need to look at poor performing areas and put together an action plan with time scales
26-50% Health & Safety to work with the management to resolve poor scoring areas and flagged to SMT.
0-25% As above but flagged to Director level.

Action Plan for Health & Safety: The low figures seen in the self-audit are clear indications that these areas are in need of some investment or a radical rethink in how they are organised and used. They are now buildings of an age whereby the use has moved on but the design and functionality and the relevance to the work in these areas today, has not. These will be flagged to the appropriate committees.

Summary of 4 years data

Clinical Area	**Corporate**	**Self**	**Date**
Sexual Health	82.0	89.0	2016
Endoscopy	94.7	78.4	2016
Laverstock	81.0	84.1	2017
Dermatology	90.2	63.3	2017
ED	97.2	90.0	2018
Breast & Gynae Facility	88.6	88.5	2018
Spinal	92.6	56.0	2019
SALT	80.0	96.0	2019
Non-Clinical Area			
Staff Club	77.5	84.2	2016
Med Eng	60.3	80.8	2016
IT	83.8	76.2	2017
Wessex Workshops	77.3	87.2	2017
Staff Club	97.9	100	2018
Waste	90.2	100	2018
Medical Records	75.8	62.5	2019
Catering	90.7	83.3	2019

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, Post Implementation Review: research with healthcare employers, managers and employees.

Prepared by the Health and Safety Executive as Research Report 1127

Overview

Part of the Health and Safety Executive's (HSE) post-implementation review (PIR) of the Sharps Regulations involved engaging with healthcare employers/managers responsible for implementing the regulations, and employees who work with sharps, to explore how the regulations work in practice and their views and experiences about their effectiveness. The key messages from this research are:

•The regulations were considered to be clearly written and organisations could readily understand what they needed to do to comply. Areas of uncertainty related to thein formation that should be documented in risk assessments and to the interpretation of the term 'reasonably practicable' regarding the use of safer sharps (i.e. sharps incorporating safety features).

•Overall, the regulations were considered practical to implement. Issues encountered in applying the regulations in practice related to the lack of market availability of certain types of safer sharps, difficulty in using safer sharps for certain procedures due to their design, and worker resistance, which however appeared to dissipate with familiarisation and/or experience in using them.

•The majority of managers and employees considered that the regulations are effective in reducing the risks associated with the use of sharps to protect healthcare workers from sharps injuries.

•Managers expressed mixed views regarding the extent to which the number of sharps injuries in their organisation had changed following the introduction of the regulations. For some, the number of sharps injuries had stayed the same, yet others had observed a reduction or indicated that they did not know.

•Specific benefits that were discussed in relation to the regulations included raising awareness of the risks associated with the use of sharps, promoting safer work practices, and encouraging organisations to review their practices and improve the management of risks associated with sharps.

•In general, managers believed that the objectives of protecting workers and reducing the risks of sharps injuries could not be achieved with a system that involves less regulation.

EXECUTIVE SUMMARY

Introduction

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations) came into force on the 11th of May 2013. They build on existing health and safety law and provide specific detail on the requirements for healthcare employers and their contractors to ensure that the risks from sharps injuries are adequately controlled. There is a requirement to carry out a post-implementation review (PIR) of the regulations after five years to evaluate their effectiveness. As part of the PIR, professional psychologists and human factors specialists from the Health and Safety Executive (HSE) undertook research to comprehensively explore how the regulations work in practice. This provided a measure of independence from the policy officials undertaking the broader evaluation and review of the Sharps Regulations. The research examined the views and experiences of a broad range of managers responsible for the implementation of healthcare policies and practices, and employees who work with sharps about: i) whether the requirements of the regulations are clear; ii) how they work in practice, including any issues encountered in their implementation; iii) how effective they are in reducing the risk of sharps injuries; and iv) whether the objectives could be achieved with a less regulatory approach.

Methods

A process evaluation approach was adopted in order to explore the views and experiences of managers responsible for implementing the regulations, and employees who work with sharps of how the regulations are working in practice. This approach is best suited to address questions of how a policy or regulation is implemented including which aspects work well or less well. Data was also collected to address economic (i.e. costs of implementation), and outcome (i.e. impact of the regulations on sharps injuries) evaluation questions, which fed into HSE's wider review of the regulations. The results of the economic and outcome evaluation are reported separately, and do not form part of this report.

A combination of quantitative (survey) and qualitative (interviews and focus groups) approaches were used. A survey was administered to managers and employees across a range of both NHS and private organisations. In order to reach as many respondents as possible, the survey was distributed to named contacts (in NHS management roles, private hospitals, GP and dental practices) obtained from an external healthcare information provider and to key stakeholders from the health and social care services sector (e.g. healthcare organisations, unions and professional associations). A total of 783 survey responses were received. Of those, 59.1% were from managers, and 40.8% from employees. Just over a third of the responses (37.0%) were from 'NHS Acute Hospitals' followed by 'NHS Community Services' (16.5%) and 'NHS Dental Services' (11.0%). Eighty-nine participants took part in twenty-seven interviews and focus groups across twelve healthcare organisations (six NHS Trusts, two Ambulance Trusts, and four private organisations) in England, Scotland and Wales. Twenty-six were managers that had a direct role in implementing the regulations in their respective organisations, and sixty-three were frontline employees.

Main findings

Clarity of the regulations

The majority of managers (93.8%) believed that the regulations were clear about what organisations need to do to manage the risks associated with the use of sharps. Similarly, the interview/focus group findings suggest that managers considered that the regulations were easy to understand and to follow, and that they set out clearly what organisations were required to do in order to comply. Some managers were uncertain about what information should be documented in risk assessments, and when the use of safer sharps is considered to be 'reasonably practicable'.
Implementation of the regulations

Overall, the survey results showed that managers considered that the regulations were practical to implement (63.0%). Organisational commitment, including financial resources for introducing safer sharps, manufacturer support (e.g. training and follow-up advice on using safer sharps) and clinician involvement (e.g. selection and trialling safer sharps) emerged as important factors in the implementation process from the interviews/focus groups. Although some participating organisations had started to implement the regulations prior to their introduction in 2013 (in response to the EU Directive in 2010), for others the regulations, and in some cases, enforcement action taken by the HSE were a key driver in implementation and in securing organisational commitment to comply.

In relation to the specific sets of regulations, the survey results and interviews/focus groups suggested that some provisions were already in place prior to the Sharps Regulations coming into force in 2013 (e.g. provision of sharps bins, 'regulation 5(1)(d)'; recording, investigating and following up sharps injuries, 'regulations 7(1) and 7(2)'; notifying the employer of a sharps injury 'regulation 8').

Regulation 5(1)(a) and (b) "Avoiding the use of sharps and use of safer sharps"
The majority of survey respondents (79.1%) indicated that safer sharps were used 'most' or 'all of the time'. The interviews/focus groups also suggested that safer sharps were integrated in daily practice with several participating organisations constantly looking for new types of safer sharps that were becoming available on the market. Issues identified regarding the use of safer sharps, across both the survey results and qualitative findings, included workforce resistance (which however appeared to dissipate with familiarisation and building up of experience and confidence in using them), lack of market availability of certain types of safer sharps (e.g. pre-filled syringes for flu vaccines, certain types of needles used in dental practice, theatres), and difficulty in using safer sharps for certain procedures due to their design (e.g. impacting on visibility for certain delicate procedures, such as eye surgery).

Regulation 5(1)(c) "Preventing the recapping of needles"
Over two thirds of survey respondents (69.0%) indicated that the recapping of needles did not occur. However, a higher percentage of responses obtained from 'NHS Pharmacy' and 'Private dental services' (68.2%, n=22 and 70.0%, n=30 respectively) indicated that needles were recapped. The vast majority of survey respondents (82.2%) stated that measures were in place to control the risks from recapping. The qualitative findings suggest that the recapping of needles was perceived to be necessary for certain clinical situations in dental practice, and in the preparation of some chemotherapy drugs in aseptic units (e.g. to prevent drug contamination and potential exposure to cytotoxic drugs).

Regulation 5(1)(d) "Secure containers and instructions for safe disposal of medical sharps close to the work area"

The survey and interviews/focus groups suggested that sharps bins were provided at the point of use and that they had been available prior to the regulations coming into force in 2013. A challenge identified from the interviews/focus groups related to the overfilling of sharps bins (e.g. safer sharps being 'bulkier', using sharps bins to dispose of inappropriate equipment, and/or forgetting to replace sharps bins due to work pressures).

Regulation 6 "Information and training"

Just under two thirds of survey respondents (61.8%) indicated that there had been changes to the health and safety information and training received following the introduction of the regulations. Typical examples identified from the interviews/focus groups included: i) updating existing training to incorporate the regulations (e.g. highlight the requirements and reinforce messages, such as the importance of disposing of sharps safely); and ii) providing training to employees on how to use safer sharps. A range of initiatives were also identified to raise employee awareness about sharps risks (e.g. awareness campaigns, posters, bulletins).

Regulations 7(1) "Recording and investigating the incident", 7(2) "Treatment and follow up of a sharp injury" and 8 "Injured employee's duty to notify their employer of a sharps accident"

Both the survey results and the qualitative findings showed that there were arrangements in place for recording, investigating, following-up and treating sharps injuries, and for notifying the employer in the event of a sharps injury prior to the regulations coming into force in 2013. The survey results also showed that sharps injuries were reported 'most' or 'all of the time' (75.3%). Consistent with this, the prevalent view among interview/focus group participants was that sharps injuries were reported (i.e. an 'open', 'no blame' culture was often referred to), and that prompt clinical advice and/or post-exposure prophylaxis were provided when needed.

Effectiveness of the regulations including benefits and disadvantages

Over two thirds of survey respondents believed that the regulations were effective in meeting their objectives (67.7%), and 78.9% agreed that compliance with the regulations reduced the risk of sharps injury. Just under two thirds of managers (59.9%) also believed that the regulations had improved the prevention of sharps injuries 'to a moderate' or 'great extent'. Further, the majority of survey respondents (77.4%) believed that the regulations were beneficial for their organisation. Key benefits that emerged across the interviews/focus groups were that the regulations had raised awareness about sharps risks (e.g. potential exposure to a blood-borne virus), had helped to promote safer work practices (e.g. through the use of safer sharps1, better sharps disposal practices), and had prompted organisations to review their practices regarding the management of sharps risks (e.g. updating policies and procedures, reviewing existing training on sharps safety).

(1 The term 'safer sharp' refers to sharps that incorporate 'features or mechanisms to prevent or minimise the risk of accidental injury', such as needles and syringes with a shield or cover that slides or pivots to protect the needle after use HSE, 2013, p. 2.)

Less than half of survey respondents (43.9%) indicated that they had encountered disadvantages as a result of the regulations while 56.1% disagreed. Disadvantages identified from the open-ended survey comments related to costs (e.g. of purchasing safer sharps) and to the use of and/or attitudes toward using safer sharps (e.g. resistance to using safer sharps, usability of safer sharps). The survey results revealed mixed views regarding the impact of the regulations on the number of sharps

injuries. Over a third of managers (41.2%) indicated that the number of injuries in their organisation had stayed the same since the introduction of the regulations, 31.7% stated that the rate had decreased, 20.2% indicated that they 'did not know' and 6.9% said that the rate had increased. The prevalent view across the managers that took part in the interviews/focus groups was that the number of injuries had stayed the same. However, a view was expressed by some managers that the use of specific types of safer sharps (e.g. safety hypodermic needles and safety cannulas) had reduced and/or eliminated sharps injuries in their respective organisations.

Extent to which the objectives could be achieved with a less regulatory approach

From the survey, 46.1% of managers indicated that the objectives (i.e. of protecting workers and controlling the risks from sharps) could not be achieved with a system that involves less regulation; 20.1% took an opposite view, and 33.8% indicated that they 'did not know'. The prevalent view amongst the managers that took part in the interviews/focus groups was that the regulations were an important means of ensuring that organisations comply, and manage effectively the risks associated with the use of sharps. There was also a perception that the regulations were particularly helpful due to their specific focus on how employers should manage the risks from sharps.

Strengths and limitations of the research

The mixed methods approach adopted enabled a comprehensive assessment of both managers and employees' views across a range of healthcare settings, providing a rich picture regarding the effectiveness of the regulations and how they work in practice. There was a good level of engagement in the research, particularly given the busy nature of healthcare settings, which was evident in the number of managers and employees that took part in the interviews and focus groups, and in the number of survey responses obtained. Whilst the number of survey responses received across non-clinical roles and some organisational settings was limited, useful insights were obtained into the views of healthcare professionals across NHS and private organisations.

Conclusion

Whilst the impact of the regulations on the number of sharps injuries appears to be mixed, with the results primarily indicating perceptions of either similar levels and/or a reduction of sharps injuries since their introduction, healthcare managers and employees generally considered the regulations to be effective in reducing injury risks from using sharps. Specific benefits included raising awareness of sharps risks, prompting organisations to review how they manage the risks from sharps, and promoting safer practices. In general, healthcare managers believed that the objectives of reducing the risks from sharps could not be achieved with a system that involves less regulation. The regulations were considered to be clear regarding what is required to comply. Areas of uncertainty related to the information that should be documented in risk assessments and to the interpretation of the term 'reasonably practicable' regarding the use of safer sharps. Overall, the regulations were considered practical to implement. Issues encountered when applying the regulations in practice related to the lack of market availability of certain types of safer sharps, initial worker resistance to using them, and difficulty in using safer sharps for certain procedures due to their design.

Summarised by Paul C Knight (Health & Safety Manager) April 2019

Full Document http://www.hse.gov.uk/research/rrpdf/rr1127.pdf

Display Screen Equipment – Workplace Risk Assessments

Keeping our staff here - and healthy

A short report on the health and safety of computer users

1. Introduction

There are a number of staff who, despite using the MLE DSE training, need additional support and advice on how to work comfortably at a computer. This additional support and advice is given by the H&S advisor, together at appropriate times with the Manual Handling Advisor and Health and Safety Manager.

The health and safety Department manage the DSE policy and provide verbal guidance to all staff that use a computer from equipment choice to medical advice and set up procedures. Where there are more complex issues such as a return to work after surgery, more formal support is given. It can be seen from the attached report on Workplace visits that there were around 103 requested formal site visits to staff offices or workplaces during the last working year. It should be born in mind that most work situations are unique. The task is to fit the workstation to the person and provide an ergonomically satisfactory solution.

These requests would be generated from a number of sources. The reasons for these requests can range from tingling or pain in the limbs or upper body to a person returning to work following a long term illness or accident. The referrals would be made from:-

- Referrals from managers
- Referrals from Occupational Health advisors
- Referrals from OH Staff Physiotherapist
- Self-referral
- A new employee with known health issues

The purpose of the referral is to establish:-

- what the problem is
- how this affects the person
- what steps have already been taken
- why this is happening and
- what can be done to make the situation better

The range of problems is vast and may include how they get to their workplace, their day to day activities, their handling and carrying of loads and the number of breaks achievable from their desk.

2. Legal

A DSE 'User; by definition is deemed to be a person who uses Display Screen Equipment (for 1 hour or more) at work in a normal shift. There is a legal obligation for employers to ensure that DSE 'users' are not put at risk by their work stations. Therefore it is incumbent upon managers and advised by the health and safety department to ensure that all practical and reasonable measures are put in place to secure the health safety and welfare of all users employed by the Trust.

3. Trust Policy

The Trust has a DSE policy which will be pointed out in the first contact to the staff member, in a lot of queries; this will be enough to guide the employee to the right advice. If this is not sufficient, then they are directed to the interactive assessment in the appendices to the policy. This provides for themselves and their manager, a specific risk assessment and the generation of a set of remedial actions. It also is a written record of any changes made. If there are still problems, then a visit can be warranted to the individual. Note: some of the 103 requests will be a single visit; however at this stage the cases are complex and will necessitate a number of repeat attendances.

4. Workplace assessments

The Assessment will include:-

1. the nature of the work undertaken
2. the equipment provided
3. the workplace layout
4. environmental factors e.g. light, ventilation, noise, temperature, space,
5. the person, aches pains, disabilities, spectacles
6. able to achieve comfortable position etc
7. workspace

It is sometimes necessary, especially if there is a specific medical problem, to suggest that the user visits their GP Occupational health advisor and/or Staff Physiotherapist – depending on the problem.

5. The Chair

The User's chair is one of the most important factors in the User being comfortable. Most Users do not know how to adjust their chair. Many users adopt habits and poor posture which gives rise to backache and other conditions. There may be occasions when, due to personal reason (such as a painful coccyx) the User is unable to sit for long periods. A sit/stand piece of equipment has been supplied to several areas including laboratories where the need to sit or stand is part of the User's requirement.

6. MLE DSE package

There is an instructive MLE package on the Trust's intranet on which staff should complete every 3 years. All the points above are covered in the package.

7. Lap-Top Users

There is a growing trend in the use of lap-tops, more frequent and extended use of lap-tops in the Trust may be as a result of staff mobility and potentially an increased pressure on work spaces and areas. This has an extra dimension to DSE assessments, especially if the users are peripatetic and/or work from home. The scope of the Trust policy is clear that users of lap-tops and other similar devices such as tablets are part of the DSE regulations and protection and support for staff is the same. This is also covered in the 'working from home policy' in that staff, although not in a workplace are still at work. Laptops should never be used to replace the standard desk computer as it is impossible for the User to achieve a safe and comfortable position. Laptops should be used only for short periods of time where a desktop computer is not available or practicable such as at a meeting.

8. Overview

Many staff felt immediately more comfortable when their work equipment was adjusted properly. For the longer term, some may require a better chair - others may require other DSE equipment to overcome symptoms of RSI, tendonitis and carpal tunnel syndrome etc.

On occasion, specialist equipment is necessary and can be ordered for the individual.

Over the last few years 'Hot Desking' has become very common and provides its own challenges for the individual and the organisation. Our advice is to avoid this as much as possible because it causes personal and complex ergonomic issues. Workstations can be set up to suit the individual, but this can be completely changed when moving to a different workstation.

Shortage of space can sometimes be an issue and it is becoming necessary in some departments to replace the standard office desk with a running length of worktop. This allows more persons to sit and takes up less space, however, it does not allow as much scope for adjustments and modern workstations are designed to exacting standards whereas fixed workspaces are not. This however must be balanced with the minimum space requirement under the regulations for each individual room.

9. Result Summary of Ailments 2018

High Risk Assessments

Slipped discs	5	
General surgery	5	
RTW	5	
Arthritis	5	
Disabled	4	
Fibromyalgia	3	

Stroke	2	
Hip replacement	2	
Cerebral Palsy	1	
Total	**32**	

Medium Risk Assessments

Painful Back	25	
Painful Neck	15	
Painful Fingers/Thumbs	9	
Painful Shoulders	7	
Painful Wrists	3	
Total	**59**	

Low Risk Assessments

Migraine	5	
General Discomfort	4	
Pregnancy	3	
Total	**12**	

Total Assessments **103**

From the number of visits concerning DSE work, there were 2 anaesthetists, 3 surgeon/consultants and 4 hospital doctors included in the assessments. Others included department managers, administrators, wards clerks, clinical staff and secretaries.
Many of the formal visits were due to a range quite serious and debilitating conditions as reflected in the high risk assessments. The remaining were general uncomfortableness which, if not checked could lead on to a more serious condition or time off work.
All of the visits were followed up at the appropriate time and further action taken as necessary.

There was only one RIDDOR reportable incident due to RSI in 2018/19 but this was not due to DSE work.

Geoff Lucas

Health & Safety Adviser (2018)

Smoking Cessation post January 1st 2019

1. Staff

The drop in sessions for staff in December (Springs) were well received but equally as popular with visitors and patients.

The booked sessions through Occupational Health were disappointing and only 4 people were seen. It is intended to continue with these on a monthly basis but expand them to include other well-being interventions.

The health & safety team have been monitoring smoking areas on a daily basis but so far there have been no staff smoking at all

2. Signage

All smoking signs and signage are in place, within the next week, vaping signs will be on all sheltered areas.

3. Areas of Concern

Smokers from the Trust are congregating at the public bus stop, outside of the Trust area, there is nothing we can do about this. There will be comments/complaints about this area, especially the litter aspect; again, littering in the public domain is with local authority enforcement. Smoking by mainly laundry staff is being undertaken on private land down the byway slipway opposite medical secretaries. A lot of these staff are congregating there and are doing so before and after shifts. Again, there is nothing we can do and the issue is a private matter for the farmer who owns the land.

There is also smoking in private cars, again, we have no mandate against privately owned vehicles unless the people are smoking with children in the car and then it is a police matter.

4. Staff Support

Wiltshire Health Trainers will be giving stop smoking advice and support on the first Tuesday of every month, booked appointments in OH. There will be comms on this and staff will be also signposted from OH Advisers. The trainers brief will be wider than just stop smoking and will include weight management, alcohol advice, emotional health and get active advice.

5. Meetings Still Attended

The Smoke Free NHS working group is STP wide and there is a commitment from all Trusts/providers to support this for another 12 months. They won't be meeting as frequently though probably every other month to maintain and monitor progress on Smoke Free and report back to the STP leadership team on any implementation issues.

The Wiltshire Smokefree Alliance is a group of organisations that supports the smokefree agenda to reduce smoking prevalence and reduce health inequalities associated with tobacco use. The Terms of reference agreed by the group included representation from SFT. It would therefore be helpful to identify an alternative representative from SFT to the group, currently if Occupational Health/safety.

The Alliance meets twice a year with a smaller working group meeting twice more throughout the year. (Due to be reviewed in April 19). The Wiltshire Tobacco Control Action Plan aims to deliver the ambitions of the Government's Tobacco Control Plan for England and members of the Alliance are expected to give feedback/updates quarterly on the agreed actions related to their organisation/area of work.

6. Complaints

We receive complaints and comments through the occupational health inbox, and customer care, examples are:-

'Just to say please don't bother sending out walking routes th9s year as each point of the hospital now is covered with people smoking, buy large stones walking down the pathways, down the hospice road and outside in bus shelter by entrance b. Apparently nothing can be done about it!'

My name is Charlene Hambly and I am the new smoking and alcohol liaison nurse specialist for the Trust. I will be working with admitted patients only and will not be working with staff in their endeavours particularly to stop smoking. However on my first day today I have been approached a lot by staff asking about the support for Staff. Hence this email. I just wanted to know what support is on offer to staff so that I can signpost knowing what they being signposted to please.

I also have a poster which is available on the Intranet and ICID which covers a whole load of health/emotional related problems – giving helplines and websites for people to seek information and help themselves. It would be great if your department could utilise this and signpost from this too. On ICID search for helpline poster and it pops up as the first hit, on the intranet is comes under supporting our staff and then helpline poster. My aim over the next coming weeks is to reinstate a robust service in the trust for staff to refer patients to and I want to put this poster into action across the Trust as it covers a whole range of things.

'Can I suggest – in order to give out a positive message to smokers to abstain from smoking on the premises, could all the cigarette ends around the entrances be cleared up regularly? As things stand, it sends a message that smoking is tolerated in these areas.

'I'm enquiring about smoking cessation are you providing a SC service from OH? If so is Champix something you offer?'

'Just curious there is no guidelines on the smoking ban coming in to effect on 1st January 2018. Will be still be able to vape/ use e-cigarettes with in the hospital grounds? There are no clear instructions on anything.'

'I see many posters and information regarding the smoking ban on site as of 30th December, can you please clarify if vaping is included in this incoming ban. If not will vaping still be contained to the current smoking shelters or will new shelters be installed to account for this.'

'Following the introduction of the new smoking policy we have encountered a problem on level 1. Where the smokers have been asked to move off site, they are smoking at the bollards at the start of the path indicated on the map below.

The smoke is blowing towards the offices on level 1 and it is quite unpleasant for the staff working at their desks. This is in winter with the majority of the windows closed. I am concerned that in the summer this will be unbearable for staff in this area. I have spoken to the smokers in my team, and they are walking down the path to avoid contributing to the problem but there are many members of staff from across the Trust who are using this as their new smoking area. I understand they are not smoking on site but it is having an impact on other staff members and I would assume the wards on level 2 as they are directly above the offices.

Dear CEO

After having gone for a lunchtime walk I have come back more stressed than when I went out to walk. How can you allow smokers to totally take over the walk exits all around the hospital? They are laughing at you. They stand right by exits and stones knowing they are just on or out of SDH jurisdiction. No longer can walkers walk by the fields or anywhere nice because smokers have totally taken those areas over and its like walking through a mob if you try to. You inhale the smoke over the other wide of the roads to where they are. It seem SDH would rather look GOOD in saying it's a non-smoking site which it isn't and upsetting the majority of your employees.

Oh and don't bother to get Occi Health to send out walking routes this year there is no point,!!

Yours stressed and thoroughly fed up

Dear Sir or Madam, Customer Care (25/03/19)

The hospital's recently changed smoking policy has resulted in a constant gathering of smoking hospital staff at the head of the bridleway joining the Odstock hospital site near its north eastern corner. This appears to continue during all working hours. The bridleway joins Downton road and the corner of the site. Displacement of any hospital activity onto a public right of way is completely unacceptable. The use of a public right of way as a gathering place for smoking and tea breaks is also unacceptable, as a result of the nuisance, litter and health hazards to other users. I request the NHS Trust and Wiltshire council to work together to find a solution to this that doesn't involve the displacement of out-of-policy hospital activity onto public rights of way.

Paul C Knight

11th February 2019

Appendix E

NHS Estates and Facilities Alert Report

EFA/2019/002

Preventing the Ingestion of Cleaning Chemicals

1. Introduction

This report contains draft details of an audit carried out across SFT by the health and safety department in response to the above alert. This audit report should therefore be read in conjunction with the above report.

An Estates and Facilities Alert (ref EFA/2019/002).was issued on the 28th February calling for a review of the risk to staff and patients concerning the possibility of ingesting cleaning materials. An extract from the alert reads as follows:-

'Many cleaning chemicals used in healthcare premises are covered by The Control of Substances Hazardous to Health Regulations (COSHH, 2002) requiring that employers have a duty for the protection of employees and others that may encounter such substances. Employers and organisations must ensure all cleaning chemicals are stored and used safely and that all staff receives training appropriate to their job role.'

In a recent one-year period there have been 18 incidents reported to NHS Improvement where patients ingested cleaning chemicals. One patient died, one became critically ill and received treatment in ITU/ICU, and three required assessment in an emergency department.*

Products involved included floor cleaner, toilet cleaner, limescale remover, cleaning sprays, cream cleaner, glass cleaner, kitchen and laundry detergents. In most cases, the cleaning items were either left in areas easily accessible to patients (wards/bedrooms/ toilets) or removed by patients from unattended and/or unsecured cleaning trollies or cupboards. Reports were received from acute, mental health and community providers

2. The Trust's response to the alert

The results of this report will be discussed at the Trust Health & Safety Committee and operational forums such as matrons and senior sister's forums. The purpose of this report is to provide a discussion paper by identifying areas of potential risk across the site and making recommendations where any potential risk is identified that are operationally viable.

3. What was found

40 premises were thought to carry possible risks and are listed below under 'places visited'. The audit was carried over the period of the 6th /7th/12th March.

All wards have washing up liquid and CIF type bottles in kitchen. Some wards have shampoo in bathrooms. All Bedpan washers have exposed chemical (detergent low hazard) in unlocked dirty sluice/ utility. All wards/departments that have a dishwasher store either tablets or powder detergents in an unlocked lower cupboard. Some have Suma Mora (5lt) rinse liquids. No kitchen area is locked or restricted accept Sarum Ward.& Sarum OP. All bathrooms were clear of chemicals unless otherwise stated. All cleaning cupboards (walk in) were locked unless otherwise stated.

Those places marked with an asterisk* were thought to be more likely to admit patients with confusion or mental health issues.

The bracketed (L) and (M) are low and medium risk respectively.

4. Places visited, Assessment, Control and Risk Factors

Risk is calculated by multiplying Patient Risk x Environmental/Chemical

All assessment values are either 1 = Low 3 = Medium 5 = High

Area	Assessment	Controls	Risk
Breamore Ward	Actichlor made up and tabs in unlocked dirty utility room x 2 NEXT to patient toilet	Actichlor, dishwasher tabs and powder easily accessible	5x5 **25**
AMU *	Dirty utility room unlocked with made up Actichlor and tabs.	High risk patients and easy accessibility	5x3 **25**
Spinal Unit * (whole)	Dishwasher Tabs and powder in all kitchens. Made up Actichlore in unlocked sluice rooms. Tabs unlocked Hydrex removed. All bathrooms/toilets clear	Reasonable accessibility	3x5 **15**
Redlynch/Pitton	Clear	Domestic cupboard Cleaner's door (digital) unlocked	3x3 **9**
Redlynch Ward	Washing up liquid and CIF type product in kitchen. Actichlor made up on sluice room worktop	Unlocked and reasonable access	3x3 **9**
Amesbury Ward *	3 x dirty utility rooms all made up Actichlor and tabs in cabinets. Kitchen with dishwasher tabs.	Unlocked and reasonable access	3x3 **9**
Whiteparish Ward	Dirty Utility made up Actichlor. Tabs	Unlocked and reasonable	3x3

	in unlocked cupboard. Kitchen dishwasher powder only	access	**9**
Tisbury Ward	Dishwasher tabs and powder in kitchen cupboards - unlocked Actichlor made up in unlocked dirty utility. Tabs in unlocked cupboard	Unlocked and reasonable access	3x3 **9**
Chilmark *	Actichlor tabs kept in locked store plus salt and dishwasher powder/tabs. Actichlor made up in unlocked sluice room. Some tabs not in cupboard.	Unlocked and reasonable access	3x3 **9**
Downton ward	Dishwasher tabs and powder in unlocked kitchen. Actichlor tabs in locked cupboard. Made up solution in unlocked sluice	Unlocked and reasonable access	3x3 **9**
Britford	Actichlor made up solution and tablets in unlocked dirty utility. Pitton/Britford cleaning cupboard Issues with not being digitally) locked. Discussed with cleaner.	Unlocked and reasonable access	3x3 **9**
Redlynch	Dishwasher tabs and powder in unlocked in kitchen cabinet. Actichlor made up in unlocked sluice. Tabs in unlocked glass cupboard	Unlocked and reasonable access	3x3 **9**
Laverstock Ward *	Dishwasher tabs and powder in unlocked kitchen. Made up Actichlor in unlocked dirty utility room. Tabs in unlocked cabinet	Unlocked and reasonable access	3x3 **9**
Odstock Ward	Hibiscrub in side rooms. Claim this is a requirement for infection prevention. Made up Actichlor and tabs in unlocked dirty utility. Dishwasher tabs and powder in unlocked in kitchen cabinet.	Unlocked and reasonable access	3x3 **9**
Durrington Ward *	Dishwasher tabs and powder in unlocked kitchen cupboard. Actichlor made up. Tabs in cabinet but not locked in unlocked sluice room. Toilet cleaner and other cleaning chemicals in bucket on floor. Advised objecting cleaner.	Unlocked and reasonable access	3x3 **9**
Farley *	Dishwasher tabs, salt and powder in kitchen cupboard. Made up Actichlor in unlocked dirty utility. Tabs locked in wall cupboard. Hydrex also stored here	Unlocked and reasonable access	3x3 **9**

Farley rehab	Dishwasher tabs, salt and powder in kitchen cupboard. Made up Actichlor in unlocked dirty utility. Tabs locked in wall cupboard Hydrex also stored here.	Unlocked and reasonable access	3x3 **9**
Spire ward *	Made up Actichlore. Tabs in unlocked cabinet. Dishwasher tabs and powder + 5lt chemical rinse in kitchen. Cleaning cupboard unlocked. Cleaner advised	Unlocked and reasonable access	3x3 **9**
Emergency Department	No exposed harmful chemicals	Busiest high risk patient area but good control	5x1 **5**
Spinal Physio	Dishwasher tabs and powder in shared kitchen + washing machine tabs.	Reasonable control.	1x3 **3**
O&G + Breast	Dishwasher tabs and powder in open kitchen. Sr will move. Cleaning cupboard unlocked Sr will speak to cleaner.	Reasonable control.	1x3 **3**
Maternity	All Actichlor solution and tabs kept locked. Several bottles of Hydrex left by sink which is said may be required in an emergency. Several bottles of Betadine removed from side rooms. Dishwasher tabs in unlocked kitchen.	Reasonable control.	1x3 **3**
Radnor ICU	Actichlor unlocked. Patients' not fully mobile – low risk	Reasonable control.	1x3 **3**
Radiology	Discussed with senior manager. Patient attended at all times.	Low risk patient access controlled or difficult	1x1 **1**
Radiology recovery	Made up Actichlore next to ward. Manned at all times – low risk. Tablets locked away	Low risk patient access controlled or difficult	1x1 **1**
Eye clinic	Discussed with Sr . No issues with patients and chemicals	Low risk patient access controlled or difficult	1x1 **1**
Pembroke ward and OP	All safely locked away though cleaning cupboard door unlocked	Low risk patient access controlled or difficult	1x1 **1**
Nunton discharge and Nunton day	No issues	Low risk patient access controlled or difficult	1x1 **1**

Plastic and Oral OP	No exposed harmful chemicals	Low risk patient access controlled or difficult	1x1 **1**
Orthopaedic OP (fracture clinic)	No exposed harmful chemicals except Hydrex surgical scrub in dispenser x4	Low risk patient access controlled or difficult	1x1 **1**
Occupational Health and Safety Services	No exposed harmful chemicals	Low risk patient access controlled or difficult	1x1 **1**
Horatio's garden	Various chemicals locked in cabinet within greenhouse.	Low risk patient access controlled or difficult	1x1 **1**
Sarum	All clear of any exposed harmful chemicals apart from bedpan washer liquid in sluice room within machine.	Low risk patient access controlled or difficult	1x1 **1**
Sarum OPD	All clear of any exposed harmful chemicals. Domestic cupboard locked as above	Low risk patient access controlled or difficult	1x1 **1**
SAL Britford Downton	Hydrex removed and placed in locked cupboard	Low risk patient access controlled or difficult	1x1 **1**
SAL Theatre	Clear	Low risk patient access controlled or difficult	1x1 **1**
Pre op assessment	All Actichlor locked away. No other exposure to harmful chemicals	Low risk patient access controlled or difficult	1x1 **1**
Spinal pool	Range of chemicals for general cleaning. Fully locked away in cupboard and within sight of pool attendant.	Low risk patient access controlled or difficult	1x1 **1**
Clarendon Ward	Currently cleared of patients. Cleaning cupboard shared with spinal dept. Lock broken on chemical door. Advised accordingly. Now temporarily locked in steel cabinet within currently unlockable unit.	Low risk patient access controlled or difficult	1x1 **1**
Med/surg outpatients	Discussed with two sisters – not thought to be any risk.	Low risk patient access controlled or difficult	1x1 **1**

5. Chemicals - putting patients at risk

Almost all wards and departments visited contained harmful chemicals which could be accessed by patients. These chemicals in the main, are Antichlor (made up solution), Antichlor tablets, dishwasher tablets and powder, rinse aid and bedpan washer detergent. To a lesser hazard degree, washing up liquid, CIF type kitchen cream cleaner.

Affixed alcohol hand gel and hand wash solution dispensers are not considered in this report though they do carry a small risk of ingestion

6. The Risk factor

- In a hospital environment, all chemicals pose a **hazard** but it is the secure nature of their use and storage that poses the risk. The **risk** is the patient (including children) accessing and ingesting any of those chemicals – for whatever reason. It is this risk which is difficult to quantify because of the:

- varying vulnerability of patients,
- the use of the materials being inconsistent,
- the storage being variable,
- the level and knowledge of staff being different, depending on experience and (according to the alert) the fact that many staff do not have English as their first language.

- The authors opinion is that the Trust is not doing all that is reasonable practicable to reduce the risk to as low as possible. There are no practical measures to prevent the patient from accessing these harmful chemicals and therefore are not adequately protected from harm.
- We have (out of 40 areas) 3 High, 15 Intermediate and 22 Low

Some wards are more at risk than others. Those with dementia patients and children are a greater risk. However, patients with dementia or who have mental health issues are not exclusive to these known wards. Children, especially visiting children who are unassigned, are particularly at risk - particularly within outpatient areas where parents or guardians allow children to wander at will.

Many of our staff are involved with the control of chemicals in a clinical environment. Nurses, health care support workers, AHP's and cleaners. It is a fact that an increasing number of these do not have English as their first language.

It has not been fully investigated as to whether this is significant for Salisbury. However, the NRLS report of the investigations conducted highlight it as one of the significant causal factors contributing to patient harm. If this is confirmed, certain staff are putting patients at risk by possibly not being able to identify a harmful substance by the information written on the product.

Nurse – Overseas staff take English understanding as part of their OSCE assessment

HCSW/AHP's – Overseas staff understanding of English is unknown

Cleaners – Our initial investigation has some degree of assurance, the following is a list of nationalities:

1. British	2. Polish	3. Cuban
4. Italian	5. Portuguese	6. Romanian
7. Nepalese	8. Asian	9. Thai
10. Philippines	11 African	12. Ghanaian
13. Hungarian	14. Moroccan	15. Turkish
16. Sri Lankan		

All the 150+ cleaners undertake the COSHH MLE whereby they must take an e-assessment which is evidence of their understanding of the legislation and the practicalities of hazard, risk and control.

7. Recommendations

Where harmful chemicals are stored or in use, they should be locked out of sight and have their access reasonably deterred.

Accessibility & the Environment

It would not be practical or necessary to lock all kitchens dirty utility or sluice rooms as this would create other operational problems. Instead, all harmful chemicals should be put away in designated cupboards and protected by some form of simple locking system. This could be in the form of a childproof lock which, if chosen carefully, should be sufficient to deter both children and vulnerable adults for a suitably limited period of time. With regard to the 5ltr bed pan washer fluid, a simple childproof cover or plate could be placed across the opening to prevent access.

Knowledge and training

At present, it is not a standard for all clinical staff to complete the COSHH MLE. We would not be advocating this for nurses and presently it is only mandatory for COSHH coordinators and cleaning staff. We would strongly recommend that this be

extended as of now to include all HCSW and refreshed every 3 years. It may be a consideration to use it for nursing staff as a one off induction module.

Discussion and Plan

Discussion at H & S Committee March 25th 2019 (Action PK)

Discussion at Matrons meeting April 2nd 2019 (Action PK)

Alert and discussion document to be raised at the Executive Workforce Committee

Multi-disciplinary assessment to be completed by June 7th 2019 (Action H&S)

8. Protection Measures from low to high risk areas

- ✓ All Appropriate areas to have childproof locks on cupboards
- ✓ Re-location and/or segregation of chemicals
- ✓ Appropriate locks on doors
- ✓ Salto locks on high risk areas
- ✓ COSHH MLE to be mandatory and monitored on MAST grid to board and picked up at PDR,s so as to guarantee the understanding of the legislation

9. Legal Notices

Management of health and safety at work regulations 1992

Regulation 3

(1) Every employer shall make a suitable and sufficient assessment of:-

(a) the risks to the health and safety of his employees to which they are exposed whilst they are at work and

(b) the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking

COSHH regulations 2015

Specific Regulations 3, 4, 5, 6, 7, and 8 on assessment, knowledge and training, prevention and control

Written by Geoff Lucas - Health and safety Advisor - 15th March 2019

Validated by Paul Knight – Health & Safety Manager – April 2019

Appendix E

Subject - COSHH Assessment of the use of Chemical Disinfectant in Clinical Areas

Assessor – Fred Sheard between Oct – Nov 2017

Submitted to - Health & Safety Committee 27th November 2017

Background

As a result of a group prosecution and a civil liability case against an NHS Trust, it was decided to complete a compliance audit of the Trust. The first group of staff to be assessed were the facilities staff who use this substance on a regular basis. It was found that all of the COSHH files, information, training and information packages were in place. The supervisers were well informed and the staff that were questioned were knowledgeable about the chemicals and the safe systems of work required.

The ward/nursing staff were less sure about safe systems of work, the properties of the materials used and the protection needed. The H&S team went about raising awareness then completed this audit to look at general compliance over a number of criteria.

Area	Tamar	Avon	Redlynch	Chilmark	Tisbury	Britford	Sarum	Pitton	**% Compliance**
Specific Room	1	1	1	0	0	1	1	1	75
Ventilation	1	1	1	1	1	1	1	1	100
Chemical Know	1	1	1	1	1	1	1	1	100
Dilution Know	1	1	1	1	1	1	1	1	100
Training	1	1	1	1	1	0	1	1	88
PPE	0	1	1	1	1	1	1	1	88
Chemical Chart	1	1	1	1	1	1	0	1	88
COSHH Link	0	0	0	0	0.5	0	1	0	19
COSHH Book	0	0	1	1	1	1	0	1	63
Book Current	0	0	1	1	0.5	1	1	1	69
%Compliance	60	70	90	80	80	80	80	90	**79**

The table below was presented to the H&S Committee

Subject Activity of all the sub-groups who report into the Health & Safety Committee. Summarised by the Health & Safety Manager in consultation with the chair/expert of each committee.

Date April 1st 2018 – March 31st 2019

Introduction

There is a requirement for all of the sub groups who report to the health & safety committee to submit their minutes for review. The process is to identify if all the groups are meeting their terms of reference, are they functioning as an active group, is there any support needed from the main committee and are there any issues for escalation that need action or referring onward to the board.

The summary of their activities, achievements and challenges is tabled below:

1. Fire Safety Group

- Only 1 attendance by WFRS for unwanted fire signal & 1 fire on site attended by WFRS.
- Fire alarm activations up 51.5% from last year.
- 22% of all false alarms are generated in staff accommodation.
- Fire warden training continues on a rolling basis. Still some departments to come forward with a nominated Fire Warden.
- Training on the use of Fire extinguishers continues on a rolling basis.
- All departments risk assessed under the Regulatory Reform Fire Safety Order (2005).
- All departments issued with Fire emergency plan but not all departments/wards participating in evacuation drills.
- There are still some issues with housekeeping on the hospital streets. (bed, bin and cage storage).
- Level 1 is still being used as a dumping ground for unwanted equipment.
- Fire doors and sets are being replaced on a rolling basis.
- A substantial amount of fire extinguishers have been missed for annual inspection by contractors and are being replaced when identified.
- Block 15 is still under temporary measures for fire safety.
- Evacuation from theatres 1 - 8 is still hindered by storage in corridors.

2. Safe Sharp Steering Group

The need for the Safe Sharp Steering Group has been considerably reduced because of the continued availability of more safe devices onto the market.

Any changes seen necessary will be overseen by the H&S Adviser and the requirement to put in place safe sharps will only be implemented using strict criteria.

If support or assistance is required, the group will be called upon to support and assist. All appropriate risk assessments are in place where safe needles cannot be used.

- This year has seen a safety scalpel trial and evaluation, but for a number of reasons the result was unsuccessful. Not least, they were deemed to be unfit for purpose.
- Safe sutures were looked at but were not readily available
- Due to the successful transition to safe hypodermics across all areas of the Trust and the appropriate follow up of all needle stick and sharp injuries, risk to staff has reduced
- Awareness of safe sharp devices is covered at junior doctors induction
- Safe sharp awareness is also covered at induction and also specifically during medical device training for infusion pumps, cannulas and venflons
- It is also part of certain teaching modules in the SIMS suites

3. Medical Gas Group

- Entonox scavenging in maternity has been installed and initial teething problems have been addressed. The main hurdle going forward is to ensure that the equipment is being used correctly by the patients to ensure the safety of staff. Some monitoring to assure this will be conducted.

- A regional wide medical gas cylinder tender was completed in 2017 which sees BOC retain the contract for Salisbury. KPIs and incidents are closely monitored by the pharmacy team and medical gases group. .
- A patient safety alert on how to use oxygen cylinders was received in Jan 2018 and has been responded to. An outstanding action is to improve the training ward staff receive on cylinder use. An MLE package is in production.

4. CAS Alerts

- All national CAS alerts and D of H Estates alerts have been dealt with and there are no outstanding issues. There is however currently one National Patient Safety alert that the Risk Team are aware of. The alert is well within its completion timescale.

5. Waste Group

- Further work on two MLE Waste packages Non-Clinical and Clinical is ongoing but the package is still not in a usable form.
- The introduction of an offensive waste stream has not been universal and this is ongoing
- Recyclable bins have been introduced into most of the ward areas and apart from a few specialist areas, the trial has been well received. It is still to be determined whether saving will be realised at the level

indicated by the company. But whatever the outcome, the carbon footprint of the Trust has been reduced.

- Policy has been completed and should ratified and on the Intranet
- Further waste segregation charts have been developed for the domestic and laboratory waste streams.
- Bin Labels with clear instructions being applied to all appropriate waste bins is ongoing as phase 2 is rolled out.
- New bins have been introduced into most of the ward areas and phase two is underway and a further capital bid is being written.

6. Water Safety Group

- Independent advice (Authorizing Engineer Water) – for the Trust is being completed by Mr Paul Limbrick of the Water Hygiene Centre.
- Annual sampling for Legionella has been completed, all positive counts have been managed in line with the Trusts policy.
- Routine sampling for Pseudomonas (6 monthly) is completed in the following areas – Radnor, NICU, Pembroke, The Burns Unit, Sarum and Avon Wards.
- ETS continue to flush, little used outlets in clinical areas in line with Trusts policy. This process has been reviewed due to poor compliance and additional resource has been made available to improve this.
- The Domestic Hot Water systems in SDH North and Central areas continue to run at elevated temperatures (above 65 ˚C) to assist in the control of Legionella.
- Risks have been raised for each of the main control areas for the management of water systems - Flushing, TMV Maintenance, Temperature Control, Routine Sampling, Temperature Control and these are linked to the main risk 1291.
- The Trusts Water Safety Policy was reviewed in line with HSG 274 and is due for review in 2020.

7. Security Management Committee

- Staffing of the security team has continued to be challenging due to ongoing major incident in early 2018/19 and additional staffing requirements, heavy reliance placed on security contractor to backfill.
- Injuries to staff as a result of violence and aggression continue to maintain a low level similar to last year.
- All incidents reviewed through Security Committee and Violence & Aggression Sub Group.
- Physical Intervention Course refresher courses took place in May 2018 with an initial course booked for August 2019.
- Local LSMS security group has now expanded with some 10 members covering central southern England with meetings taking place bi-monthly..
- CCTV is now been fully converted to HD cameras with the CCTV control Room being refurbished.
- LSMS provides monthly inductions to staff covering security matters.
- Reported crime on the hospital site continues to very low and are mainly attributed to opportunist thefts.

8. Laboratory Groups

- The laboratories have spent a great deal of time preparing for the HSE visit to Microbiology and subsequently working on the action plan and carrying out the action from this plan so that all will be completed by July 2019.
- The Autoclaves continue to cause the laboratories issues with significant down time causing back up of waste from Microbiology. A contingency plan is in place to rectify this going forwards and the staff in Microbiology are to receive additional training in the use and maintenance of the autoclaves as part of the actions highlighted from the HSE visit.
- Staff from Microbiology now attend the Trust's Decontamination committee
- There continues to be issues around cleanliness of white laboratory coats. Discussions have taken place with the laundry and alternative suppliers of coats will be investigated.
- The committee will now be chaired by Joanne Harris after Christine White's departure

9. Radiation Protection Committee

- The committee has a new chair as the executive lead, this is the head of OD & People
- Work is ongoing as a result of the HSE and CQC visit and the committee are still putting in measures from the project plan
- A proposal for further specialist support both for radiation protection, MRI scanning (part of the capital bid) and EMF radiation are either being scoped or are already in place. The biggest challenge is radiation protection support for medical physics.
- The Trust is still registered with the HSE as a 'radiation operator' the license being required under the IRR regulations as updated February 2019.
- There are still procedural issues dealing with radiation protection that need firming up, RPS's are still very thin on the ground and cover for this role has been challenging and the work on Diagnostic Reference Levels (DRL's) is continuing.
- Further comments on the suitability of the Radionuclide Laboratory in Pharmacy have been made by our 'Medical physics Experts' in that although it is not unsafe, it does not meet current standards and it needs upgrading
- The number of reports to CQC under IR(ME)R
- All consultants who operate certain Mini C Arm equipment have had training
- Environment agency audit showed no issues to report and there has been no further interest this year from CTU.

10. Risk Report Card

We have seen a positive increase in reporting and especially the reporting of near miss / no harm incidents. There has been an improvement overall within

the areas of slips, trips and falls and exposure to chemical / electrical hazardous material incidents.

This year there has been an increased in incidents relating to needlestick injury, IT issues and ‘abuse’ categories.

Prior to October 2018, the data included in the report cards was only for incidents that had been reported on Datix as Type = Incident Affecting Staff Since October 2018 (when we noticed the staff abuse figures were lower than expected) Manually correcting of the data for the Abuse and Sharps/Needlestick categories has since occurred, to also include relevant incidents categorised as ‘Incidents affecting multiple people/organisation’.

The data on the trends table of the attached report has these corrected figures for the 2018/19 financial year, but not the 2017/18 financial year. This will therefore account for some of the increase in abuse incidents, and incidents reported overall.

With accurate reporting, we are now confident that ‘abuse’ is now the highest reported area, which is a new theme.

HSE Notice on the Category 3 Containment facilities in Microbiology

1. **Response Letter to HSE from CEO**
2. **Action Plan in response to the HSE visit to Microbiology SFT 22nd January 2019/Written March 2019**
3. **Project Plan written April after HSE accepted Action plan**

Ref:

Cara Charles-Barks
Chief Executive
Salisbury NHS Foundation Trust
Salisbury
Wiltshire
SP2 8BJ

Telephone (01722) 336262 Ext. 4249
e-mail cara.charles-barks@salisbury.nhs.uk

Mrs Audrey Harris
HM Specialist Inspector
Microbiology and Biotechnology Unit
The Lateral
8 City Walk
Leeds
LS11 9AT

Dear Madam

Thank you for your visit to the Containment Level 3 (CL3) Laboratory on the 22nd January 2019 and the subsequent improvement notice on the 29th of that same month.

The Trust takes its obligations to protect its staff, put in place strong systems of work and to honour all its obligations under current legislation, extremely seriously. There has been a lot of time and effort by our staff to enable compliance and we are disappointed that this has fallen short of the required standards. The laboratory staff have worked really hard to ensure the safe operation of this facility but are now engaged in the process of strengthening the processes and written documentation to support that stance.

A multidisciplinary team are now engaged in a number of meetings to formulate a project plan, to include target dates and responsibilities that we will share with you by the end of February 2019. This plan will set in motion a number of strategic and operational goals and generate documentation electronically for your perusal from by early April 2019 onwards.

This project plan will be governed by the Laboratory team, the consultant microbiologists, the health & safety union representative and the health & safety manager. The laboratory health and safety committee will meet regularly to invigilate progress with the minutes of their meetings progressing up to the health & safety committee.

I and other executive board members will be kept up to date on progress on a regular basis but the key objectives will be to:-

- Clarify in writing the roles and responsibility of individuals
- Re-write job descriptions accordingly
- Improve the technical knowledge of all the staff in this area
- Look critically at our quality systems and integrate this will our UKAS framework
- Under our UKAS framework develop an audit and action system that revolves around the plan, do, check, act principle
- Scrutinise the details of our risk assessments and the process by which they are generated
- Look at the risk assessment documentation in line with our Trust risk management process

We hope to fully comply with the notice and the terms of the schedule by the end of May 2019 and to take all other measures required to put us in a better position operationally in dealing with biological hazards.

I have been extremely heartened by the engagement of the laboratory staff in this process, there is a real desire to get this right. The management structure that supports this process is a key factor, but it is the actions of our front line staff that are the most vital.

The CL3 documentation will also be overseen by our Consultant Microbiologist, Paul Russell, who we are fortunate in being able to use his expertise in his part role within Porton Down. We have already placed our laboratory safety adviser on a specialist Category 3 Containment Course at Porton Down to strengthen our day to day operational knowledge. The intention is that all appropriate staff will follow this and any other technical development routes as part of their knowledge and skills framework.

We have already decided to integrate key estates and CL3 laboratory staff into the decontamination group meetings. The CL3 Laboratory and connected autoclave management will be a standing agenda items. The committee will able to share expertise to ensure open and frank discussions about operational and engineering CL3 and Autoclave issues. This will include the submission of all testing, technical and engineering documentation before the committee and how that has been shared between parties.

If there is any further assistance I can give, or there is anything that the Trust has to comply with, then please do not hesitate to contact myself, Paul Hargreaves, Director of OD and People, the operational director responsible for managing health and safety or the health and safety manager.

Yours sincerely

Cara Charles-Barks

Chief Executive

2 Action Plan in response to the HSE visit to the Department of Microbiology SFT 22nd January 2019

Submitted to:-

- The Trust Health & Safety Committee
- The Pathology Health & Safety Committee
- The CEO, the Director of OH & People and Consultant Microbiologists

The terms of the statutory notice and attached schedule, served on 26th January required us under the 'Management of Health and Safety Regulations 1999, Regulation 5 (1) and associated codes of practice to formulate a plan as set out below:-

Your current arrangements for the effective planning, organisation, control, monitoring and review of the preventative and protective measures necessary to minimise the risk of exposure of your employees to hazard group 3 biological agents are inadequate; because

(1) The staff responsible for the Containment Level (CL) 3 facility lacks the necessary knowledge and understanding of the control measures to enable them to adequately discharge their responsibilities and provide assurance of sustained safe operation.
(2) You have failed to ensure that an adequate system is in place for the assessment of risk arising from your work with hazardous biological agents, and the adequacy of appropriate control measures

1. Findings	Action required (specific)	How success will be measured measurable/achievable	Lead	How will this be reported on (realistic/achievable)	Deadline for completed timelines	Progress
Take steps to ensure that your management arrangements relating to Containment Level (CL) 3 are effective and suitably formalised.						
The documentation of clear descriptions of the roles and responsibilities of personnel involved in the health and safety management of the CL3 laboratory. This should include both	Write Micro H&S policy to set out roles and responsibility of key personnel both within and externally to the department, e.g. estates	1. Microbiology H&S policy/Code of practice in place in department.	SH	Production of H&S policy/Code of practice	End of May	

staff in the pathology department and estates staff with CL3 responsibilities.						
	Job descriptions updated with relevant roles in the department outlining H&S responsibilities	2. Job description signed by Laboratory management and staff members involved in H&S	JH	Sample of updated job descriptions E-mailed to HSE	End of May	
2. Findings	**Action required (specific)**	**How success will be measured measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**
Implement a mechanism to ensure that those staff with responsibilities for the operation, monitoring or maintenance of control measures/equipment, clearly understand what they have to do to discharge their responsibilities and provide assurance that the required maintenance and monitoring is undertaken appropriately and in a timely manner.	SH to attend NADP training course, Porton	Attendance at course and dissemination to other key staff members	SH	Certification of attendance/ Outline of course content to other key staff. Other CL3 staff to attend on a year by year rota.	15/02/19	DONE
	Training on autoclave operation, maintenance and control measures to key management	Attendance of course to be held by Audere/Eastwood Park for identified staff	AG/SH/JoH	Certificate of attendance at relevant training courses. Course content to ensure understanding I. Of equipment operation. II. Key operating parameters. III. Test procedures. IV. Interpretation of test results Course to be integrated into local COP	Next available dates On completion	
	Obtain training from British Clinical Services	Attendance of training by identified staff	JoH	Certification of attendance/ Outline of course content.	End of April	

	in cabinet function and servicing			SOP to be updated and reported to the Decontamination Committee	On completion	
	Training from Crowthorne to clarify emergency fumigation procedure	Attendance of training by identified staff	SH	Certification of attendance/ Outline of course content SOP to be updated	End of April	
3. Findings	**Action required (specific)**	**How success will be measured measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**
Implement a system to enable adequate liaison between CL3 laboratory manager(s) and the estates team in relation to planned maintenance, testing or repair of control measures including autoclaves, in order to ensure the appropriate level of awareness of local management as to the purpose and frequency of any tests, the results and the remedial action necessary. The system must also	Organise weekly/monthly meetings with AG to review autoclave maintenance and raise any issues	Meetings set up and reports being signed in appropriate time. Lab management representative to attend the Decontamination committee	SH/Jo H/AG	Signed off report from autoclave PM and quarterly validation from 26/03/19 Results to be reported at each decontamination meeting Chair to be informed (PK)	30/04/19 Next date Next date	
	Discussion around reporting of autoclave breakdowns and escalation up and down from Microbiology to Estates Datix report with	Breakdowns being correctly reported to Estates Department and information fed back from Estates to Microbiology	SH/Jo H/ AG	Completion of downtime logs on autoclaves Downtime events to be	End of April	

ensure that the CL3 manager(s) have sight of any maintenance or testing reports relating to CL3.	decontamination lead copied in			recorded on a local breakdown log and reported to the decontamination committee		
4. Findings	**Action required (specific)**	**How success will be assessed measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**
Implement a system to ensure staff with health and safety management responsibilities for CL3 activities or facilities have sufficient information, instruction and training to understand all aspects of the operation of the laboratory, including the basic functions, maintenance and testing requirements of control measures.	SH to attend NADP training course, Porton	Attendance at course	SH	Certification of attendance/ Outline of course content. Reported to the Pathology H&S Committee	15/02/19 Next meeting 21/03/19	DONE
	Training on autoclave operation, maintenance and control measures to key management	Attendance of course to be held by Audere/Eastwood Park for identified staff	AG/SH/JoH	Certificate of attendance at relevant training courses/ Outline of course content. Reported to the Lab H&S Committee. Logged at next personal development review	Next available dates Next date 21/03/19 Annual	
	Obtain training from British Clinical Services in cabinet function and servicing	Attendance of training by identified staff	JoH	Certification of attendance/ Outline of course content Reported to the Lab H&S Committee. Logged at	30/04/19 Next date 26/03/19	

				next personal development review	Annual	
	Training from Crowthorne to clarify emergency fumigation procedure	Attendance of training by identified staff	SH	Certification of attendance/ Outline of course content	End of March	
Take steps to ensure that your arrangements for the control of activities at CL3 are effective.						
Implementation of a system to ensure your risk assessments for activities at CL3 accurately reflect the task or procedure to which they relate and that relevant control measures are applied. This should include but is not limited to consideration of: • The biological agents that may be present and their hazard groups. • The forms in which the biological agents may be present. • The diseases caused by the agent and how it can be transmitted. • The activities being carried out. • The likelihood of	Draw up suitable template for risk assessment	Agreement on new risk assessment template by Micro management and Trust H&S staff	SH	Successful production of 2-3 new style risk assessments Sent to HSE	31/03/19 Mid-April	
	Update risk assessment policy to reflect new procedure	Production of new risk assessment policy	SH	New risk assessment policy agreed and in place. Signed off by Consultant Microbiologist and sent to HSE	30/04/19 Mid May	

exposure and consequent disease. • Control measures to be applied and how exposure will be controlled.						
5. Findings	**Action required (specific)**	**How success will be assessed measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**
Take steps to ensure that your monitoring and review arrangements for CL3 is appropriate to provide assurance that the containment and control measures are consistently and correctly applied.						
Implementation of a programme of planned proactive inspections of (i) the facilities in which work with Hazard Group 3 agents is undertaken and (ii) the safe working practices employed in their use.	Draft weekly checklists to include fabric checks etc.	Weekly checklist in routine laboratory use	SH	Production of completed and signed weekly checklist Example sent to HSE	Mid-May	
	Draft monthly checks to include dust trails etc.	Monthly checklist in routine laboratory use	SH	Production of completed and signed monthly checklist Example sent to HSE	31/03/19 Mid-April	
	Draft quarterly audit schedule to include anemometer checks, daily pressure readings, equipment, PPE, procedures etc.	Audit procedures in Micro in Micro audit schedule and incorporated in laboratory QMS system	SH	Production of audit to be carried out and signed off with and non-conformances raised and actioned according to laboratory protocol. Annual report to go to Pathology H&S Committee and the Decontamination Committee – Report to be signed off by Consultant Microbiologist.	End of May Annually	

6. Findings	Action required (specific)	How success will be assessed measurable/achievable	Lead	How will this be reported on (realistic/achievable)	Deadline for completed timelines	Progress
Implementation of a system to ensure the effective management oversight and review of significant inspection findings and remedial actions taken.	Implementation of department H&S meetings	Meetings held with checklists and audits as an agenda item. Any issues taken to Pathology H&S meetings or Pathology management meetings	JoH/SH	Minutes from meetings	End of April	

Plan written by Jo Harris/Sunel Hanekom, copied to the Director of OD & people as nominated operational lead for H&S by the CEO and signed off by the consultant microbiologist.

Key to references

SH	Sunel Hanekom	Laboratory Safety Officer
JH	Julian Hemming	Consultant Microbiologist
AG	Andy Gillespie	Operational Estates Manager & Appointed Person
JoH	Jo Harris	Microbiology Laboratory Manager
PK	Paul Knight	Health & Safety Manager


January 29th Notice Served
July 28th Notice Expir
Weekly Staff Project Meetings
Progres
Assuranc
Evidence
Polic
February
March
April
May
June
July
HSE Project Plan Compliance
5 12 19 26 5 12 19 26 2 9 16 23 7 14 21 4 11 18 25 2 9 16 23
HSE project plan sent to HSE
HSE Project plan accepted by HSE
Assurance Documentation sent to HSE
All Eviden
Operational Policy
Part 1 of the notice
Clear Roles and Responsibilities
Production of H&S Policy & COP
Updated job descriptions
Part 2 of the notice
Clear Technical Knowledge
Attendance at accredited Cat 3 course
Training on Autoclave operation
Training on Autoclave user
Training on Autoclave testing
Courses integrated into SOP
SOP reported toDecontamination Meeting
Cat 3 Cabinet Training (Manufacturer)
Training on emergency fumigation
Part 3 of the notice
Operational Clarity
Weekly/monthly review of Autoclave
Autoclave results to Decontamination Mtg
Reporting breakdows with SOP/Estaes
Microbiology staff attend Decon Mtg
Part 4 of the notice
Effective Management Responsibilities
Attendance at accredited Cat 3 course
Reporting through Trust Committees
Logging progress at PDR's
Control through new risk assessment template
Risk Assessment accredited training
Risk assessment policy signed off by CM
Sample Risk Assessments sent to HSE
Part 5 of the notice
Audit and Assurance
Planeed programme of inspections and audit
Monthly checklists with exception reporting
Results through management and H&S Comm
Non compliances signed off by CM
Part 6 of the notice
Monitoring
Management control through scrutiny
Part 7ancillary provisions
Provision of a system schematic by Estates
User tour of pipework/extract system by Estates
5 12 19 26 5 12 19 26 2 9 16 23 7 14 21 4 11 18 25 2 9 16 23
Summary
February
March
April
May
June
July
30 Elements to the plan

Action Plan in response to the HSE visit to the Department of Microbiology SFT 22nd January 2019

Submitted to:-

- The Trust Health & Safety Committee
- The Pathology Health & Safety Committee
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1. Findings	Action required (specific)	How success will be measured measurable/achievable	Lead	How will this be reported on (realistic/achievable)	Deadline for completed timelines	Progress
Take steps to ensure that your management arrangements relating to Containment Level (CL) 3 are effective and suitably formalised.						
The documentation of clear descriptions of the roles and responsibilities of personnel involved in the health and safety management of the CL3 laboratory. This should include both staff in the pathology department and estates staff with CL3 responsibilities.	Write Micro H&S policy to set out roles and responsibility of key personnel both within and externally to the department, e.g. estates	1. Microbiology H&S policy/Code of practice in place in department.	SH	Production of H&S policy/Code of practice	June 14th	DONE
	Job descriptions updated with relevant roles in the department outlining H&S responsibilities	2. Job description signed by Laboratory management and staff members involved in H&S	JH	Sample of updated job descriptions E-mailed to HSE	June 14th	DONE
2. Findings	**Action required (specific)**	**How success will be measured measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**
Implement a mechanism to ensure that those staff with responsibilities for the operation, monitoring or maintenance of control measures/equipment,	SH to attend NADP training course, Porton	Attendance at course and dissemination to other key staff members	SH	Certification of attendance/ Outline of course content to other key staff. Other CL3 staff to attend on a year by year rota.		DONE
	Training on autoclave	Attendance of course to be held by Audere/Eastwood Park	AG/SH/JoH	Certificate of attendance at relevant training courses. Course content		DONE 3rd June

clearly understand what they have to do to discharge their responsibilities and provide assurance that the required maintenance and monitoring is undertaken appropriately and in a timely manner.	operation, maintenance and control measures to key management	for identified staff		to ensure understanding I. Of equipment operation. II. Key operating parameters. III. Test procedures. IV. Interpretation of test results Course to be integrated into local COP		
	Obtain training from British Clinical Services in cabinet function and servicing	Attendance of training by identified staff	JoH	Certification of attendance/ Outline of course content. SOP to be updated and reported to the Decontamination Committee		DONE
	Training from Crowthorne to clarify emergency fumigation procedure	Attendance of training by identified staff	SH	Certification of attendance/ Outline of course content SOP to be updated		DONE
3. Findings	**Action required (specific)**	**How success will be measured measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**

Implement a system to enable adequate liaison between CL3 laboratory manager(s) and the estates team in relation to planned maintenance, testing or repair of control measures including autoclaves, in order to ensure the appropriate level of awareness of local management as to the purpose and frequency of any tests, the results and the remedial action necessary. The system must also ensure that the CL3 manager(s) have sight of any maintenance or testing reports relating to CL3.	Organise weekly/monthly meetings with AG to review autoclave maintenance and raise any issues	Meetings set up and reports being signed in appropriate time. Lab management representative to attend the Decontamination committee	SH/Jo H/AG	Signed off report from autoclave PM and quarterly validation from 26/03/19 Results to be reported at each decontamination meeting Chair to be informed (PK)		DONE Subject to training 3rd June
	Discussion around reporting of autoclave breakdowns and escalation up and down from Microbiology to Estates Datix report with decontamination lead copied in	Breakdowns being correctly reported to Estates Department and information fed back from Estates to Microbiology	SH/Jo H/ AG	Completion of downtime logs on autoclaves Downtime events to be recorded on a local breakdown log and reported to the decontamination committee		DONE Down time log in place. Estates to complete
4. Findings	**Action required (specific)**	**How success will be assessed measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**
Implement a system to ensure staff with health and safety management responsibilities for	SH to attend NADP training course, Porton	Attendance at course	SH	Certification of attendance/ Outline of course content. Reported to the Pathology H&S Committee	15/02/19 Next meeting 21/03/19	DONE

CL3 activities or facilities have sufficient information, instruction and training to understand all aspects of the operation of the laboratory, including the basic functions, maintenance and testing requirements of control measures.	Training on autoclave operation, maintenance and control measures to key management	Attendance of course to be held by Audere/Eastwood Park for identified staff	AG/SH/JoH	Certificate of attendance at relevant training courses/ Outline of course content. Reported to the Lab H&S Committee. Logged at next personal development review		
	Obtain training from British Clinical Services in cabinet function and servicing	Attendance of training by identified staff	JoH	Certification of attendance/ Outline of course content Reported to the Lab H&S Committee. Logged at next personal development review		DONE
	Training from Crowthorne to clarify emergency fumigation procedure	Attendance of training by identified staff	SH	Certification of attendance/ Outline of course content		DONE
Take steps to ensure that your arrangements for the control of activities at CL3 are effective.						
Implementation of a system to ensure your risk assessments for activities at CL3 accurately reflect the task or procedure to which they relate and that relevant control measures are applied. This should include but is not limited to	Draw up suitable template for risk assessment	Agreement on new risk assessment template by Micro management and Trust H&S staff	SH	Successful production of 2-3 new style risk assessments Sent to HSE		DONE
	Update risk assessment policy to reflect new procedure	Production of new risk assessment policy	SH	New risk assessment policy agreed and in place. Signed off by Consultant Microbiologist and sent to HSE		DONE July 1st[h]

consideration of: • The biological agents that may be present and their hazard groups. • The forms in which the biological agents may be present. • The diseases caused by the agent and how it can be transmitted. • The activities being carried out. • The likelihood of exposure and consequent disease. • Control measures to be applied and how exposure will be controlled.						
5. Findings	**Action required (specific)**	**How success will be assessed measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**
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Implementation of a programme of planned proactive inspections of (i) the	Draft weekly checklists to include fabric checks etc.	Weekly checklist in routine laboratory use	SH	Production of completed and signed weekly checklist Example sent to HSE		DONE

facilities in which work with Hazard Group 3 agents is undertaken and (ii) the safe working practices employed in their use.	Draft monthly checks to include dust trails etc.	Monthly checklist in routine laboratory use	SH	Production of completed and signed monthly checklist Example sent to HSE		
	Draft quarterly audit schedule to include anemometer checks, daily pressure readings, equipment, PPE, procedures etc.	Audit procedures in Micro in Micro audit schedule and incorporated in laboratory QMS system	SH	Production of audit to be carried out and signed off with and non-conformances raised and actioned according to laboratory protocol. Annual report to go to Pathology H&S Committee and the Decontamination Committee – Report to be signed off by Consultant Microbiologist.	End of May Annually	DONESubject to training 3rd June
6. Findings	**Action required (specific)**	**How success will be assessed measurable/achievable**	**Lead**	**How will this be reported on (realistic/achievable)**	**Deadline for completed timelines**	**Progress**
Implementation of a system to ensure the effective management oversight and review of significant inspection findings and remedial actions taken.	Implementation of department H&S meetings	Meetings held with checklists and audits as an agenda item. Any issues taken to Pathology H&S meetings or Pathology management meetings	JoH/SH	Minutes from meetings	End of April	DONE

Plan written by Jo Harris/Sunel Hanekom, copied to the Director of OD & people as nominated operational lead for H&S by the CEO and signed off by the consultant microbiologist.

Key to references

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