PUBLIC SESSION

MEETING OF THE BOARD OF DIRECTORS
to be held in the Seminar Room, Education Resource Centre
on Thursday 26th May 2011 at 9am

AGENDA

			Enc
1	Welcome and apologies Apologies should be sent to Jackie Howell at jackie.howell@bwhct.nhs.uk, tel 0121 627 2601		
2	Declarations of interest		
3	Minutes of the meeting held on 26th April 2011		**1**
4	Matters arising from the minutes of the meeting held on 26th April 2011 (where not covered by agenda items)		
5	Report of the proceedings of the Board in private session, April 2011	HH	**2**
	Items for Discussion	***45 mins***	
6	Red Risk Register and Assurance Framework	SIP	**3**
7	Report by the Chief Executive	SP	**4**
8	Integrated Performance Report, April 2011	JO NS JaB	**5**
9	Patient Quality & Safety Report	PT/JO	**6**
10	Infection Control/ Matron's reports	JO	**7**
11	NHSLA Progress Update	JO	**8**

12	Report on compliance with CQC Essential Standards	JO	**9**
13	Annual DIPAC report	JO	**10**
	Items for Decision	***45 mins***	
14	Approval of the Annual Report and Accounts, year ended 31st March 2011	JaB	**11 To follow**
	a. Report of the recommendations of the Audit Committee	RR	
	b. Annual Report, year ended 31st March 2011		
	c. Rationale for Going Concern basis		
	d. Statement of Accounts, year ended 31st March 2011		
	e. Statement on Internal Controls		
	f. Quality Report, year ended 31st March 2011		
	g. ISA 260 Report	PwC	
	h. Letter of Representation		
15	Approval of the Annual Plan 2011 for submission to Monitor	SP	**12 To follow**
16	Corporate Objectives	SP	**13**
	Items of Report	***10 mins***	
17	Update from the Chairman of Council	HH	**Oral**
18	Questions from the public on matters relating to the agenda		
19	**Exclusion of the public** To RESOLVE that representatives of the press and other members of the public be excluded from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	**At 11am**	

Dates of next meetings

Thursday 30th June 2011
Thursday 28th July 2011
Thursday 29th September 2011
Thursday 27th October 2011

Minutes of the meeting of the Board of Directors held in public On Thursday 28th April 2011 in the Seminar Room, ERC, BWH

PRESENT :	Helen Hemberg (Chair) Jason Burn Nigel Gardner Jane Owen Steve Peak Robin Rison Neil Savage Marianne Skelcher Peter Thompson
IN ATTENDANCE :	Michele Emery (Head of Neonatal Nursing and shadowing Jane Owen) Steve Parsons, Head of Corporate Affairs Diana Wyllie (Minute Taking)
APOLOGIES :	Ian Booth Robin Wall

FTP/0411/1 **Welcome and Apologies**

FTP/0411/1.1 The Chair welcomed members to the Board meeting. A particular welcome was extended to Michele Emery who was shadowing the Director of Nursing and Midwifery for the day and to the three members of the public; Michelle Walsh, Becky Wilson and Louise Toner (Governor).

FTP/0411/1.2 Apologies for absence were noted from Ian Booth and Robin Wall.

FTP/0411/2 **Declarations of Interest**

FTP/0411/2.1 There were no declarations of interest from Board members.

FTP/0411/3 **Minutes of the Previous Meeting**

FTP/0411/3.1 It was noted that Mr Rison had advised some minor corrections to the Secretary, which had been included in the signature version of the minutes.

FTP/0411/3.2 The Board approved the minutes of the previous meeting held on 31st March 2011 as an accurate record of proceedings.

FTP/0411/4 **Matters Arising from the Previous Meeting**

FTP/0411/4.1 There were no matters arising from the previous meeting not already covered on the agenda.

FTP/0411/5 **Report of the Proceedings of the Board in Private Session – March 2011**

FTP/0411/5.1 The Board received Enclosure 2 and noted the items discussed at the March 2011 private meeting; it also noted the items to be discussed later in the private meeting today would cover Committee reports, two root cause analysis reports, draft corporate objectives, forward cash flow forecast, update on contracts with commissioners, and a report on the use of the internal auditor for non-audit services.

ITEMS FOR DISCUSSION

FTP/0411/6 **Red Risk Register and Assurance Framework**

FTP/0411/6.1 The Board received Enclosure 3. The Head of Corporate Affairs reported on the following highlights from the report :

- Risk No. 130 *Failure of staff to comply with theatre dress code standards for non-emergency procedures* – this risk had been downgraded to amber status since the previous Board meeting.
- Two new red risks had been included on the register since the previous meeting; No. 192 *Significant delays in letters from NNU due to lack of Medical Secretarial support*; and No. 194 *Risk of lack of availability anaesthetic machine leading to cancellation and delay of operating lists*.
- Two red risks during the month had had new controlling actions recorded namely; No. 138 *Inadequate consultant presence of delivery suite*; No. 186 *Medical grade medical cover March – September 2011*.

FTP/0411/6.2 With regard to the Red Risk Register Board members raised the following items :

- Following the presentation of the IT Strategy at the February 2011 a Director raised a concern that this had not been translated into an entry on the risk register. The Board were assured that work was being undertaken and a risk would be included upon final discussed with the Executive Directors. The risk would be included on the register by the next Board meeting in May 2011.
- A member of ORAG noted that there had been a discussion in the April 2011 ORAG meeting with regard to the status of IT systems; Damon Harris, Head of IT, had been tasked with providing a full report on IT systems for the October 2011 ORAG meeting. The Board noted that this was supplementary to the IT Strategy discussions which was being taken forward by the Finance Director and Executive Directors.
- No. 136 *Midwifery staffing below national recommendation* – Following a query about whether this risk's rating should be reviewed downwards, the Director of Nursing, Midwifery and Operations

clarified that this risk still needed to be classed as a red risk, as the Trust would be unable to meet the national standard described in Safer Childbirth RCOG 2007 with a recommended staffing ratio of 1:26. She reminded the Board that the matter had been fully discussed and agreed by the Board at its February 2011 meeting, and again briefly discussed at the March 2011 meeting. Although the Trust had adequate controls in place it would be unable to meet the national standard and would, therefore, be at risk of failing the NHSLA standard for this area; therefore, the risk would need to remain categorised as a red risk.

- No. 138 *Inadequate consultant presence on delivery suite* – in response to a query the Medical Director noted that the Safer Childbirth Report had been "peer reviewed" by the Royal Colleges of Midwives, Obstetricians & Gynaecologists, Anaesthetists and Paediatricians. The Safer Childbirth guidelines recommended 168 hours of Consultant presence on delivery suite; the Trust's current level was 78 hours. The Board noted the actions in place to mitigate this risk.
- No. 192 *Significant delays in letters from NNU due to lack of Medical Secretary support* (new risk) – The Director of Nursing , Midwifery and Operations explained that interim arrangements to reduce the delay and catch up on the backlog letters had been put into place and were having an effect. Cross Directorate cover was still being discussed.
- No. 194 *Risk of lack of availability anaesthetic machine leading to cancellation and delay of operating lists* (new risk) – In response to a query from a Director, the Director of Finance agreed to clarify at the Standing Finance Committee whether or not anaesthetic machinery was included within the capital expenditure for next year.

FTP/0411/6.3 The Board noted the Red Risks currently on the Register and the control measures in place with regard to these risks.

ACTION : Jason Burn agreed to clarify at the Standing Finance Committee whether or not anaesthetic machinery was included within the capital expenditure for next year.

FTP/0411/7 **<u>Amber Risk Register</u>**

FTP/0411/7.1 The Board received Enclosure 4. The Head of Corporate Affairs reported that there were currently 42 amber risks on the Register. These broke down as :

- 2 amber risks with uncertain (red) levels of control (No's 87 and 102)
- 9 amber risks with inadequate (amber) levels of control (No's 91, 130, 132, 133, 134, 183, 193, 195 and 196)
- The remaining 31 amber risks had adequate (green) levels of control.

FTP/0411/7.2 The Board then discussed the Amber Risk Register with discussion focussing upon the following risks :

- No. 41 *Part of Neonatal facility funded by charitable funds* – it was noted that once the accounts for the 2010/11 had been finalised, then

this risk would be closed.

- No. 87 *Failure to achieve NHSLA standards* – the Board felt that the actions within this risk should be made clearer in order to demonstrate that the Trust was now applying and working towards Level 2 NHSLA standard.
- No. 91 *Clinical Genetics Patient Records* – The Board noted that it appeared that some actions within this risk were missing. The Head of Corporate Affairs was tasked with requesting the Genetic Directorate to ensure that risk was updated.

ACTION : Steve Parsons to request the Genetics Directorate to update Risk No. 91 ASAP.

- No. 111 *Non-compliance with cancer waiting standards (BWH patients)* – It was noted that this risk had recently been downgraded from the Red Register to the Amber Register, but there was some concern expressed that it remained classified as Amber. The Director of Nursing , Midwifery and Operations would request that the Gynaecology Directorate reviewed the risk; the risk would also be discussed by ORAG with a view to a further downgrade. The Board also noted that internal audit had recently undertaken a review of managing cancer pathways, and the final report was currently awaited. The Board emphasised the importance of achieving waiting times, which remained of paramount importance to the hospital as any delay profoundly impacted upon the patient.

ACTION : Jane Owen to request Gynaecology Directorate to review Risk No. 111 and advise findings to ORAG in June 2011, to enable ORAG to review the risk rating further.

- No's 132, 133 and 134 – *Livelink Document Management System* – The Director of Workforce & Organisational Development reported that there had been a lengthy debate on these risks at the April 2011 ORAG meeting, with the Committee requesting that a report was presented to the Executive Directors within the next four weeks and a Business Case to the Management Board within the next eight weeks. As background, the Board noted that the document management system had been procured a number of years ago, and had been utilised in the last two years to manage the policy system, but had proved to be unpopular with users and was not particularly user friendly. The Trust was now reviewing the possibility of moving towards Microsoft's Sharepoint system which was more user friendly and would also be beneficial in the management of the Trust's intra-net and Board papers. Resource and license implications were currently being investigated and reports, as mentioned above, were being prepared.
- No. 146 *Bed blocking in Maternity Directorate* – Again a query was raised as to whether this risk should be downgraded from the Amber Risk Register. The Director of Nursing and Midwifery would request the Maternity Directorate to undertake a review of the risk and a full report would be provided to the next ORAG meeting.

ACTION : Jane Owen to request Maternity Directorate to review

Risk No. 146 and provide full report to June 2011 ORAG meeting.

- No. 167 *Insufficient number of cardio-respiratory monitors which intercommunicate on the Neonatal Unit* – It was noted that this equipment had now been funded by Charitable Trustees as agreed at their March 2011 meeting and the Board felt that it should now be closed. Neonatal Directorate to action.

  ACTION : Steve Parsons to advise Neonatal Directorate to remove Risk No. 167 from Risk Register now that equipment was being funded from Charitable Funds.

FTP/0411/7.3 The Board noted the entries on the Amber Risk Register together with the respective control measures.

FTP/0411/8 **Report by Chief Executive**

FTP/0411/8.1 The Board received Enclosure 5.

FTP/04111/8.2 Before referring to his written report the Chief Executive reported that during the previous day (Wednesday 27th April 2011) an MRSA case had been confirmed within the Trust. An RCA review was being undertaken on Tuesday 3rd May 2011, and the initial report would be circulated to the Board as early as possible. The Director of Nursing, Midwifery and Operations advised the Board that, due to the nature of the infection, swabs of staff would be taken as part of the next stage in the investigation process. The Chief Executive noted that following the recent planned, but unannounced, CQC visit to the Trust the Trust had a number of areas which it had feedback to provide to the CQC and would take this opportunity to also inform them of the MRSA case.

ACTION : Jane Owen to circulate to Board members a copy of the RCA relating to the MRSA case as soon as this was available.

FTP/0411/8.3 The Head of Corporate Affairs noted that in regulatory terms MRSA was not a significant issue for Monitor's compliance monitoring in respect of this Trust. He drew the Board's attention to the relevant provision from Monitor's Compliance Framework document 2011/12 :

> *"Where an NHS Foundation Trust has an annual MRSA objective of six cases or fewer (the de minimis limit) AND has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's Compliance Framework."*

FTP/0411/8.4 In the light of this, and that the Trust has had zero MRSA cases for a number of years, the single case would not adversely affect the Trust's rating.

FTP/0411/8.5 The Board noted that Monitor would be informed of the case.

ACTION : Steve Peak to inform Monitor of the confirmed MRSA case .

FTP/0411/8.6 A Director queried as to how the morale of staff would be supported, given

that this would now be reported as part of the Medical Director's Friday Metrics. Both the Chief Executive and Medical Director would be emphasising to the organisation the importance of ensuring that the focus remained on maintaining the Trust's excellent track record with until now zero cases.

FTP/0411/8.7 A Director queried the apparent contradiction between having a *de minimis* allowance for MRSA, but not for *C. Difficile* infections. The Head of Corporate Affairs advised that Monitor had addressed the issue in responding to the consultation on the Compliance Framework, but had taken a decision to follow the Government approach of 'zero tolerance' on this metric.

FTP/0411/8.8 The Board noted that South Birmingham PCT had been notified of the MRSA case.

FTP/0411/8.9 The Chief Executive then referred the Board to the circulated Chief Executive's Report.

FTP/0411/8.10 As a result of Listening into Action and his Chief Executive Conversations, a group had been formed in order to formulate a set of staff-led and owned values for the Trust. Members of the group were invited to make their presentation to the Board.

Staff Presentation on BWH Values

FTP/0411/8.11 The following members of staff were present for the presentation to the Board : Steve Stanier, Gail Alexander, Kathryn Bishop Michele Emery (already present at the Board meeting), Michaela Revel-Maton and Julie Edwards.

FTP/0411/8.12 Steve Stanier and Micheala Revel-Maton undertook the presentation which covered :

- The design outlining the 7 values :
  - be friendly, polite and helpful;
  - be welcoming, caring and professional;
  - keeping the patient informed and explaining what is happening;
  - treat everybody equally with dignity and respect;
  - treating the patient in the way that we would like to be treated;
  - be committed to getting the patient an answer;
  - listening to the patient.
- The one style design which had numerous options and uses
- An outline for the individual costs for each proposed area for implementation with a total cost of £4,998.
- The next steps which would need to include a launch with promotional activity, training, and embedding the values within the organisation.

FTP/0411/8.13 Following the presentation all Board members were extremely impressed with the work undertaken by the staff group and congratulations were given to all. It was noted that the values would be linked into patient experience

and would be fed back via the "tablet" patient questionnaire surveys undertaken by the volunteer staff.

FTP/0411/8.14 Directors suggested that, in order to be successful, these values would need to be embedded into the organisation and form part of the staff appraisal process, including the Executive Directors. They should also be recommended to Council to be included as part of the Non-Executive appraisal process.

FTP/0411/8.15 The following specific queries were raised :

- A Director suggested that "listening" should be included nearer the top rather than at the bottom of the "WE WILL" list.
- Some concern was expressed over references to branding in the presentation; it was clarified that the aim was "branding the values" within the organisation.

FTP/0411/8.16 The Board concluded that this was an extremely positive piece of work undertaken by a group of staff; it was noted that the Charities had agreed to fund this work at a cost of £4,998 in order to roll out the Values within the Trust.

ACTION : Jason Burn and Steve Peak to organise release of Charitable Funds to the value of £4,998 for the roll-out of the Values Project.

ACTION : Steve Peak to consider tactics with staff group for the roll-out and launch of Values project within the organisation.

FTP/0411/8.17 The Chair thanked the staff who had attended the Board to undertake the presentation and requested that the Board's appreciation was also extended to the staff who were part of the group, but who had been unable to attend the presentation.

FTP/0411/8.18 The Chief Executive then referred the Board back to his Chief Executive's report (Enclosure 4). The following were noted :

- *CQC Visit* – The Director of Nursing, Midwifery and Operations reported that the Trust had received its planned, but unannounced, CQC visit in mid April 2011; there had been six CQC members for the visit which had been very thorough. The Trust had been complimented on the quality of its PCA information provided ahead of the CQC visit and thanks were given to Michelle Walsh and Coralie Rogers. Overall the visit had been successful and the Trust had received positive feedback which included complimentary feedback from both staff and patients to the CQC visitors.
- *CQC Inpatient Survey*– The Chief Executive reported that the results of the inpatient survey had now been published, and although the Trust had performed well, its performance was not as good as in the previous year in a number of areas. The Trust had held discussions with the Commissioners, as certain CQUIN payments were dependent on improving performance in the survey and had provided some supplementary evidence to enhance our scoring, meaning that a score of 80% had now been agreed equating to an additional

£20,000 of funding.

The Chief Executive advised that an action plan would be drawn up in order to ensure focus was placed on the areas for improvement. This would be supported with the Trust's own "tablet" inpatient questionnaires undertaken by the volunteers to ensure that focus and feedback on particular areas was undertaken and performance monitored.

- *Service Line Reporting* – The Board noted that all the necessary actions in order to populate the structure with the 2009 data and relevant testing had now been completed down to the HRG level. The Trust was, therefore, on target to implement the "click view" reports available to the Directorates from May 2011. The Director of Finance was currently investigating whether the system could be incorporated on to the network link rather than just available on local PCs in order to make the system more widely available and useable within the Trust.
- *Productive Theatre programme* – The Chief Executive reported that the Human Factors Workshop with the relevant staff would be taking place on 5th May 2011 and timescales would be shared with the Board following this session.

ACTION : Steve Peak to share timescales of Productive Theatre Module with Board members after 5th May 2011.

- *GMP for Maternity redevelopment* – The Board noted that the GMP figures would be known by 3rd May 2011. The Board's original scheme approval had been limited to a cap of £2.55m, but the building provider had now indicated an increase in costs which were being finalised with a clear mandate to reduce them Concern was expressed with regard to the upwards cost variance; the Chief Executive noted that when the Board initially agreed the development it had capped the price, so any increase in the cost of the project would be re-submitted to the Board for further discussion. This was likely to be required, which could cause some slippage; however, it was still expected that the scheme would be deliverable by January 2012. The Board noted if desirable, a formal Board session could be scheduled to discuss the final costs in association with the Board Seminar session on 19th May. The Board expressed disappointment with the possible increase in costs, but noted that the developer had indicated a possible increase in costs at the commencement of the process. The Board also noted that this was the developer who had built very successfully the recent Neonatal Unit.

ACTION : Neil Savage/Steve Parsons to arrange for discussion of GMP for the Maternity redevelopment scheme at Board seminar session on 19th May 2011 if required.

FTP/0411/8.19 The Board received and noted the contents of the April 2011 Chief Executive's Report.

FTP/0411/9 **<u>Corporate Performance – Quarter 4 2010/11</u>**

FTP/0411/9.1 The Board received Enclosure 6. The Board noted the following achievements with regard to the corporate objectives from the 17 target areas:

- 13 are rated green (12 in Quarter 3)
- 3 are rated amber (3 in Quarter 3)
- 1 is rated red (2 in Quarter 3)

FTP/0411/9.2 Discussion then centred around the following areas :

FTP/0411/9.3 *Identify a capital scheme that facilitates the introduction of an ambulatory care centre for Gynaecology* – This objective had been categorised as green as an outline business case had been produced. However, the case had not been submitted for discussion to the Board as the costs were in excess of the initial budget. A Director felt that the objective had been read to imply the agreement of the proposal, although this was not actually stated; and suggested a learning point for the 2011/12 objectives to ensure that there can be no confusion with the description of objectives and thus their achievement or otherwise.

FTP/0411/9.4 *Deliver the agreed financial plan submitted to Monitor* – the Board noted that this objective had been achieved against difficult circumstances, but a suggestion was made that for 2011/12 the objective should be broken down to demonstrate achievement against income generation and CIPs. Some Directors felt this would not assist the Board, suggesting that being flexible within the year as to when and how business opportunities may be taken may actually generate more income whilst less CIPs may be realised, giving overall a larger surplus. The Board concluded that a corporate objective stating that FRR of 3 and the planned surplus would be achieved should be included, but that it was the responsibility of the Management Board as to how this was achieved and delivered.

FTP/0411/9.5 In conclusion the Board agreed that the objectives for 2011/12 needed to be clear as to what was to be achieved overall with the detail being delegated as to how this was achieved to the Management Board.

FTP/0411/9.6 The Board noted the RAG ratings of the objectives and agreed that the appropriate amber rating had been assigned to the following objectives :

- Developing an agreed IM&T Strategy for Board approval;
- Developing an agreed, costed Estate Strategy that sets out key deliverables for the next ten years;
- Delivery of all national targets and Monitor compliance.

FTP/0411/9.7 The Board noted the progress against all targets to the end of Quarter 4.

FTP/0411/10 **<u>Directorate Performance – Quarter 4 2010/11</u>**

FTP/0411/10.1 The Board received enclosure 7. The Board noted that although the Clinical Support Directorate had now been disbanded and divided into the four remaining Directorates, for the purposes of financial monitoring the former Directorate's services would be treated as a unit in order that close financial monitoring could continue.

FTP/0411/10.2 The Board considered and noted the Executive Assessment of the Directorate performance for Quarter 4 2010/11.

FTP/0411/11 **Integrated Performance Report March 2011**

FTP/0411/11.1 The Board received Enclosure 8.

Activity Performance

FTP/0411/11.2 The Director of Nursing, Midwifery and Operations highlighted the following from the March activity performance report :

- *Theatre utilisation* – this had increased in March 2011 to 82% and the number of cancellations on the day for non-medical reasons was well within the target at 8 for the full year.
- *Cancer Referrals to Treatment Target Times* – all cancer waiting times have been achieved for the quarter and the year.
- *18 RTT* – performance against both these targets has been achieved for the year.
- The Board noted that as a specialist Trust we had been given an extra tolerance level for achieving the 62 day cancer target, but the Trust had achieved a much higher level of performance. Steve Parsons was asked to confirm whether the additional tolerance had been continued by Monitor/ CQC.

ACTION : Steve Parsons to ascertain whether Trust had retained an extra tolerance level in order to achieve cancer target and report back to Board.

Workforce Performance

FTP/0411/11.2 The Director of Workforce and Organisational Development highlighted the following from the March workforce report :

- *Contracted WTE* – this had reduced to 1441.48 wte, remaining below the Trust's target.
- *Agency/Bank Spend as a % of Directorate pay bill* – this had improved to 2.26% and remained below target levels.
- *Sickness Absence* – attendance has improved for the third consecutive month with sickness reducing to 3.59%. However, the Director emphasised the importance of maintaining pressure to keep to these levels. It was noted that particular improvement had been achieved in the Maternity Directorate.
- *Staff Appraisal* – appraisal uptake had improved to 81.02% which exceeded the in-year target for the first time in 2010/11. It was noted that this now set a good foundation for 2011/12 and after discussion, the Board set a target for this financial year of 85%.
- It was noted that morale issues were being experienced in relation to the Management of Change processes, but overall the CQC had received positive feedback from the staff during their recent visit.
- A Director commented that overall the workforce matrices were moving in the right direction which was encouraging and pleasing to see.

Finance

FTP/0411/11.3 The Director of Finance highlighted the following from the March 2011 Finance Report :

- The end of year position at March 2011 was a surplus of £506,000 before an impairment loss. The operating surplus means that the Trust had met the annual plan and the impairment loss did not affect the calculation of the financial risk rating, which had achieved 3 for the full year. This included the release of all of the 2010-11 contingency allowances
- A successful conclusion to negotiations with the Specialised Commissioners had led to the receipt of £125,000 of additional income (representing 100% payment for over-performance) which was not in the forecast position.
- The Neonatal Unit had been re-valued and showed a £5.9m loss of value against the cost of construction, which had lowered the Trust's asset base and, therefore, has been of financial benefit to the Trust in terms of a reduced PDC payment. The Director of Finance noted that the impairment was a technical issue that did not affect the Trust's financial stability
- The Trust had £9.5m cash in the bank and had exceeded the forecast position.
- Work on the restructuring costs was continuing with the Trust's external auditors and would be reported to the next Standing Finance Committee.

ACTION : Jason Burn to inform Standing Finance Committee of restructuring costs at next meeting.

FTP/0411/11.4 The Director of Finance then responded to questions from Board members :

- With regard to table 3.2 associated with Directorate variances, the Director of Finance confirmed that the table indicated the variance from plan and the arrows indicated movement from the previous month.
- A Director queried whether the excess expenditure on the capital programme should have been subject to Board approval, noting that this query had been raised in previous years. The Director of Finance agreed to provide clarity at the next Standing Finance Committee with regard to the figures in table 5.1 associated with the capital programme and to confirm the relevant provisions in the SFI's.

ACTION : Director of Finance to provide clarity at the next Standing Finance Committee with regard to the figures in table 5.1 associated with the capital programme and the requirements of the SFI's in respect of authorisations.

- The Director of Finance clarified that the Neonatal Unit had been constructed during the financial year and as such had been capitalised and written off within the same month. However, in relation to the Asset Register the Director of Finance would clarify the position at the next Standing Finance Committee.

ACTION : Director of Finance to clarify position on Asset Register of

Neonatal Unit at the next Standing Finance Committee.

FTP/0411/11.5 The Chair thanked the Director of Finance for the comprehensive report and congratulations were given to the Directors, teams and staff on the achievement of the Trust's financial outcome with a surplus of £506,000 given the challenging financial background.

FTP/0411/12 **Patient Safety Report**

FTP/0411/12.1 The Board received Enclosure 9. The Medical Director advised that from this month, the Patient Safety Report would also include a section on patient experience and a quality dashboard.

FTP/0411/12.2 With regard to the patient experience and quality dashboard he acknowledged and thanked the volunteers for the huge support they had provided in the collation of this data via the tablets. Results of the first survey had provided very positive feedback from patients and this was to be reported to staff shortly.

ACTION : May 2011 Patient Experience Report to include themes on feedback from patients in order to further enhance the report.

FTP/0411/12.3 The following was noted during discussion :

- Members' Council also to receive this report for the relevant month of their meetings.
- 68% of complaints had been responded to within the targeted response time. Overall there had been an increase in the number of complaints, but in no particular area and was in part related to the changes related to PALS.
- With regard to the tablet patient questionnaire the Board suggested that the phrasing of questions may need to be reconsidered in order to ensure that patients are able to give clear and targeted responses which can not be misconstrued . It was noted that a number of the questions used replicated those asked in the national patient surveys, to ensure that there was comparability between the two

FTP/0411/12.4 The Board noted the Patient Safety and Quality Report for the month of March 2011.

FTP/0411/13 **NHSLA Progress Update**

FTP/0411/13.1 The Board received Enclosure 10.

FTP/0411/13.2 The Director of Nursing, Midwifery and Operations reported that at the informal assessment visit on 11th May 2011 the acute evidence collected to date will be presented and reviewed in preparation for Level 2. Work was continuing with respect to the Maternity Assessment, again an informal assessment would be taking place on 11th May 2011. It was noted that formal assessment would take place in December 2011 for Level 2 and would be quickly followed by assessment for Level 3; there was some concern about whether the Trust would be able to meet this timescale based on the current position, although the Board was not currently being asked to

reconsider the approach.

FTP/0411/13.3 The Board acknowledged that this was a very tight timescale; the collection of data for evidence was an extremely time consuming process, but of paramount importance for the achievement of Level 2.

FTP/0411/13.4 The Board noted the progress against the timescales outlined in the report.

FTP/0411/14 Outstanding Actions

FTP/0411/14.1 Received Enclosure 11. The following was noted with respect to the outstanding actions :

- Attendance at Baby Show – the Head of Corporate Affairs noted that the Baby Show was being held on 20th – 22nd May 2011; as the Board had previously discussed, there was the opportunity for Directors to attend and meet members and the public.

ACTION : Board members to notify Steve Parsons of availability to help at Baby Show in May 2011.

- Follow-up on use of NHS numbers as patient identification as per NPSA circular in July 2010 – The Director of Nursing, Midwifery and Operations reported NHS numbers should not be generated via the hospital, which was in line with the national approach and timescales. Babies will be identified via the tag "baby of mother ….." which will identify the mother's hospital registration number and name.

ITEMS FOR DECISION

FTP/0411/15 Regulatory Submissions to Monitor – Quarter 4 2010/11

FTP/0411/15.1 The Board received Enclosure 12 which the Head of Corporate Affairs outlined.

FTP/0411/15.2 The Board noted that Louise Toner, Senior Governor, had written to Monitor at Council's request, outlining their position that escalation would be a disproportionate response. A response had been received and would be reported to Council at its May meeting.

FTP/0411/15.3 The Board carefully considered the declaration to be made in respect of the forward financial performance of the Trust, having regard to the forward projections within the papers. The Board noted that the latest projections, taking into account the anticipated timings of efficiencies, indicated that Q2 of the year would generate an FRR2 rating, although it was hoped that performance during the year would enable that to be improved. In line with the Board's previous prudent practice, it would declare that it was not confident of maintaining FRR3 through the following 12 months.

FTP/0411/15.4 With respect to the recommendations the following was agreed :

a) To note the financial performance of the trust for Quarter
b) To note the service performance of the Trust for Quarter 4

c) To note that the Trust would be rated “Red” for Governance in Quarter 4, following the Trust failing to meet the full-year target for C. Diff, and consequentially considered by Monitor for escalation,
d) To authorise the Chairman to sign Declaration 2 (non compliance) for service performance
e) To authorise the Chairman to sign Declaration 2 (non confidence on maintaining FRR 3 on the following 12 months) in respect of future financial performance.
f) To note the changes to members of Council
g) To approve the submission of the financial/service information, together with relevant commentary, to Monitor for the fourth quarter

FTP/0411/15.5 The Chairman signed the declaration in accordance with the above.

ITEMS FOR REPORT

FTP/0411/16 Trust Chair’s Report

FTP/0411/16.1 The Chair had no further specific items to report to the Board.

FTP/0411/17 Update from the Chairman of Council

FTP/0411/17.1 The Board received Enclosure 13 for information.

FTP/0411/18 Annual Report on Attendance at Board Committees

FTP/0411/18.1 The Board received Enclosure 14 and noted the attendance figures for the relevant Committees.

FTP/0411/19 Sealing Report

FTP/0411/19.1 The Board received Enclosure 15 and it was noted that Seal No. 52 had been affixed on 25th March 2011 associated with the lease for the provision of a Nationwide Building Society ATM. The value was nominal.

FTP/0411/20 Questions from the Public

FTP/0411/20.1 There were no questions from the public.

FTP/0411/21 Exclusion of the Public

FTP/0411/21.1 The Board then resolved that representatives of the press and other members of the public be excluded from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Date of Next Meeting
Thursday 26th May 2011

ENCLOSURE 2

SUBJECT :	Report of private business transacted at the April 2011 Board
REPORT BY :	Steve Parsons, Head of Corporate Affairs
AUTHOR :	

CONTEXT AND BACKGROUND FOR REPORT

The Standing Orders for the Board of Directors require that business considered in a private session of the Board is reported in public.

This report outlines the business considered in private during the April 2011 Board meeting.

KEY ISSUES FOR BOARD OF DIRECTORS' CONSIDERATION AND DECISION

- Committee minutes were received from CGC, ORAG and Standing Finance Committee
- The Board considered 2 RCA reports, and was updated about incidents under consideration that would be reported to the Board in due course
- The Board were updated on the ongoing discussions with Birmingham Children's Hospital FT regarding future developments
- Update reports from the Chairman and Chief Executive were received
- The Board considered the draft Corporate Objectives for 2011-12
- The decision of the Audit Committee to approve the use of the Trust's auditors for certain non-audit services was endorsed.

RECOMMENDATIONS

The Board is invited to note the proceedings in private in April 2011.

ENCLOSURE 3

SUBJECT :	Red Risk Report and Assurance Framework- May 2011
REPORT BY :	Steve Parsons, Head of Corporate Affairs
AUTHOR :	

CONTEXT AND BACKGROUND FOR REPORT

As part of the Trust's risk management and mitigation processes, the Trust Board receives a report monthly update on the risks currently shown as red on the Trust's Risk Register.

The Board has requested that the following are provided within each report:

- Details of the controls currently in place in respect of each risk (shown on the attached list)
- An update on the progress made towards the mitigation of each risk since the previous report

Red Risks are subject to a monthly review by the named manager with responsibility for the risk, as set out in the Risk Management policy. Risks are more closely reviewed through ORAG or CGC, as appropriate, as set out in the Board Assurance Framework.

The information related to the controls in place has been taken directly from Datix and (where relevant) edited to ensure that it reflects the current rather than historic position.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

There are currently 6 Red Risks on the Register. During the month, three risks have been downgraded:

- Risk 188 (Histology samples) has been rated Moderate
- Risk 192 (Turnaround times for correspondence in NNU) has been rated High (Amber)
- Risk 194 (Anaesthetics machine) has been rated High (Amber)

One risk has been upgraded to Extreme (Red) this month:

- Risk 123 (Pharmacy SLA)

During the month, the following risks have had new controlling actions recorded:

- Risk 123 (Pharmacy SLA)
- Risk 136 (Midwifery Staffing)
- Risk 138 (Consultant presence on Delivery Suite)

RECOMMENDATIONS

The Board is invited to note the Red Risks currently on the Register, and the controls in place regarding those risks.

ID	Title	Latest controls stated	Directorate	Risk level (current)	Risk level (Target)	Adequacy of controls	Risk Type	Risk Subtype
3	Norton Court	24. Joint development options also being considered with BCH (January 2011 onwards - Both organisations to consider at March 2011 Board meetings.)	Facilities and Estates	Extreme	Low	Adequate	Corporate	Multiple
123	Pharmacy SLA	16th May 2011 Change of risk owner to M Emery as R Monaghan has left the Trust. M Emery setting up Pharmacy users Group to meet monthly and address issues.	Neonatal Directorate	Extreme	Moderate	Inadequate	Clinical	Clinical
136	Midwifery Staffing below National Recommendation	12/05/2011 -HoM to complete bottom -up staffing review to gain assurance of correct midwifery establishment	Maternity Directorate	Extreme	Moderate	Adequate	Clinical	Compliance
138	Inadequate Consultant presence on Delivery Suite	12/05/2011 -change in rota on delivery suiteThis has not had any adverse affect on consultant delivery suite presence as covered by other consultants; Outcome of expansion project awaited- will deliver 1 WTE consultant	Maternity Directorate	Extreme	Moderate	Adequate	Clinical	Compliance
143	Unable to treat patients due to Lack of HDU facility	*No update available at time of report*	Gynaecology Directorate	Extreme	Low	Inadequate	Clinical	Clinical
186	Middle Grade Medical cover March-Sept 2011	*No update available at time of report*	Neonatal Directorate	Extreme	Moderate	Uncertain	Clinical	Compliance

CHIEF EXECUTIVE'S REPORT – May 2011

1.0 Quality and Safety focus

1.1 Outcomes

The 12 month rolling average for corrected Neonatal mortality rate fell to 2.9 per thousand deliveries at the end of March. Our adjusted still birth rate rolling average increased to 2.9 per 1000 deliveries not including intrauterine transfers.

1.2 Processes

At the time of writing we had not received the report from the CQC assessment visit held in April.

2. Organisational Development (OD) Strategy and Human Resource matters

2.1 Service Line Reporting (SLR) & Management

To confirm that the necessary actions to populate the SLR with 2010/11 data is on schedule and the click view module that will allow desktop access to the system has been loaded. At the Board meeting Jason Burn plans to give a demonstration of the system to Board colleagues.

2.2 Listening Into Action

Listening Into Action - Staff Engagement Update

A summary of key staff engagement and involvement activity in the past month is summarised below.

Norton Court Makeover

Norton Court makeover weekend was a huge success earlier this month. After months of planning the makeover, a 05:00 start saw Warren Hubbard, Head of Estates, painting the ceiling and by 09:00 some fifteen members of staff, plus the occasional relative and volunteer, had armed themselves with paintbrushes, jet washers, spades, DIY equipment and rolled their sleeves up. Rain soaked the gardening team but spirits were kept high and by the afternoon, the team had benefited from the arrival of the Chief Executive who soon found himself with brush in hand (as directed by the team) and by the father of a baby who had been in our NNU for the last 7 weeks. By early Sunday afternoon most of the painting inside was complete, the bollards and the benches outside had been given a coat of paint, the canopy had had a new coat of paint and the parking cone removed from the roof before the final six people who had braved a second day of painting trooped home.

"Anticipation was high this morning." "I couldn't wait to see the reception area so I popped in on my way to the office this morning, and it looks fantastic"; "it really makes a huge difference walking into Norton Court reception now… even outside looks wonderful and "Can't believe the difference it has made," "Its like a completely different building", and "what an improvement this has made to

my workplace entrance", were just some of the comments overheard the following Monday morning.

Finishing touches are now being made to the project, including frosting the glass doors, two vending machines, wall art outside cytology and stairs to Genetics and BWH Values in reception. A picnic bench is being painted so staff can enjoy their break outside in the summer months and more plants, both artificial and real, are being planned to brighten up the area.

The following staff should be thanked for their contributions and enthusiasm to the project:- Andrew Cuthbert, Joyce Perks, Maggie Lett (devastated not to be there at the weekend but a tour de force behind the fundraising), Warren Hubbard, Jenny Manley, Frank Gough, Maureen Frost, Chris Morgan, Peter Marks, Phil Williams, Pooja Dasani, Amanda Lugg, Neil Metcalfe (volunteer), Jatinder Mavi (who provided much needed financial advice and support) and Dom McMullan.

This project's fundraising and sponsorship efforts have seen the group raise around £700 towards the cost of the project, together with sponsorship from Bourneville Garden Centre (approximately £400), Fallen Angel, Harborne and B & Q raffle prizes. Other forms of sponsorship and gifts have come in through suppliers and will be seen shortly in the form of artwork.

The group is now undertaking discussions on how best to make a visual impact on the stairs to clinical genetics and an official opening date is being planned for mid June.

Sickness Absence

The recent sickness absence "long shifts" event saw a constructive discussion of a number of issues surrounding long shifts and the impact on the hospital, staff and patients, including whether or not they benefited staff, patients and hospital; the management and costs of covering absences on long shifts and staff welfare. The group's next steps are to supplement existing policy advice by producing an aide memoire about managing sickness good practice plus useful tips to ensure that the implications of sickness and long shifts are effectively managed.

Tackling Smoking

A lively debate began this month on the subject of tackling smoking outside the hospital with the group's first meeting. A summary of the comments and ideas made there and from staff who sent comments will be circulated to those interested in this topic next week with a view to agreeing the next steps.

Antenatal Pathway

Staff welcomed a mother-to-be to the Antenatal Pathway Group this month to look at the issues surrounding the antenatal pathway experience from a first hand patient perspective. The group is now developing their initial thoughts and plans around improving the patient's journey in this area.

BWH values

Following last month's presentation at the Board, the Values Group has now ordered the publicity toolkit, Powerpoint templates, banners and digital images. This month the group has been finalising their plans for launching the BWH Values next month and have had parts of their meeting filmed for the DVD.

Our Brief

A third issue has been produced and distributed this month.

The IT User Group

The Group met on 4th May and has progressed a wide range of issues raised through the engagement process. Challenges explored at the meeting included:

- Community midwife laptops
- IT projects for the financial years 2011/12, 2012/13
- Wireless networking
- Intranet development
- IT literacy
- Monthly service update by UHB
- Project management by UHB
- IT Customer Service and Choice

Staff Engagement DVD

Individual staff and LiA groups are being filmed this month for the staff engagement DVD. The DVD will be launched at the proposed BWAFTAs – the Birmingham Women's Awards For Tremendous Achievement. This event will showcase the DVD to demonstrate the Trust's recent approach to improving staff engagement through LiA and will include an opportunity to highlight and reward those who have got involved in improving engagement.

Finally, a number of other staff engagement activities are being finalised, including a monthly inter-departmental, regular charity staff cake sales, a staff pantomime / talent show or a sports event. Meetings coming up include the BWH Values / Commitment group meeting on 31st May, Tackling Bureaucracy on the 14th June and managing sickness absence.

Staff Survey

The Executives have consulted Management Board and the Trades Unions over the past two months about the priorities arising out of the recent staff survey results reported to the last Board.

There is general agreement that the key priorities for responding to the last staff survey should be:

- **Improving staff engagement and involvement** – achieved through continuing to roll out the Listening into Action methodologies, Board Walkabouts and a review of the recognition agreement.

- **Valuing staff** – achieved through the embedding of the new reward and recognition scheme, implementation of the BWH Values developed by the Commitment Group, a forum for clinical and management leaders on the 1st of July to discuss, listen and develop ideas of what every member of the Trust should do to improve each others approach to valuing colleagues and their own sense of being valued.

- **Appraisal and personal development** – through availability of appraisal and appraisee training, rolling out 360 Clinical for Consultants' appraisals, setting and monitoring a higher target of 85% appraisals and PDPs across all staff groups.

- **Attendance Management** – through reviewing the current Trust Attendance Management policy in partnership with staff side colleagues, supporting the LiA Sickness Absence group to explore and implement new approaches to managing sickness and reviewing the occupational health service level agreement.

- **Hand washing facilities** – through supporting the Infection Control committee to review and improve on availability and staff perceptions of the availability of hand washing materials.

2.3 Service Improvement through Lean Methodologies

2.3.1 Productive Theatre

The Productive Theatre Module was launched on the 18th February 2011. The planned Human Factors Workshop took place on 20th April to scope the project delivery timescales.

The initial key project milestones are the following:

(a) To undertake an ongoing team brief/debrief audit – 18th May.

Objective – To supply the necessary evidence around compliance with the mandatory brief

(b) To commence ongoing patient delay audit – 18th May.

Objective - To highlight reasons for patient delays throughout the patient journey from the ward to theatre and into post operative recovery. To provide quarterly reports to generate ideas for improvements to be then trialled and audited.

(c) To establish a LEAN workshop for those involved in the Productive Theatre project – 1st June

Objective - To be led by NHS Elect, focusing on 'Lean' philosophy and implementation, providing the necessary training for those involved and to generate further ideas to be carried forward and implemented throughout theatre.

(d) To undertake a LEAN exercise focusing upon Anaesthetic rooms, main store room and equipment – 1st week in August

Objective – To involve stores, pharmacy and procurement personnel to achieve:

- Re-labelling and re-stocking.
- Equipment 'parking bays' to be identified.
- New anaesthetic store trolleys for each anaesthetic room
- Focus upon top 20 consumables list from stores to identify better value for money

(e) To implement operational status at a glance – 1st week in August

Objective – To provide details of key operational matters to be updated on a regular basis throughout the working day. The board will highlight staffing numbers, patients in theatre and still to arrive and theatre data in real time, showing list progress.

2.3.2 Genetics Electronic Document Management System

Key staff have received their training for the new system's EMC Scanning Software and Input accelerator. UHB have set up the required servers and the software is being loaded week commencing 16th May in readiness for operational implementation thereafter.

2.3.3 NHS Elect

Lean methodologies project support and staff training has been agreed with NHS Elect and the following projects have been put forward to support the Trust in delivering its objectives:

Neonatal Directorate - Project name: Pharmacy Services Review
Objective: To scope further efficiency improvements in the Pharmacy Service (via SLA with UHB). This would include benefits analysis of a ward-based service (including reducing waste and associated expenditure, saving time in discharge process, advice to patients, quality of service). In addition, consideration of pharmacist prescribing, and a proper electronic prescribing system.
Project leads: Nick Reading / Michele Emery
Timeframe for delivery: Qs 1 and 2.

Corporate Directorate – Project name: Recruitment Process Review
Objective: To review the internal and external recruitment processes to ensure optimal efficiency, maximising free advertising, reducing advertising costs and giving the shortest possible vacancy to appointment lead times.
Project lead: Estelle Carmichael
Timeframe for delivery: Qs 1 and 2.

Genetics Directorate - Project name: Referral pathway in general genetics
Objective: To ease implementation of the Electronic Document Management System (EDMS), ensuring maximum efficiency from the system and to give greater control of the 18 weeks Referral To Treatment (RTT) target.
Project lead: Laura Boyes
Timeframe for delivery: Q3

Maternity Directorate - Project name: Maternity Expansion - efficiency review of postnatal discharge
Objective: To provide assurance that new discharge processes are efficient and fully embedded prior to "go live" of 8,000 deliveries and ability to audit and report on improvements made.
Project leads: Nick Reading & Karen Dugmore
Timeframe for delivery: Qs 3 & 4.

Gynaecology Directorate - Project Name: Re-development of EPAU/Acute gynaecology services.
Objective: To explore models of working and resource utilisation for efficient amalgamation of EPAU/Acute gynaecology and re-development of gynaecology outpatient services. This would include use of staff, use of available premises and equipment and to identify useful outcome measures such as to increase throughput and reduce outpatient waiting times.
Project leads: Manjeet Shehmar/Phil Toozs-Hobson
Timeframe for delivery: Qs 3 and 4.

2.4 Reward & recognition

Monthly awards

Colleague award

The monthly colleague award winner for April was Gail Alexander, Hotel Services Manager. A summary of the citations to support Gail's nomination both this month and on previous occasions is below:

"Gail is an extremely dedicated Manager. She is always trying to do the best for her staff and she is committed to improving the patient environment. Gail is prepared to work any hours in order to see members of her team who provide a 24 hour service. Gail is always willing to cover other areas within the Facilities function during periods of short staffing and she always gives her free time to support the organisation" "

Patient award

The patient award for April went to Jane Harkin, Midwife. A summary of the citation to support Jane's nomination is as follows:-

"Jane treated me very well and listened to me and discussed my treatment with me. She was the person who reassured me when I was bleeding and in shock."

Well done and many thanks to Gail and Jane who will both be presented with a card of thanks from the Board together with a cheque for £100

2.5 Management of Change

The Board will be aware that the initial consultation period with staff groups on changes to a number of posts and skill mix have concluded and the outcomes for the majority of staff involved are now known. Clearly this is a challenging time for large numbers of our staff and the Trust has in place a range of support mechanisms to help individuals. The Board should also note that a number of staff have appealed or confirmed their intent to appeal against the outcomes of the management of change process. Consequently arrangements are being set up to hear the appeals.

3. Communication matters

Intranet Development
The intranet group are in the final stages of developing a business case for the intranet for an Enterprise Content Management System, this would take on board the Intranet and a Document Management System.

Website
The new website being built alongside the current system is still on course for completion during the summer. We will arrange an opportunity to share this with Board Members followed by a forum for staff to view at a later date.

Baby Show
Communications have developed a series of posters for display at the Baby Show. In addition staff members, governors and volunteers will be giving out health information, promotional items and membership forms with an aim to attract new members for the Trust.

Quiet Room Opening
The Communication team is working with Bereavement Services to arrange the official opening of the new Family Quiet Room in June

Media

ITV 1 Series on Maternity
We are awaiting feedback from Maverick as to whether they may consider 'The Women's' for this series.

BBC 2 Reel History of Britain
Melvyn Bragg visited the Trust on 10/5/2011 and interviewed Midwife Antoinette Connelly as well as new parents on Ward 4. The programme focus is the Birth of the NHS and features footage of midwives training at the QE Hospital in the 1930s. The transmission date will be publicised when known.

BBC Asian Network
The Asian Network are producing a programme about Fertility and Sperm Donation within BME communities. They have interviewed Jackson Kirkman- Brown and an Asian sperm donor for the programme talking about the need both nationally and in the region for men from minority ethnic backgrounds to come forward and donate sperm.

4. Other matters

The Trust is collaborating with UHB and University of Birmingham in a bid to become one of three Cancer Research UK (CRUK) funded technology hubs relating to research and cancer diagnosis. CRUK have short-listed six centres and have undertaken site visits as part of the assessment process and visited Birmingham Women's Hospital on the 17th May. The assessment went well with good attendance from University and UHB partners to the sessions. The decision to award technology hub status will be made by CRUK in the middle of June.

5. Challenges

The key challenges for the Trust over the coming months are:

- To continue to focus upon the need to deliver the Trust's challenging financial plans.
- To continue with the management of change processes and respond to staff concerns highlighted thus far.
- To ensure that plans are being considered at a detailed level that focus upon the second and third year of the Trust's Annual Plan.

Steve Peak
Chief Executive

ENCLOSURE 5

SUBJECT :	Integrated Performance Report April 2011
REPORT BY :	Jane Owen, Director of Nursing, Midwifery and Operations Neil Savage, Director of Workforce and Organisational Development Jason Burn, Director of Finance and Information
AUTHOR :	Jane Owen, Director of Nursing, Midwifery and Operations Neil Savage, Director of Workforce and Organisational Development Jason Burn, Director of Finance and Information

CONTEXT AND BACKGROUND FOR REPORT

The Board has agreed that performance data should be provided monthly in the form of a 'dashboard', covering the main areas of performance for the Trust.

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

Maternity

Under target for deliveries in April by 37 births

Cancer referral to treatment target times

All cancer waiting times have been achieved for the month

18RTT

Performance against the non admitted % has reduced. Further work is being undertaken to validate this data.

Workforce

Contracted WTE

This is within target and continues to fall, having reduced by a further 10 WTEs in the past month.

Agency/Bank Spend as a % of directorate paybill

This is within target having fallen over the previous month's spend at 1.35%. Executive scrutiny of individual requests for agency continues.

ENCLOSURE 5

Sickness Absence

This is on target. At 3.5%, the trend of improving attendance levels has again improved over the previous month. This increased attendance needs to be very carefully managed over the next year.

KSF Outline / PDR

At 81.39% while short of the 85% target, appraisal rates have improved slightly, continuing the upward trend.

Pay as a % of Income

This figure is outside target but is based on the draft finance budget pending full budget reconciliation.

Grievances

Staff Grievances have increased to 3 in the month and are expected to increase further over the next two months in light of the various management of change and skill mix reviews.

Finance

A separate detailed report on the Trust's financial position has been provided for the Board.

RECOMMENDATIONS

The Board is invited to note the Trust's performance in April 2011.

Birmingham Women's NHS foundation Trust - Trust Board Dashboard Indicators

01-Apr Data **Month 1**

Patient Activity	Target YTD	Actual YTD	Move	Status Vrs Target	Year End Forecast
Elective Spells	258	264	▲		
Gynae Emergency Spells	132	117	▼		
Obstetric Spells	857	827	▲		
Outpatient New	2,552	2,694	▼		
Outpatient Follow up	4,016	4,698	▲		
Outpatient Procedures	779	1,106	▲		
Total Deliveries	606	569	▼		

Demand & Waiting Lists	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
Referral Rates - Gynae	1746	1814	▼		
Referral Rates - Maternity	2044	1963	▼		
Referral Rates - Genetics	750	740	▼		
Admittied within 18 weeks	90%	94.3%	▲		
Non-admittied within 18 weeks	95%	95.1%	▼		

Finance	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
Year to date I&E position	£(75)k	£(83)k			£400k
Year to date I&E normalised					
In month run rate	£(75)k	£(83)k			
In month run rate normalised					
Year to date Ebitda	£305k	£298k			£4,965k
Year to date Ebitda margin	4.10%	4.10%			5.60%
Year to date CIP performance					
CIP recurrent/non-recurrent delivery					

Workforce	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
Contracted WTE	1441.48	1431.45	▼		
Agency/Bank spend as a % of directorate paybill	2.85%	1.35%	▼		
Sickness Absence Rate %	3.50%	3.50%	▼		
Staff Turnover Rate %	14.10%	9.48%	▼		
Employee Investigations	<4 wks	3	▼		
KSF - Staff groups with Job Outlines %					
Staff Appraisal%	85%	81.39%	▲		
Pay as a % of Trust Income	69.83%	71.58%	▲		
Staff Grievances	1	3	▲		
Harassment and Bullying	1	0	▼		
NHS Staff Satisfaction	72%	74%	▲		

CQC Targets	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
Cancer 2 week wait	93%	93.1%	▼		
Cancer 1 month to treatment standard	96%	100.0%	►		
Cancer 1 month subsequent treatment standar	94%	Nil	►		
Cancer 2 month GP urgent referral to treatmen	85%	100.0%	▲		
Cancer 2 month Cervical Screening Report RT	90%	Nil	►		
Cancer 2 month from upgrade to treatment	No target	100%	►		
Cancelled Operations on day of surgery	1	0	▲		
Cancelled Operations not admitted within 28 da	0	0	►		
Maternity HES data quality indicator	<10%	6.9%	▼		

Efficiency	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
Theatre utilisation	80%	82%	►		
Outpatient DNA Rate - Gynaecology		13.1%	▼		
Outpatient DNA Rate - Maternity		9.4%	▲		
Outpatient DNA Rate - Neonatology		27.4%	▼		
Outpatient DNA Rate - Genetics		14.7%	▲		
New to Follow up ratio	1.4	1.39	▲		

Quarterly Tables

Finance Report

Month 1 – April 2011

1. Overview

The following, summarised, report has been prepared to provide an initial indication of the Trust's financial performance for Month 1 (2011/12). Further work is being undertaken to refine budgetary phasing, which takes into account the projected delivery of efficiency and productivity schemes, etc. Full reporting will commence for Month 2 onwards.

In assessing the Trust's position at Month 1, a deficit of £83k is noted. This equates to an £8k adverse variance against plan, details of which are provided in the table below:

BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST INCOME & EXPENDITURE REPORTING PERIOD : - April 11 (Period 1)						
Form F1	**This Month**			**Year To Date**		
	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's
Income (+)						
Healthcare Income	5,654	5,582	(72)	5,654	5,582	(72)
Private Patient Income	84	83	(1)	84	83	(1)
Other Income	1,625	1,561	(64)	1,625	1,561	(64)
Total Income	7,363	7,226	(137)	7,363	7,226	(137)
Operating Costs (-)						
Pay Costs	(4,865)	(4,761)	104	(4,865)	(4,761)	104
Non Pay Costs	(2,193)	(2,168)	25	(2,193)	(2,168)	25
Total Operating Costs	(7,058)	(6,929)	129	(7,058)	(6,929)	129
EBITDA	305	298	(8)	305	298	(8)
EBITDA % Margin	4.1%	4.1%	0.0%	4.1%	4.1%	0.0%
Depreciation (-)	(281)	(281)	0	(281)	(281)	0
Interest (+/-)	6	6	0	6	6	0
Dividend (-)	(106)	(106)	0	(106)	(106)	0
Surplus / (Deficit) Before Impairment	(75)	(83)	(8)	(75)	(83)	(8)
Fixed Asset Impairments (-)	0	0	0	0	0	0
Surplus / (Deficit) cfd	(75)	(83)	(8)	(75)	(83)	(8)

1.1. Financial Risk Rating

Based on the performance noted above the Trust's Financial Risk Rating (FRR) for Month 1 is a 2, calculated as shown below:

		Rating	Weighted Average Rating	Rounded Score
EBITDA Margin	4.1%	2	0.5	
EBITDA acvievement of plan	90.4%	4	0.4	
Return on Assets	0.7%	2	0.4	
I&E Surplus Margin	-1.1%	2	0.4	
Liquidity	19.7	3	0.75	
			2.5	2
Overriding rules				2

The overriding rules score of 2 is triggered as two of the 'financial criteria' within the metrics score a 2, these being the EBITDA margin and the average score for Return on Assets & I&E Surplus Margin.

Whilst the Trust is reporting a deficit for Month 1, this is consistent with the position noted as part of the exercise undertaken for the quarter 4 re-forecasting of the financial risk rating (FRR).
In undertaking the exercise the proposed plan for 2011/12 was used as the basis for the calculations, with the phasing of income and expenditure taking into account the proposed delivery of efficiency/productivity schemes, working days in the month for income, etc. rather than straight twelfths.

The output from the re-forecasting exercise has been provided again below for information, but has been extended to provide the EBITDA and I&E position at the end of each quarter, that formed part of the calculations

2011/12 FRR Metrics	Qtr 1		Qtr 2		Qtr 3		Qtr 4	
EBITDA	5.1%	3	4.6%	2	5.2%	3	5.7%	3
EBITDA achieved	100%	5	100%	5	100%	5	100%	5
ROA	2.5%	2	1.5%	2	2.8%	2	4.0%	3
I&E Margin	-0.3%	2	-0.7%	2	-0.1%	2	0.5%	2
Liquid Ratio	22.1	3	23.0	3	21.5	3	24.1	3
Weighted average		2.8		2.6		2.8		3.0
Rounded Score		3		3		3		3
Over-riding Rules		**3**		**2**		**3**		
EBITDA	£1.085m		£1.980m		£3.366m		£4.990m	
I&E Surplus/(Deficit)	£(63)k		£(315)k		£(77)k		£400k	

2. Healthcare Income & Activity

Total income for Month 1 is £7.2m, which is £137k behind plan.

The main drivers for the adverse variance are an assessment of credits applicable to out of area treatments, totalling £79k, and an adverse variance against plan for hosted organisations of £32k, which is offset in full by favourable variances in expenditure.

- Healthcare Income – Activity

The table below provides details of activity, by specialty, for Month 1:

		Activity - Month 1			Full Year
		Target	Actual	Variance	Target
Maternity	Normal spells inc. excess bed days	856	827	(29)	10,433
	Outpatients (New & Follow up)	4,483	5,402	919	64,087
Gynaecology	Elective spells	258	264	6	3,706
	Non elective spells	132	117	(15)	1,610
	Outpatients (New & Follow up)	1,994	1,857	(137)	28,530
	Outpatient procedures	783	1,106	323	11,181
Neonatal	Intensive Care cot days	204	256	52	2,486
	High Dependancy cot days	176	234	58	2,146
	Special Care cot days	836	749	(87)	10,206

- Private patient income

Private patient income at Month 1 totals £83k and is on plan. Performance remains within the Trust's private patient income cap of 2.2%.

3. Directorate Positions

The table below shows the combined positions of pay, non pay and directorate income. Healthcare income, split by directorate, will be included within the finance report from Month 2 onwards.

As at Month 1, there is a favourable variance against plan of £60k across all directorates.

	Month 1 - April 2011				Month 1 - April 2011			
	In-month Actual				In-month Variance against Plan			
	Pay	Non Pay	Directorate Income	Total	Pay	Non Pay	Directorate Income	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Maternity	(1,356)	(167)	37	(1,486)	(1)	14	(22)	(8)
Gynaecology	(746)	(359)	4	(1,102)	39	(28)	(25)	(14)
Genetics	(1,108)	(327)	305	(1,131)	(9)	39	(11)	19
Neonatal	(688)	(146)	56	(778)	(29)	5	14	(11)
Facilities	(210)	(161)	37	(334)	23	26	8	57
R&D	(43)	(62)	105	0	4	(2)	(2)	(0)
Corporate Services	(292)	(757)	178	(871)	9	6	2	17
Hosted Organisations	(285)	(172)	457	0	68	(37)	(32)	(0)
TOTAL	**(4,728)**	**(2,151)**	**1,178**	**(5,701)**	**104**	**25**	**(69)**	**60**

4. Efficiency Programme

The efficiency programme required by the Trust in 2011/12 totals £6.2m, split across service developments and efficiency & productivity schemes as follows:

	£m
Service Developments	1.3
Efficiency & Productivity Schemes	4.1
Contract negotiations / Start-point adjustments	0.8
	6.2

Analysing the total by directorate, directorate targets are:

	£m
Maternity Services	1.4
Neonatal	0.9
Gynaecology	1.0
Genetics	1.2
Clinical Support*	0.4
Corporate inc. Facilities	0.8
Trust-wide	0.5
	6.2

*The total value of schemes for Clinical Support has been shown separately above, but will be monitored as part of the appropriate directorate, based on the revised structure.

Monitoring arrangements of the Trust's efficiency programme have been strengthened for 2011/12, which includes additional performance meetings scheduled with directorates on a monthly basis throughout the year. The sole focus of these additional meetings will be on progress in delivering the schemes. Updated information from these meetings will then be shared with the Trust's Standing Finance Committee, in detail, on a monthly basis with a summary of the position being provided within the Trust's monthly finance report.
In addition the Trust has also commissioned an independent review of the efficiency programme for 2011/12, undertaken by PricewaterhouseCoopers LLP. The outcomes of this review will assist the Trust in understanding and assessing the areas of highest risk and in developing mitigating actions.

5. Conclusion

The Board is asked to note the Trust's financial position as at Month 1 (April 2011), which in summary is:

- In month deficit — £(83)k — - £8k behind plan
- FRR as at Month 1 — 2

BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST INCOME & EXPENDITURE REPORTING PERIOD : - April 11 (Period 1)						
Form F1	**This Month**			**Year To Date**		
	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's	Plan £ 000's	Actual £ 000's	Fav/(Adv) £ 000's
Income (+)						
Healthcare Income	5,654	5,582	(72)	5,654	5,582	(72)
Private Patient Income	84	83	(1)	84	83	(1)
Other Income	1,625	1,561	(64)	1,625	1,561	(64)
Total Income	7,363	7,226	(137)	7,363	7,226	(137)
Operating Costs (-)						
Pay Costs	(4,865)	(4,761)	104	(4,865)	(4,761)	104
Non Pay Costs	(2,193)	(2,168)	25	(2,193)	(2,168)	25
Total Operating Costs	(7,058)	(6,929)	129	(7,058)	(6,929)	129
EBITDA	305	298	(8)	305	298	(8)
EBITDA % Margin	4.1%	4.1%	0.0%	4.1%	4.1%	0.0%
Depreciation (-)	(281)	(281)	0	(281)	(281)	0
Interest (+/-)	6	6	0	6	6	0
Dividend (-)	(106)	(106)	0	(106)	(106)	0
Surplus / (Deficit) Before Impairment	(75)	(83)	(8)	(75)	(83)	(8)
Fixed Asset Impairments (-)	0	0	0	0	0	0
Surplus / (Deficit) cfd	(75)	(83)	(8)	(75)	(83)	(8)

Birmingham Women's
NHS Foundation Trust

SUBJECT :	Patient Safety and Quality Report
REPORT BY :	Peter Thompson
AUTHOR :	Peter Thompson

CONTEXT AND BACKGROUND FOR REPORT

Following on from the meeting of the Board of Directors in November 2009 it was decided to produce a monthly board patient safety report. This includes data for the mortality rates and our weekly patient safety indicators. From April 2011 the report will also include a section on patient experience and a quality dashboard.

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

The weekly patient safety indicators were first published on Friday 15th January 2010. We have now agreed the indicators for this year and this will incorporate 2 changes. These new data were published from the beginning of the new financial year.

Corrected Neonatal mortality and Stillbirth rates are now expressed both as a rolling 1 year rate and graphically with statistical process charts. As not all post-mortem reports are available within a month we will continue reporting 2 months behind from this point onwards. In addition we have added the 'crude' stillbirth and neonatal death rates.

At present, the graphs on the dashboard are not available electronically but the data is within the report.

In this months report we have also included Care Quality Commission Quality Risk Profiles for the Trust.

RECOMMENDATIONS

To note and discuss the findings of the report

Birmingham Women's NHS foundation Trust - Trust Board Dashboard Quality Indicators April 2011

Clinical Quality					
	Target Month	Actual Month	Move	Status Vrs Target	Year End Forecast
Written Complaints	n/A	11			
Responded to within agreed timescale		61%	▼		
MRSA Bacteramia	0	1	▲		1
Cdiff	0	0			0
BreastFeeding initiated	67%	67.2%	▲		
Smoking during pregnancy	11%	14.1%	▲		
% of Women seen by 12 weeks	90%	95.8%	▲		

Neonatal & Stillbirth rates					
	Mean	Actual Month	Move	Status Vrs Target	Year End Forecast
BWH Birth/NND >22 Weeks Without abnormality - Rate per 1000		5	▲		
Stillbirth Rate - Corrected 1		0.0	▼		

Weekly Safety indicators

Please find this week's patient safety indicator results 20/05/2011.

Indicator	Number of weeks since last occurrence (start date 7/1/2010)	Number of occurrences year to date (from April 2011)
MRSA bacteraemia	3	1
Clostridium Difficile	40	0
Inadvertent bowel or bladder damage during gynaecological surgery	7	0
Unexpected returns to gynaecology theatre †	2	2
Caesarean sections for placenta praevia where the consultant anaesthetist and obstetrician were not present	0	1
Inborn babies that require therapeutic cerebral cooling for presumed peripartum hypoxia	1	4
Ventilated inborn babies below 28 weeks gestation where administration of surfactant within 1 hour of birth was not achieved	9	0
Inborn births before 25 weeks where the neonatal consultant was not present at the resuscitation when required to be present by the Trust's early care guideline	0	1
Incorrect laboratory report released by genetics laboratories	1	2

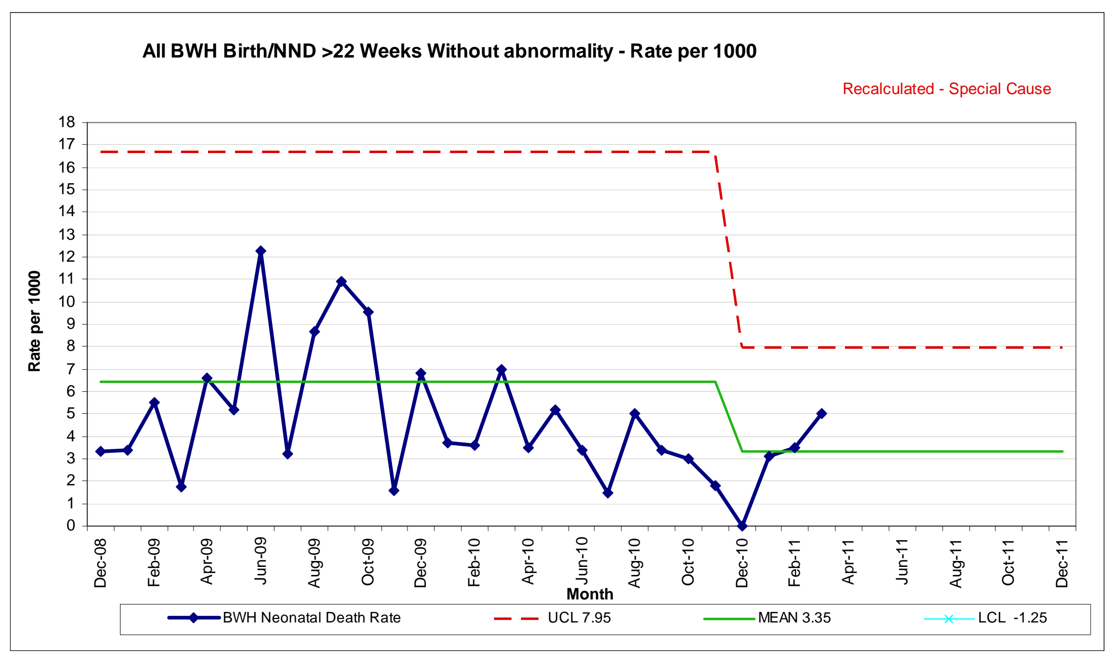
† A small number of these cases will be expected each year

1. Mortality Rates

The following statistical process charts show the expected variation in the monthly mortality figures and as long as the results are within the control limits and there is not a continual upward trend variations around the mean are secondary to natural variation, not necessarily changes in systems.

<u>Corrected Neonatal Mortality Rate</u>

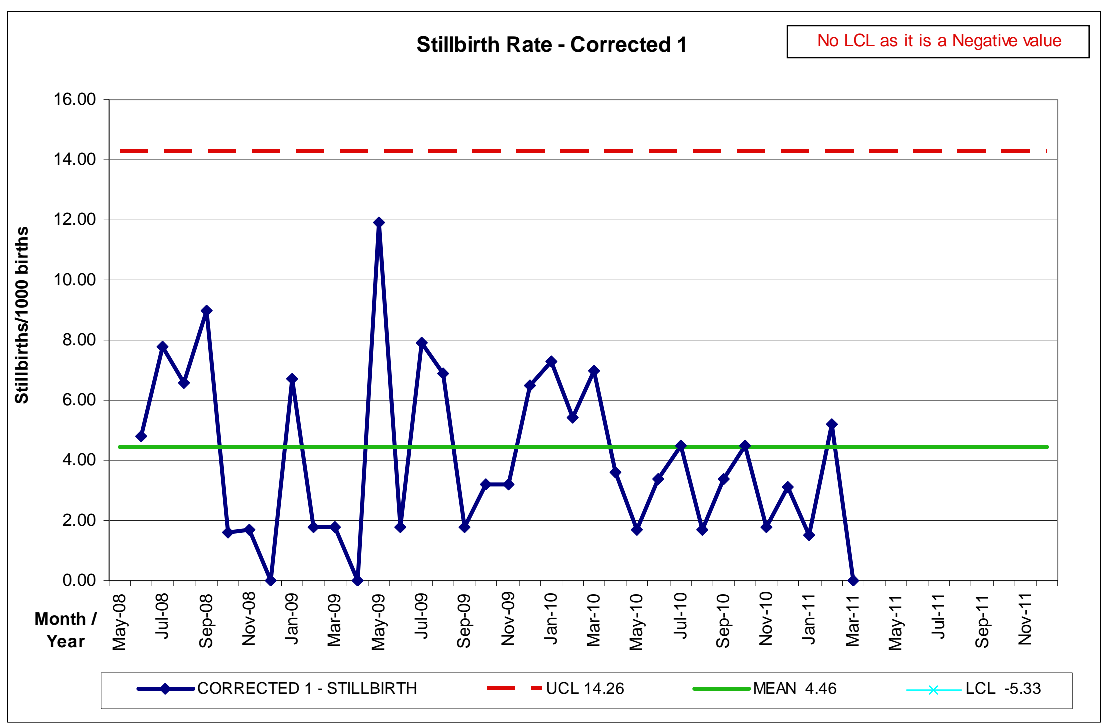
Rolling annual rate corrected for major congenital abnormalities, delivery <22 weeks gestation and birth weight <500g up to end of March 2011 is 3.1/1000. This compares to a crude neonatal death rate of 6.7/1000 for the same period.



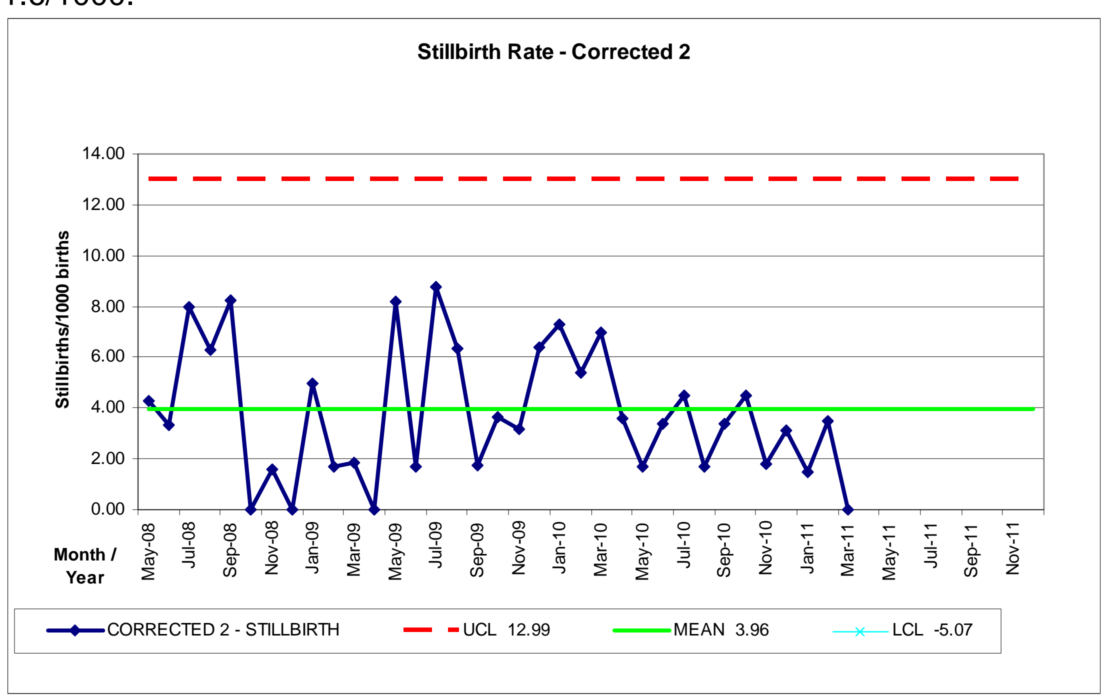
UCL = Upper control limit
LCL = Lower control limit

Adjusted Stillbirth Rates

Rolling annual rate, up to and including March 2011, corrected for major congenital abnormalities and birth weight <500g is 2.2/1000. This compares to a crude still birth rate of 5.1/1000 for the same period.



Rolling annual rate, up to and including March 2011 corrected for major congenital abnormalities, birth weight <500g and intrauterine transfers is 1.6/1000.



Patient Safety Initiative

Board and Governor's Walkabouts

The schedule for these visits around the hospital for June 2011 was not available at the time of submitting the report.

Serious Untoward Incidents (SUI)

Table of the occurrence of SUIs in the month of April 2011

Directorate	Number of SUI s April
Clinical support	0
Genetics	0
Gynaecology	0
Maternity	5
Neonatology	1

Patient Experience

Since the beginning of the patient experience project on 31st January we have collected a total of 614 completed surveys. This includes 23 online questionnaires and 7 outpatient texts. The period 31st January – 31st March was reported on at the April board meeting and will be used as a baseline for future feedback enabling comparison following actions aimed at improvement.

A meeting is planned with departmental representatives in late May to discuss the findings of these early surveys. Discussion planned:

- Improving survey uptake in Clinical Genetics, Outpatient areas and community Midwifery etc
- Feedback to patients on 'You said…we did' format.
- Discussion around what patients would like improving.

<u>Feedback to staff</u>
There has been a display in ERC for staff which has focussed on the positive feedback with opportunity for staff to leave their comments. There is also a Patient Nominated Staff Member award included with the monthly staff recognition awards. (60 nominations since February)

<u>Future plans</u>

- Feedback to patients on new board in reception
- Continue cycle of feedback-analysis-change-evaluation
- Assessment of surveys themselves; which forum works, expand promotion or re-evaluate approach

- Training for complaints department and clinical governance on CRT system for access at end of project.

Baseline report (31st January -31st March)

Analysis of first report showed that where patients felt that they had not had significant information given in a way they could understand they then scored others areas down.

Sample of comments

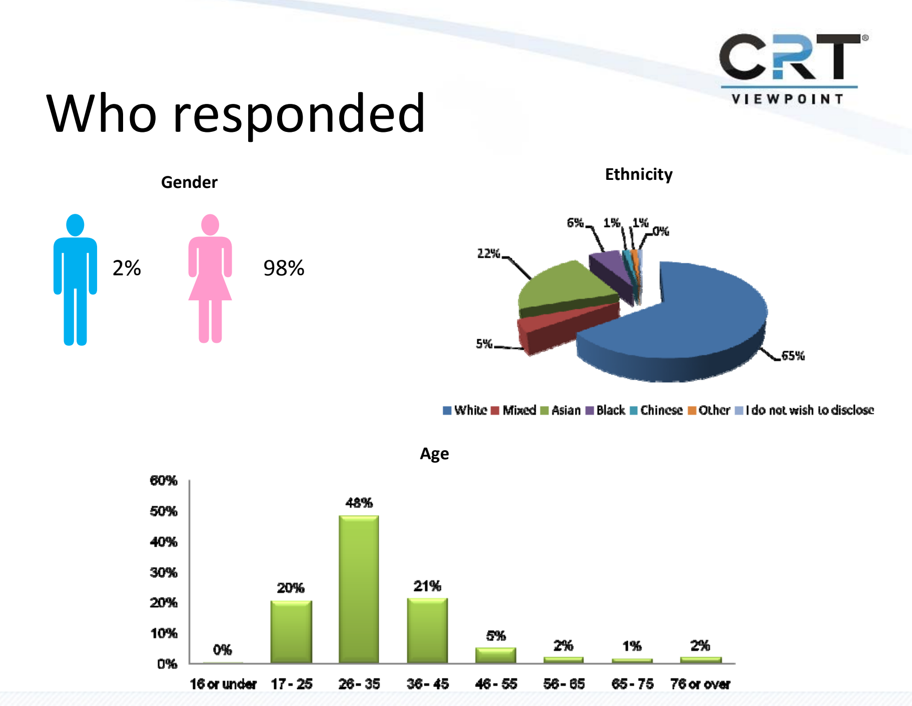
'Atmosphere is lovely'

'The midwives were great, no matter how much you were constantly buzzing the buzzer they would always come in with a smile and were truly nice'

'All staff have treated me with real respect, care and patience'

The staff have all been so supportive and kind. I feel very lucky to have such good care

Report on period 31st January-30th April



Patient Satisfaction

	Inpatient Satisfaction Rating	Outpatient Satisfaction Rating	Neonatal Satisfaction Rating
Involved in decisions about care and treatment	77%	80%	-
Find someone to talk to about your worries & fears	73%	64%	73%
Understand answer to important questions asked	73%	79%	68%
Privacy when discussing condition and treatment	83%	90%	-
Cleanliness of the ward or room you were in*	97%	99%	-

Excellent 80%+ Good: 65% - 79% Fair: 50% - 64% Poor: 40% - 49% Very poor: Under 40%

Patient satisfaction calculated by taking the % for the top answer.
* Cleanliness based on a 4 point scale, top 2 answers taken for patient satisfaction

CRT
VIEWPOINT

Patient Satisfaction

	Inpatient Satisfaction Rating	Outpatient Satisfaction Rating	Neonatal Satisfaction Rating
Cleanliness of the toilets and bathrooms*	90%	-	-
Professionals wash/clean their hands between touching patients	87%	84%	-
Treated with respect & dignity	89%	88%	-
Sufficient written information on benefits & risks of treatment	75%	84%	-
Overall care received	86%	85%	91%
Recommend hospital to family or friends	79%	85%	-

Excellent 80%+ Good: 65% - 79% Fair: 50% - 64% Poor: 40% - 49% Very poor: Under 40%

Patient satisfaction calculated by taking the % for the top answer.
* Cleanliness based on a 4 point scale, top 2 answers taken for patient satisfaction

Figures show an improvement on period 31st January-31st March.

Numbers surveyed

25,306 patients admitted year 2010/11. (Approximately 6300 patients per quarter) Therefore it is estimated that we are currently surveying 10% of patients that are admitted. Thus our survey has a high population and therefore accuracy

Age	Admissions	Surveyed	Ethnicity
17-25	16.4% 47.8%	20% 65%	White
26-35	30.1% 3.2%	48% 5%	Mixed
36-45	11.3% 23.3%	21% 22%	Asian
46-55	3.5% 6.1%	5% 6%	Black
56-65	1.7% 0.9%	5% 1%	Chinese
66-75	1.2% 5%	1% 1%	Other
76 over	0.6% -	2% -	declined

CQC Quality Risk Profiles (QRPs)

The Care Quality Commission publishes monthly Quality and Risk Profiles (QRPs) on all providers. These are in pdf format and quite lengthy, however, they contain valuable information regarding the essential standards of quality and safety of services and also help in the ongoing assessment of where risks may lie.
The Care Quality Commission is aware that the current format of these reports is rather cumbersome and is looking at producing these in a different format in the future although it is not clear if that is a final decision and if so when.

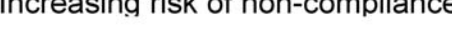
QRPs are an important tool to support continuous monitoring of compliance with the essential standards, by ensuring that everyone is working from the same information, and to improve the provision and commissioning of care. The QRP is useful in supporting monitoring of quality, by identifying areas of lower than average performance and, where necessary, taking action to address them.

The information in the QRP is organised by the 16 essential outcomes of quality and safety. A dashboard gives an overview of the trust performance. The dashboard for April can be seen on the next page, with a guide on how to use/interpret it.The full document can be viewed at the link below. Future reports will highlight any areas of concern by exception reporting. More detailed reviews will be undertaken by the clinical governance committee.

C:\Documents and Settings\obsjo\Desktop\QRP April 2011.pdf

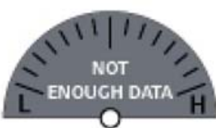
ENCLOSURE 6

A key to the dials in the QRP



Reducing risk of non-compliance

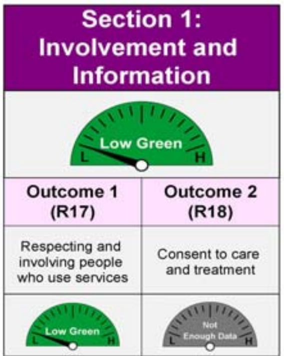
Increasing risk of non-compliance

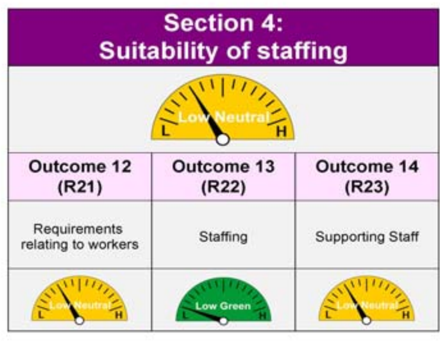


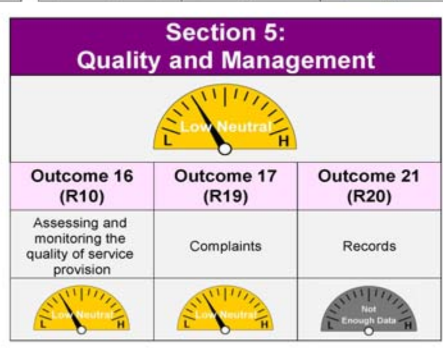
Some data is available, but it is not sufficient to calculate a risk estimate.

There is no data available to inform this outcome or group of outcomes.

Section Summary Of Underlying Outcomes







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SUBJECT :	Matron's reports Q4 (January – March 2011)
REPORT BY :	Jane Owen DIPC
AUTHOR :	Michelle Emery, Charlotte King, Justine Jeffery, Jacky Cotton, Tariq Rehman

CONTEXT AND BACKGROUND FOR REPORT

These reports provide information on issues affecting infection prevention and control, across the directorates. They have been presented and discussed in full at the April 2011 Infection Control Committee.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

Neonatal

- To note the ongoing enhanced hand hygiene education and infection screening.

Maternity

- Improved hand hygiene compliance for March 2011
- Significant improvements to delivery suite environment /cleanliness since revised systems have been implemented
- Also improvement in compliance with routine MRSA screening

Gynaecology

- An infection control forum has been established and is working well

Clinical Support

- From 1st April the directorate will be split up. This is the final report for clinical support

Overall, trust compliance for hand hygiene standards is 92%, just short of the 95% target.

RECOMMENDATIONS

To discuss and note the content of these reports.

**DIRECTORATE REPORT TO
THE INFECTION PREVENTION & CONTROL COMMITTEE**

Quarterly period	January – March 2011 Q4
Directorate	Neonatal
Matron	Michele Emery/Charlotte King

1. **Infection Control Surveillance**

1.1 <u>Newly detected cases of colonisation or infection with MRSA</u>

- 1 case of colonisation - Baby identified via admission screening to the Neonatal Unit, mother not initially screened prior to C Section.
- No cases of bacteraemia with MRSA.

1.2 *Mandatory MRSA & VRE bacteraemia surveillance*

- No cases.

1.3 Mandatory Clostridium difficile surveillance

- No cases.

The Neonatal Unit continued to have several patients isolated with multi-resistant E-Coli and pseudomonas that has necessitated on occasions the co-horting of several patients to reduce the risk to other patients within the Neonatal Unit. All other patients have been isolated in single rooms.

Distilled water is no longer used for washing the babies however for the present baby baths are no longer in use until further notice.

The automatic taps continue to be problematic and following the death of a baby who had isolated pseudomonas the DIPC initiated an outbreak group with regular meetings. Following screening of the taps the main problems appear to be pseudomonas in the incoming water supply, low water usage and pseudomonas around the tap outlets and also from the PALL filters that have been installed. The tap suppliers have been involved with this issue and have now provided brass flow straighteners for some taps as a trial.

Microbiology will continue daily surveillance of these taps to monitor the incidence of pseudomonas. The flow of water through the tap has been increased to 50 seconds after it was discovered that the metered water usage was approximately one fifth of the expected usage.

Weekly rectal swabs for the screening of gram negative organisms continue. Hand hygiene observations have also been enhanced. All staff members within the Directorate have been asked to complete a questionnaire following self –directed learning from a power point presentation on hand hygiene Enhanced cleaning of the environment and medical equipment continues. All parents continue to be advised on an individual basis by the Neonatal Consultants of specific organisms.

2. Audit Data

HAND HYGIENE AUDITS (Compliance Scores - Green ≥ 95% Amber 90 – 94% Red ≤ 89%)				
Ward/Dept	**January**	**February**	**March**	**Process used to feed back results to all ward staff**
NNU	**91%**	**97.2%**	**92.5%**	**Staff made aware of results by email**
TC	**100%**	**100%**	**100%**	**Limited data available**
Exception Report – action undertaken for compliance scores < 95%				
As stated above enhanced hand hygiene update has been initiated through power point presentation and questionnaire. This is to increase awareness and the vital role hand hygiene plays in reducing the risk to our patients. TC: more observations required for future				

3. Patient Environment & Medical Equipment Cleanliness

Quarterly Departmental Environment Audit		
Ward/Dept	**Date Completed**	**Score (%)**
NNU	**January 26 2011**	**86%**
NNU	**February 25 2011**	**90%**
NNU	**March 14 2011**	**91%**
TC	**Jan 27 2011**	**94%**
TC	**Feb 25 2011**	**90%**
TC	**March 2 2011**	**97%**
Exception Report **Key areas of non-compliance that could not be resolved locally & actions taken**		
NNU: Dusty trolleys, milk stained lockers, incubators/baby therms and cots dusty and slash marked. There are plaster settlement cracks in some internal walls, Estates are aware, Head of Nursing to arrange a programme to fill cracks which will involve relocating babies to other rooms during that process. TC: Require 6 step technique poster at sink and storage issues		

Medical Equipment Cleanliness Audit				
Ward/Dept	**Timeframe/Result**	**January**	**February**	**March**
NNU	Date Completed	**26th**	**25th**	**14th**
	Score (%)	**75%**	**68%**	**88%**
TC	Date Completed	**27th**	**25th**	**2nd**
	Score (%)	**94%**	**91%**	**97%**

Exception Report

Key areas of non-compliance that could not be resolved locally & actions taken

NNU- Cleaning records and documentation not completed or updated. The issue of dusty trolleys continues despite enhanced education, emails and posting previous results to all staff.

TC- Cleaning records and documentation have not been completed or up to date

Multidisciplinary Environment Inspections		
Ward/Dept	**Date Completed**	**Outcome of Inspection**
Neonatal Unit	**Feb 3 2011**	**Not deemed to be putting patients at immediate risk**

Exception Report

Outstanding actions & any non-compliance that has not been resolved

See Environment Inspection Team Action report: Appendix 1

All outstanding issues completed.

Mattress and Pillow Audit		
Ward/Dept	**Audit Undertaken (Y/N)**	**% Score**
NNU- Incubators	**March 2011**	**100%**
NNU- Baby therms	**March 2011**	**95%**
NNU- Cots	**March 2011**	**100%**
TC- adult beds/mattress	**Feb 28 2011**	**100%**
TC-baby cot mattress	**Feb 28 2011**	**100%**

Exception Report – key issues identified & actions taken

NNU – all mattresses labelled. Non compliance included damaged mattress which was disposed of and outside staining of others

Aseptic Technique Audit		
Ward/Dept	**Date**	**Score (%)**
NNU	**Feb 2011**	**100%**
NNU	**March 2011**	No data available although completed
TC	**Feb 2011**	**93%**
TC	**March 2011**	No data available although completed

Exception Report – key issues identified & actions taken

TC: Gloves and aprons were not observed to be worn by staff during drug administration

All staff has been reminded by email.

Further internal audits will be completed in April 2011 as no data available for reporting in Q4

ANTT will be launched in NNU Directorate in May 2011 and all staff will be assessed by IC lead and Clinical Educator.

4. High Impact Interventions

No. 1a CVC Insertion						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
NNU	20	24	Not reported	100% compliance		
No. 1b CVC On-going care						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
NNU	20	19	Not reported	Documentation	Education and updates	Emails and one to one
No. 2a PVC Insertion						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
NNU	20	36	Not reported	Documentation		
No. 2b PVC On-going care						
Ward	**Target No. obs per week/month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
NNU	20 per month	37	Not reported	Documentation		
TC	10	25	Not reported	Documentation		
No. 6b Urinary Catheter Care – On-going care						
Ward	**Target No. obs per week/month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
TC	**No data submitted**					
No. Ventilator Care (includes ET ventilation, CPAP, SIPAP) Insertion						
Ward	**Target No. obs per week/month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
NNU	20 per month	No data				
No. Ventilator Care (includes ET ventilation, CPAP, SIPAP) On-going care						
Ward	**Target No. obs per week/month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
NNU	10 per month	**84**	Well above target set	Documentation continues to be a problem. Support arm not utilised therefore risk of humidity draining towards baby	Education	Emails and one to one education

High Impact Interventions

From the data submitted the targets for 1a, 1b, 2a, 2b, 6b, and Ventilator Care Insertion have not been met this is due to clinical staff not completing observation forms when procedures occur. To try to improve this we plan to trial a self assessment for HIIs audit.
There aspect of documentation is anticipated to be rectified with the new documentation which will be launched April/May 2011

ENCLOSURE 7

Appendix 1

EIT Inspection Visit Action Report

Date of EIT inspection visit: 3rd February 2011 Date of Report: 3rd February 2011

Ward Area: Neonatal Unit

EIT Members: Michele Emery, Pam Cooper, Roger Bengough, Jenny Henry, Julie Suviste

Outcome: Not deemed to putting patients at immediate risk DMT follow up - Yes EIT Revisit – No

Issue	Immediate Action	Timescale	Person Responsible	Follow up actions	Person Responsible	Timescale
Lower level cleaning						
Floor edges and corners – build up debris evident and were generally unclean and stained in the Dirty Utility and the Equipment Stores	Clean and monitor as part of Department cleaning schedules	1 Week	Department Manager/ Estates	Reiterate to domestics of thorough cleaning and adherence to cleaning schedules. Concentrated cleaning of some floor areas required	ME/CK	Completed 21/2/11
Clean Utility						
Surfaces & tops of cupboards, refrigerator cluttered.	De-clutter & re-organise storage to facilitate cleaning	1 Week	Department Manager/	Area de cluttered but NIC to check on daily basis Tops de cluttered Requested HCAs remove and store appropriately	ME/CK ME/CK	Completed 21/02/11
Dirty Utility	Store above floor level	1 Week	Department Manager/ Housekeeping Manager			Completed 21/2/11
Sharps boxes and other items stored on the floor.	Clean and monitor as part of Department cleaning schedules	1 Week				
Floor stained and dirty.						
Clean Store						
Items stored on top of the storage shelves & the floor	Assess/reduce ordering of stock – store above floor level	1 Month	Department Manager	Liaise with Productive Ward lead	ME/CK	On going floor cleared 21/02/11
Tops of the storage units were dusty	Clean and monitor as part of Department cleaning schedules	1 Week	Department Manager	Liaise with HCAs	ME/CK	
Linen Room Storage boxes stored on the floor Two bath stands – rusty in places	Re-organise and order & install further shelves as required Condemn	1 Week Immediately	Department Manager & Estates	Bath stands removed Bath plugs now available	ME/CK	

Clinical Waste Store Mixed storage, baby clothes some in open carrier bags, domestic consumables . spare apron dispensers. No shelving in the room, meaning that everything was stored on the floor. **Medical Gas Store** Mixed storage – floor polishers, domestic consumables, medical gases	Dedicate storage room, remove inappropriate items. Order & install shelving to ensure items are stored above floor level Dedicate storage room, remove inappropriate items.	1 Week 1 Month 1 Week	Department Manager Department Manager & Estates Department Manager	Room cleared of all inappropriate items Estates contacted re shelving Gas cylinders only	 PC ME	21/02/11 Awaiting quotation Awaiting shelving in waste disposal hold
Clinical Patient Rooms (Primrose) Top of clinical trolley – unclean sticky residue evident. Clinical trolleys – drawer runners dusty Window blinds broken	Clean and monitor as part of Department daily cleaning schedules Repair/Replace	1 Week 1 Week	Department Manager Department Manager & Estates	Ward environment and equipment audits had already been completed and highlighted similar issue. To re audit and all staff informed of results Company contacted and have viewed		Awaiting report
Blood Gas Room Blood stains evident on the blood gas analyser	Clean and ensure that spillages are cleaned promptly	Immediate	Department Manager	Remind medical staff to dispose of blood samples carefully and clean up immediate spills Reiterate on induction with new medical Staff	ME/CK	11/02/11
Transport Incubator Store Base of incubator unclean/dusty Boxes of clinical equipment stored on the floor, near to the door way	Clean & monitor as part of equipment cleaning schedules Remove & store above floor level	Immediate Immediate	Department Manager	Transport team contacted	ME/CK	Completed 21/2/11
General Issues Several posters on the wall in the Parent's locker room	Purchase & install notice board to reduce on-going damage to the walls	1 Month	Department Manager & Estates	Notice board purchased	ME	08/02/11

Report circulated to: Department Manager & Infection Control Lead for the Department
All to be reminded that it is their responsibility to ensure the equipment used is clean and fit for purpose.

The Nurse in charge to ensure that the ward environment and equipment clean and fit for purpose
To re instigate the daily check sheets completed on a daily basis

Birmingham Women's

NHS Foundation Trust

Essence of Care Audit
March 2011
Neonatal Unit
Ward Environment

Health Promotion	
Is the following information available to parents and visitors?	Percentage
Neonatal Unit Brochure	100%
Health Promotion/education resources (breastfeeding, BLISS)	100%
Control of infection	100%
Smoking Cessation	100%
Alcohol (Aquarius)	0%
Drug abuse (Frank, Addiction)	0%
Mental Health (CAMHS, Connexions)	100%
Open access for parents promoted	100%
PALS	100%
RAG rating	77%
Recommendations: Discharge Liaison Nurse awaiting leaflets from Safeguarding team for Safeguarding board.	

Privacy and Dignity	
Are visitors greeted /acknowledged on arrival at ward?	100%
Upon answering the phone, do staff introduce themselves?	100%
Is care taken when using the telephone to prevent confidential information being shared?	100%
Are precautions taken to cover view of computer screens?	100%
Family have access to an area that safely provides privacy?	100%
Private area provided for mothers to breastfeed or express breast milk	100%
RAG rating	100%
Recommendations: None	

Environment	
Is the name of the nurse in charge clearly displayed	0%
Is there any form of ward orientation accessible and visible to patients i.e. ward profile/ward leaflet?	100%
RAG rating	50%
Recommendations: Display board or computer screen showing who is in charge of the shift so that parents know who they can talk to if there is a problem.	

Generic	
Are there weighing facilities?	100%
Is there oral hygiene equipment available i.e. cotton buds/sterile water at each cot	100%
Is there personal hygiene equipment available i.e. nappies/cotton wool	100%
Fetal Medicine alert forms available for staff prior to delivery of babies with identified problems.	100%
RAG rating	100%

Recommendations: None

Comments
There are overall improvements since the last audit. We are investigating a screen which the ward clerks will put the daily staff on electronically for parents and visitors to be able to identify staff.

Case note and documentation audit

Record Keeping	
Have initial assessment records been completed in black ink	100%
Consent signed in care plan	20%
Have the carers main language been identified	70%
Has baby been admitted onto badger database	90%
Do care plans and medical notes correlate	100%
Red Book available (single life long multi-agency record)	90%
RAG rating	78%
Recommendations: New consent form being introduced which states what parents are consenting for. Reinforce need to document main language to ensure interpreters are used appropriately.	

Patient Identification	
BW Number	100%
NHS Number	0%
Surname	100%
Forename	60%
DOB	100%
Sex	100%
RAG rating	76%
Recommendations: Use of NHS number on name bands providing continuity of identification if baby is transferred to another hospital. Also the Badger system uses the NHS number so searches would be more accurate. However we are unable to do this a present as there is no way of printing the NHS number onto the baby labels	

Tissue Viability	
Does the patient have a care plan in place?	100%
Is there evidence the plan of care has been implemented?	100%
Is there evidence of evaluation?	100%
RAG rating	100%
Recommendations: None	

Neonatal Pain	
Does the patient have a care plan for identification of pain in the neonate?	0%
Is there evidence the plan of care has been implemented?	0%
Is there evidence of evaluation?	0%
RAG rating	0%
Recommendations: SWMNN pain assessment tool to be implemented. Sucrose use to be launched on the 3rd April 2011	

Safety/Safeguarding	
Evidence of a family Communication record in notes	100%
Purple Family Supplement Record in Safeguarding folder	100%
Documentary evidence available on baby's future environment documented	10%
RAG rating	70%
Recommendations: Improve safeguarding procedures by assessing future environment. Discharge liaison Nurse to incorporate this into teaching sessions	

Communication	
Baby's own name recorded on notes	90%
The religious affiliation of the family is assessed & documented	10%
RAG rating	50%
Recommendations: Reinforce importance of good documentation on nursing admission sheet and when doctors are completing Badger admission information.	

Nutrition	
Evidence of recorded weight on admission	60%
Evidence of nutritional needs identified daily? I.e.: mls per kg/ calorific content of TPN	100%
Is there evidence of evaluation	100%
Growth charts plotted at least once weekly.	50%
RAG rating	77%
Recommendations: Nutrition War Round to ensure that growth charts are in the notes and plotted weekly. Most of the babies who were not weighted were ex-utero transfers, so weren't weighed on admission.	

Hygiene	
Does the patient have a plan of care	100%
Is there evidence the plan of care has been implemented?	100%
Documentary evidence that cares have been performed	100%
Evidence available of parents involvement in cares	70%
Parents previous experience of caring for a baby has been documented	90%
RAG rating	92%
Recommendations: Head of Nursing to raise awareness with nursing to encourage parents' involvement in their babies' care recognising that not all parents of very sick babies will want to do this.	

Comments
Signing of consent forms is worse than previous audits especially for those babies who are transferred to BWNFT ex-utero and babies admitted to special care. Consent forms have now been printed on pink paper and placed into the Parents' Communication section of the notes to encourage completion. Printed name labels do not include NHS number; this may have cost implications if the printers or labels need to be changed to include NHS numbers. Of those babies without forenames on their labels, one had its original printed label which said twin 1, the others were young babies who may not yet have been given a first name. The babies who had no evidence of a communication record were two who were

transferred ex-utero and one whose mother was a patient on intensive care.
Baby's future environment to be a requirement in the admission to discharge care pathway which is currently being formatted.

Procedural pain is being addressed with the launch of sucrose for pain relief on the 3rd April 2011.

Safeguarding documentation of babies' future environment is to be added to the care pathway.

There has been an overall improvement in all aspects of communication although nutrition scores have worsened since the quarter two audit. Although the two babies not weighed on admission were ex-utero babies requiring intensive care. Those without weights plotted at least once a week either had no growth chart in the notes or were too young to need it plotting. Hygiene has improved, though there was less documentation of parents' involvement in cares.

Uniform Audit								
Correct uniform	Hair	Jewellery	Shoes	ID Badge	Tights/Socks	Make-up	Nails	General Smart Appearance
100%	100%	100%	100%	100%	100%	100%	100%	100%
Recommendations:								
RAG rating								**100%**

ENCLOSURE 7

Action Plan Essence of Care Quarter 4

Recommendation	Action	By whom	When	Completed
Awaiting leaflets from Safeguarding team for Safeguarding board.	Discharge Liaison Nurse to investigate	Sally Lennon	April 2011	
Display board or computer screen showing who is in charge of the shift	Head of Nursing to liaise with Medical Physics Department	Michele Emery	April 2011	
Consent form introduced on pink paper which states list of procedures cover by the consent	Clinical Director	Dr Morgan	April 2011	April 2011
Document parents' main language to ensure interpreters are used appropriately.	Discharge Liaison Nurse to enforce in teaching sessions	Sally Lennon	On going	
Use of NHS number on name bands	Head of Nursing to discuss with Delivery Suite Manager	Michele Emery	April 2011	
SWMNN pain assessment tool to be implemented	Development Care Lead	Cheryl Curson	April 2011	
Sucrose to be used for procedural pain relief	Development Care Lead	Cheryl Curson	April 2011	
Assess babies' future environments.	Discharge liaison Nurse to incorporate this into teaching sessions	Sally Lennon	On going	
Reinforce importance of good documentation on nursing admission sheet and when doctors are completing Badger admission information	Head of Nursing and Clinical Director to send global email and reinforce on ward rounds	Michele Emery and Dr Morgan	April 2011 Ongoing	

Nutrition War Round to ensure that growth charts are in the notes and plotted weekly	Nutrition Lead and Dietician		April 2011 and on going	
Head of Nursing to raise awareness with nursing staff to encourage parents' involvement in their babies' care	To add to Team Meeting agenda and email all staff results of this audit	Michele Emery	April 2011 and on going	

ENCLOSURE 7

Action Plan Essence of Care Quarter 3

Recommendation	Action	By whom	When	Completed
Ensure all leaflets available.	Discharge liaison nurse to obtain outstanding leaflets from Safeguarding team.	Sally Lennon	January 2011	C/F to Q4
Display board showing who is in charge of the shift so that parents know who they can talk to if there is a problem.	Photos of all staff who act as shift leaders to be taken and display created.	Michele Emery Pete Williams	January 2011	C/F to Q4
Ensure consent form completed and filed in notes.	Email to be sent to Doctors and nurses and Doctors educational supervisors to stress importance of consent form being completed.	Julie Harcourt Neonatal Consultants	December 2010	December 2010
Reinforce need to document main language to ensure interpreters are used appropriately.	Raise issues of poor documentation on training days and staff induction. Email to Doctors and nurses.	Neonatal Consultants Diana Young Sandra Wright Julie Harcourt	Ongoing December 2010	C/F to Q4
Ensure red books are distributed to all babies on admission.	Ensure admission packs are available with red books in.	Healthcare Assistants	December 2010	December 2010
Use NHS number on name bands providing continuity of identification if baby is transferred to another hospital and Clevermed goes by NHS number so searches would be more accurate..	Investigate possibility of name labels being printed with NHS number on.	Michele Emery	January 2011	C/F to Q4
SWMNN pain assessment tool to be implemented. Sucrose use to be launched with new formulary.	New formulary launched in Jan 2011. Educational strategies around pain management to be implemented Jan 2011.	Cheryl Curson	January 2011	C/F to April 2011

Improve safeguarding procedures by assessing future environment.	Admission to discharge care pathway to include assessment of the home environment being formatted.	Sally Lennon	January 2011	In progress
Reinforce importance of good documentation on nursing admission sheet and when Doctors are completing Clevermed admission.	Raise issues of poor documentation on training days and staff induction. Email to Doctors and nurses.	Neonatal Consultants Diana Young Sandra Wright Julie Harcourt	Ongoing December 2010	December 2010
Ensure growth charts are in the notes and plotted weekly.	Email to Doctors and Nurse.	Julie Harcourt	December 2010	C/F to Q4
Promote involving parents in cares early, even if only containment holding and document .	Bliss pilot audit initiated including looking at parent experience and promotion of family centred care.	Julie Harcourt	December 2010	On going

Essence of Care Audit
Transitional Care Ward
March 2011
Ward Environment

Health Promotion	
Is the following information available to parents and visitors?	Percentage
Transitional Care Brochure	100%
Health Promotion/education resources (breastfeeding, BLISS)	100%
Control of infection	100%
Smoking Cessation	100%
Alcohol (Aquarius)	0%
Drug abuse (Frank, Addiction)	0%
Mental Health (CAMHS, Connexions)	0%
Postnatal exercises/Continence	100%
PALS	100%
RAG rating	70%
Recommendations: Awaiting leaflets from Safeguarding team for Safeguarding board. Leaflets /Posters for alcohol/drug misuse/mental health not on the ward need to source. New TC Brochure to be completed as currently under review.	

Privacy and Dignity	
Are visitors greeted /acknowledged on arrival at ward?	100%
Upon answering the phone, do staff introduce themselves?	100%
Is care taken when using the telephone to prevent confidential information being shared?	Unable to observe
Are precautions taken to cover view of computer screens?	100%
Family have access to an area that safely provides privacy?	100%
Is the privacy and dignity of patients maintained during direct care and in handover.	100%
RAG rating	95%
Recommendations: to consider obtaining "Do Not Disturb" signs for curtains whilst procedures are taking place	

Environment	
Is the name of the Midwife in charge clearly displayed	0%
Is there any form of ward orientation accessible and visible to patients i.e. ward profile/ward leaflet?	100%
RAG rating	50%
Recommendations: Midwife in charge is not displayed? Need to wear shift leader badge It is not at all clear for patients who they are speaking to as all uniforms are the same and we do not have name badges	

Generic	
Are there weighing facilities?	100%
Are inappropriate activities at meal times, such as cleaning and routine activities curtailed for example as in the protected meal time's	100%

initiative?	
Is there personal hygiene equipment available i.e. nappies/cotton wool/ sanitary towels	100%
Are procedures in place to ascertain presence, and to identify misuse of alcohol and drugs?	100%
RAG rating	100%
Recommendations: None	

Comments
Parents are made aware that they will need to provide cotton wool and nappies on arrival to TC. Mothers who abuse substances hazardous to health are made aware on arrival to the ward of expected standard of behaviour towards staff/ appropriate care for baby.

Case note and documentation audit

Record Keeping	
Have initial assessment records been completed in black ink	100%
Consent signed in care plan	70%
Have the carers main language been identified	90%
Has baby been admitted onto badger database	95%
Do care plans and medical notes correlate	95%
Red Book available (single life long multi-agency record)	95%
RAG rating	85%
Recommendations: Consent forms done on NNU verbal consent for procedures obtained and documented on TC in babies notes, this must be done every time e.g. when taking blood.	
Patient Identification	
BW Number	100%
NHS Number	95%
Surname	100%
Forename	60%
DOB	100%
Sex	100%
RAG rating	80%
Recommendations: Use NHS number on name bands providing continuity of identification if baby is transferred to another hospital. Fore names to be updated on discharge on patient notes.	

Tissue Viability	
Does the patient have a care plan in place?	100%
Is there evidence the plan of care has been implemented?	100%
Is there evidence of evaluation?	100%
RAG rating	100%
Recommendations: None	

Neonatal Pain	
Does the patient have a care plan for identification of pain in the	0%

neonate?	
Is there evidence the plan of care has been implemented?	0%
Is there evidence of evaluation?	0%
RAG rating	0%

Recommendations: SWMNN pain assessment tool to be implemented. Sucrose use to be launched in April. May also use mothers' expressed breast milk for procedural pain relief

Safety/Safeguarding	
Evidence of a family Communication record in notes	70%
Purple Family Supplement Record in Safeguarding folder	100%
Documentary evidence available on baby's future environment documented	0%
RAG rating	56%

Recommendations: Addresses checked prior to discharge but environment is difficult to assess. Not all TC babies have a communication record documentation in mums white postnatal notes or medical notes.

Communication	
Baby's own name recorded on notes	70%
Parents first language recorded in notes	70%
The religious affiliation of the family is assessed & documented	70%
RAG rating	70%

Recommendations: Update babies' forename on discharge/encourage all staff to do this. Encourage religious support from clerical staff/allow access to ward.

Nutrition	
Evidence of recorded weight on admission	95%
Evidence of nutritional needs identified daily? I.e.: mls per kg/ calorific content of TPN	100%
Is there evidence of evaluation	100%
Growth charts plotted at least once weekly.	50%
RAG rating	82%

Recommendations: Ensure growth charts are in the notes and plotted weekly.

Hygiene	
Does the patient have a plan of care	100%
Is there evidence the plan of care has been implemented?	100%
Documentary evidence that cares have been performed	100%
Evidence available of parents involvement in cares	95%
Parents previous experience of caring for a baby has been documented	85%
RAG rating	90%

Recommendations: Ensure all parent craft is documented CLEARLY in the mothers' white postnatal notes and on the discharge pathway.

Comments
Parents need to be told prior to admission if coming to TC that they need to provide cotton wool, nappies, and will be asked to bring in their own bottles if bottle feeding.

Bladder and Bowel Care	
The Guidelines for Bladder Care and the Prevention of Urinary Retention & Bladder Damage Post Delivery have been followed	100%
There is evidence of assessment in the postnatal record	100%
Patient's who have sustained a 3rd or 4th degree tear	100%
There is evidence of referral to the OASIS clinic	100%
RAG rating	100%
Recommendations: When patients have been catheterised policy is followed and documented in mums' white notes. Patients who needed follow up had referral as protocol.	

Care Environment	
The patient feels that staff are consistently approachable, courteous, trustworthy, friendly, responsive to their needs and supportive of their rights	100%
There is sufficient storage for the patient's belongings	100%
The patient has been informed of what they should expect to see and do in relation to infection control measures and is empowered to challenge staff where there are poor hygiene practices	90%
The patient knows who is looking after them	100%
Staff respond to the patient's requests for assistance in a timely and willing manner	100%
RAG rating	100%
Recommendations: Staff introduce themselves on taking over care however as we do not have name badges it is sometimes difficult for patients.	

Communication	
The woman has communication needs	90%
The appropriate measures have been taken to provide effective communication i.e. interpreting service, sign language	100%
Straightforward language is used when communicating with people and carers	95%
Explicit or expressed valid consent is sought from individual people for care to be provided	100%
Patients and carers know who to contact first if they have any questions regarding care	100%
RAG rating	95%
Recommendations: Mostly all communication needs met/ not always documented clearly in notes.	

Food and Drink	
The level of assistance required is assessed on every occasion that food and drink is served	100%
The patient requires a plan of care for food and drink	N/A
There evidence that the plan has been implemented	
RAG rating	100%
Recommendations: All patients assessed able to care for own hydration and nutrition.	

Prevention and Management of Pain

Prevention and Management of Pain	
Pain observed regularly along with other vital physiological measurements (that is, pain is one of the 'vital signs')	100%
Patients are offered the opportunity to manage their pain, and/or its impact on their lives, to an acceptable level	100%
RAG rating	100%
Recommendations: Part of MEWS chart assessment/analgesia offered with regular drug rounds	

Personal Hygiene	
The patient needs assistance with her personal hygiene needs	Not observed
Care and assistance with personal hygiene is provided according to the patient's needs?	Not observed
RAG rating	N/A
Recommendations: All patients were self-caring	

Prevention and Management of Pressure Ulcers	
The patient has risk factors for pressure ulcers	N/A
There is evidence that all relevant staff are involved in planning, implementation, evaluation and revision of advice and care, for example, dietician, nurse, doctor, occupational therapist, physiotherapist, tissue viability nurse etc	N/A
RAG rating	N/A
Recommendations: All patients assessed mobile not at risk of pressure ulcers.	

Promoting Health and Well-being	
The patient knows where to find leaflets/information on ward	100%
The patient knows where to find the health information and advice office for advocacy services	100%
RAG rating	100%
Recommendations: Leaflets out on the ward, accessible to all patients.	

Record Keeping	
The patient can access her records	100%
Care records are comprehensive, accurate, clear and free from unauthorised abbreviation	100%
The patient's confidentiality is respected according to Caldecott principles	100%
The hand held antenatal notes, birth notes and postnatal notes are all available in the medical notes	100%
RAG rating	100%
Recommendations: Mums all have access to own white postnatal notes, kept at end of bed.	

Respect and Dignity	
The patient is addressed as they wish and is spoken to using their preferred name. This information is documented	100%
Privacy is maintained effectively, for example, using curtains, screens	100%
Personal boundaries are identified and communicated to staff, for example, by using the patient's own language	100%

RAG rating	100%
Recommendations: Some patients keep curtains around bed 24/7, to look into utilizing signs for procedures that may be taking place e.g. postnatal checks/breast feeding	

Safety	
The patient was oriented to the care environment taking into account their feelings, concerns, abilities, skills and cognitive level?	100%
The patient has experienced continuity of care and staff (where possible)	80%
Family history, social context and significant events prior to, and since, admission and/or treatment, are ascertained, recorded and shared as appropriate, for example, with colleagues or police (as appropriate)	100%
RAG rating	95%
Recommendations: Continuity difficult due to long shifts/nights it is aimed for when allocating patients at morning handover.	

Self Care	
Mental health issues have been identified	Not observed
There is evidence of a Family Supplemental Record (FSR)	100%
There is evidence of a plan of care as identified by their risk	100%
There is evidence of Specialist Midwife involvement	100%
There evidence of ongoing assessment	100%
Options of care delivery are discussed and the patient's choices and preferences obtained, respected and met (where appropriate)	85%
Consistent information is provided by staff	100%
Patients and carers know how to access services and resources, for example, by using the Citizen's Advice Bureau, NHS Direct etc	80%
RAG rating	95%
Recommendations: No patient in assessed group had mental health issues. FSR present in all notes when needed.	

Comments
The main problems identified in this audit highlighted patients awareness/unawareness of who is who! They found it difficult to know who the Midwife was for the shift as it was not obvious by uniforms. Difficult to tell who is in charge even for staff at times? Leaflets for alcohol/drugs/ mental health not on ward, need to be sourced.

Uniform Audit								
Correct uniform	Hair	Jewellery	Shoes	ID Badge	Tights/Socks	Make-up	Nails	General Smart Appearance
100%	100 %	100%	100 %	100 %	100%	100 %	100 %	100%
Recommendations: None								
RAG rating								**100%**
Comments								

All staff issued with ID card. Not many staff with name badges as no funds in budget for this. To discuss with Head of Nursing

ENCLOSURE 7

Action Plan Essence of Care Quarter 4

Number	Recommendation	Action	By whom	When	Completed
1.	Safeguarding leaflets needed	Contact Safeguarding Team	Sally Lennon	May 2011	
2.	Source leaflets for alcohol/drug misuse/mental health	Contact relevant specialist nurses	S Woodhouse	May 2011	
3.	Discuss "Midwife in Charge" Badge	Discuss at ward meeting	S Bunch-Taylor	April 2011	
4.	Discuss "Do not Disturb" signs	Discuss at ward meeting	S Bunch-Taylor	April 2011	
5.	Documentation- Ensure all staff document consent for procedures	Audit	S Bunch-Taylor	Next quarter	
6.	Documentation – Ensure all staff document parent craft	Audit	S Bunch-Taylor/Sally Lennon	Next Quarter	
7.	Observe new guidelines for the use of Sucrose in pain relief for babies when undertaking procedures	Discuss at ward meeting	All Staff	April 2011	
8.	Check ALL patient name bands/security tags	Discuss at ward meeting	All Staff	April 2011	

DIRECTORATE REPORT TO
THE INFECTION PREVENTION & CONTROL COMMITTEE

Quarterly period	January –March 2011
Directorate	Maternity
Matron	Justine Jeffery

1. Infection Control Surveillance

1.1 Newly detected cases of colonisation or infection with MRSA

- 4 cases of colonisation/infection.
  3 mothers; 2 detected via admission screening, 1 detected following a positive admission swab from her baby (not initially screened pre C Section).
  1 baby - umbilical swab (mother not screened as she did not fit screening criteria).

- No cases of bacteraemia with MRSA.

1.2 Mandatory MRSA & VRE bacteraemia surveillance

- No cases.

1.3 Mandatory Clostridium difficile surveillance since

- No cases.

2. Audit Data

HAND HYGIENE AUDITS (Compliance Scores - Green ≥ 95% Amber 90 – 94% Red ≤ 89%)				
Ward/Dept	**January**	**February**	**March**	**Process used to feed back results to all ward staff**
Ward 1	**70%**	**60%**	**95%**	**Team meeting/display**
Ward 3	**100%**	**100%**	**100%**	**Team meeting/display**
Ward 4	**100%**	**100%**	**100%**	**Team meeting/display**
Delivery Suite	**100%**	**85%**	**95%**	**Targeted teaching/display**
Birth Centre	**92%**	**100%**	**100%**	**Email/display**
Exception Report – action undertaken for compliance scores < 95%				
Ward 1 Compliance improved during the quarter, non-compliance usually following contact with a patients' environment. On-going measures; Encourage staff to decontaminate hands after 5 points of contact, ensure alcohol gel is available in every bed point, hand washing facilities available in every bay/side room, ensuring soap and tissues well stocked. **Delivery Suite** Disappointing score in February. Medical staff identified and targeted teaching carried				

out during the end of February- rate now improved.

Other Infection Control Audit Activity – Ward Kitchens (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)			
Ward	**Month**	**Score**	**Process used to feed back results to all ward staff**
1	**March**	**90%**	**Team meeting**
3	**March**	**94%**	**Team meeting**
4	**March**	**90%**	**Team meeting**
DS	**March**	**83%**	**Team meeting**
Birth Centre	**March**	**86%**	**Team meeting**
Exception Report – key areas of non-compliance & actions taken			
There were a number of themes within this report for the Directorate. The kitchen areas all had issues with surfaces and drawers not being clean and free from dust. Toasters were also not visibly clean. A number of dusty vents and loose tiles were also noted. Missing requirements have been replaced within the kitchens identified and inappropriate equipment removed, Overall an improvement in compliance this quarter.			

5. Patient Environment & Medical Equipment Cleanliness

Quarterly Environment Audit		
Ward/Dept	**Audit Completed (Y/N)**	**Score**
Ward One	**28/3/2011**	**94%**
Ward Three	**2/2/11**	**95%**
Ward Four	**2/2/11**	**94%**
Delivery Suite	**1/3/11**	**90%**
Birth Centre	**22/2/11**	**98%**
Exception Report Key areas of non-compliance that could not be resolved locally & actions taken		
Ward 1 PPE's are inside every side room not outside, and there are no hand washing facilities in the domestic cupboard but are within the bay where the cupboard is. Unfortunately these cannot be changed. **PNF** Sluice walls damaged, Manager aware. Aprons not outside every side room, order placed. Some chairs need replacing-2 removed. Damaged catheter stand removed-new stands now arrived. Injection trays not cleaned, staff reminded to clean and regular spot checks undertaken. **Birth Centre** Storage of items above ground level in delivery rooms, shelving available is inadequate. Ward manager requested estates to install extra shelving in linen cupboards. Order has now been approved Q06/11 **Delivery Suite** Environment much improved following a period of maintenance. Some issues identified following the completion of the programme e.g. dispensers/hand washing posters not replaced. Estates department aware. Problems with flooring in the rear of the department continue-floor replacement planned for early April.		

Medical Equipment Cleanliness Audit				
		January	**February**	**March**
Ward 1	Audit Completed (Y/N)	**Yes**	**Yes**	**28/3/11**
	Score (%)	**97%**	**100%**	**100%**
Ward 3	Audit Completed (Y/N)	**8/1/11**	**2/2/11**	**8/3/11**
	Score (%)	**92%**	**92%**	**94%**
Ward 4	Audit Completed (Y/N)	**8/1/11**	**2/2/11**	**8/3/11**
	Score (%)	**92%**	**94%**	**93%**
Delivery Suite	Audit Completed(Y/N)	**3/1/11**	**7/2/11**	**21/3/11**
	Score (%)	**94%**	**88%**	**96%**
Birth Centre	Audit Completed(Y/N)	**13/1/11**	**22/2/11**	**14/3/11**
	Score (%)	**96%**	**100%**	**100%**

Exception Report
Key areas of non-compliance that could not be resolved locally & actions taken

Ward 1
Good Compliance throughout the quarter but some gaps in cleaning documentation.

PNF
Cleaning schedule not filled in, responsibility not defined; Ward Manager is in process of defining responsibility for MA's during PDR. Equipment cleaned, but green stickers not utilised, staff reminded to do this. Blood in BM machine box-cleaned and staff reminded to do this. Close observation.5 aseptic technique audits completed for each ward for February

Delivery Suite
New cleaning regime providing assurance. Spot checks continue to be performed by Manager, Link Midwife and Head of Midwifery. Directorate continues with plan to employ Band 1 equipment cleaners for delivery suite. JD banded and recruitment expected in Spring 2011.

Multidisciplinary Environment Inspections

Ward/Dept	Date Completed	Outcome of Inspection i.e not deemed to be putting patients at immediate risk
BC	3/3/11	Not deemed to be putting patients at risk
PNF	21/1/11	Not deemed to be putting patients at immediate risk
Fetal Medicine	21/1/11	Not deemed to be putting patients at risk

Exception Report
Outstanding actions & any non-compliance that has not been resolved

Birth Centre

Action plan completed. Storage currently being addresses by estates.

Post natal Floor

Action plan completed. Identification of staff group responsibilities ongoing vis PDRs.

Fetal Medicine

Action plan complete

Mattress and Pillow Audit		
Ward	**Audit Undertaken (Y/N)**	**Date**
Ward 1	**Yes**	**21/3/11**
Ward 3/4	**No-due in next quarter**	
Delivery Suite	**Yes**	**3/1/11, 17/2/11, 23/3/11**
Birth Centre	**Yes**	**19/1/11**
Exception Report – key issues identified & actions taken		

Ward 1
Several beds found with no numbers. Beds labelled and added to database

Delivery Suite
Audit undertaken monthly due to concerns raised in the environmental inspections. Initially in January 5 beds noted to be stained and housekeeper informed immediately. No repeat of this issue noted during spot checks, audits or environmental inspections. Audits will continue monthly to provide assurance.

Birth Centre
Zip broken to bottom section of mattress. Replacement provided.

7. MRSA Screening Compliance in Obstetrics 2011	Feb/March
Emergency	
Number of patients eligible for emergency screens*	162
Number of emergency screens undertaken (%)**	145(89.5%)
Total emergency screens positive	0
Elective	
Number of patients eligible for elective screens***	77
Number of elective screens undertaken (%)****	74(96%)
Total elective screens positive	2
* Number of emergency C Sections	
** screens requested by Wards 1, 3 & 4, Fetal Med, DS & Triage	
*** Number of elective C Sections	
**** screens requested by Mat OP	
Overall compliance	**93%**
Exception Report-Outstanding actions & any non-compliance that has not been resolved	**Area responsible for action**
Emergency CS women admitted to HDU are often a group that is missed-awareness posters/team meeting and discussion as part of the ongoing HDU training.	

6. High Impact Interventions

No. 2a PVC Insertion						
Ward	**Target No. obs per month**	**No. obs in month**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
Ward 1	5	2	Auditor on rotation to D/S so unable to observe more insertions.	PPE	Staff encouraged to use PPE	IC board/ team meetings
Ward 3	5	4	Not many venflons inserted	Drs not filling in pvcs,50% compliance	Midwives asked to observe drs and remind them	Infection Control Board
Ward 4	5	2	Not many venflons inserted	Drs not filling in pvcs,66% compliance	Midwives asked to observe drs and remin them	Infection Control Board
DS	20	49	Link Midwife carries out audit- need to involve others	Site prep, PPE and documentation	Feedback to staff groups.	Infection control board/Team meetings/Morning teaching
DS - HDU	10	30		100% compliance.		Infection control board/Team meetings/Morning teaching
DS- HDU CVCs		3		100% compliance		

No. 2b PVC On-going care						
Ward	**Target No. obs per week/month**	**No. obs In month**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
Ward 1	5/20	18	Auditor on rotation to D/S so unable to observe more.	Documentation	Staff encouraged to use and shown where kept.	IC board/ team meetings
Ward 3	5/20	20		100% compliance		Infection Control Board/verbal
Ward 4	5/20	20		100% compliance		Infection Control Board/verbal
DS - HDU	5/20	30		Hand hygiene Completion of documentation	Staff groups received feedback on areas of poor compliance	Infection Control Board/Team meeting

DS HDU CVCs		3		90% compliance-documentation improving with new booklet.	Staff groups received feedback on areas of poor compliance	Infection Control Board/Team meeting

No. 6a Urinary Catheter Care - Insertion						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
DS	20	60	n/a	90%-Documentation post procedure	Feedback to staff	Communication meeting
DS - HDU	5	0	Inserted prior to arrival			Display/Team meeting

No. 6b Urinary Catheter Care – On-going care						
Ward	**Target No. obs per week/month**	**No. obs in month**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
Ward 3	5/20	20		None100% compliance		
Ward 4	5/20	20		None/100% compliance		
DS	5/20	0				
DS - HDU	5/20	20	n/a	85% compliance-documentation	Feedback to staff	Communication meeting/email

ENCLOSURE 7

Birmingham Women's NHS

NHS Foundation Trust

Essence of Care Audit
Monday, 14 March 2011
Ward Environment

(Compliance Scores – Green ≥ 80% Amber 60 – 79% Red ≤ 60%)

Nutrition	**Ward 1**	**PNF**
Patient has recorded weight and BMI in HHN	100%	70%
If risk identified, e.g. BMI<18 >35 has an individual care plan been developed?	No cases	No cases
If risk identified, has individual care plan been followed?	N/A	N/A
RAG rating	**100%**	**70%**

1 set of handheld notes were not available for audit
1 set of notes had no details of BMI recorded

Action
Midwifery assistants reminded to record all BMI's at the booking visit in the hospital and the community.

Bladder and Bowel Care

	Ward 1	**PNF**
Has the 1st void been recorded (postnatal only)	NA	50%
If urinary problems identified was a fluid balance commenced?	None observed	50%
Was 3rd or 4th Degree tear sustained? If yes, has a referral been made to the OASIS Clinic (post natal only)	NA	No cases audited
RAG rating	**-**	**50%**

PNF
2 women had indwelling catheters
2 women who were identified with having urinary problems had a fluid balance chart
Whilst the first void scored 50% this is a marked improvement of the last score. New postnatal notes are now in use.

Action
Delivery staff reminded to record the 1st void

Pressure Ulcers

	Ward 1	**PNF**
Did the woman have an epidural, spinal or general anaesthetic? If yes,	No cases to audit	70%
Evidence of assessment in Recovery?		100%
Evidence of evaluation?		100%
Please complete the personal & oral section below		
RAG rating	**-**	**100%**

No actions required

Personal & Oral Hygiene (this section links with pressure ulcers section)		
	Ward 1	**PNF**
Personal hygiene needs assessed on admission	NA	0%
Patients with personal hygiene needs have individualised care plan	NA	0%
Documented evidence of oral hygiene assessment	NA	0%
RAG rating	**-**	**0%**

Most women are self caring however the postnatal notes do not include a section for personal & oral hygiene.

Action
To consider an addition to the postnatal notes when next reviewed

Communication *(information can be found in the Pregnancy Hand Held Notes)*		
	Ward 1	**PNF**
Documented assessment of communication needs	100%	78%
If communication needs identified, evidence of documented plan of care.	100%	100%
If yes, care plan directs use of interpreters	100%	100%
If yes, care plan directs use of visual aids	No cases	No cases
If yes, care plan directs use of speech & language therapists	No cases	No cases
RAG rating	**100%**	**93%**

One set of hand held notes not available
Women identified requiring the use of interpreting service was clearly recorded in the pregnancy handheld notes.

Action
All midwives to be reminded to complete appropriate sections of handheld notes

Lifestyle / Self Care		
	Ward 1	**PNF**
Evidence of lifestyle assessment on admission (includes smoking, alcohol intake) (HHN's)	90%	78%
Evidence of ongoing lifestyle assessment (HHN's) e.g. Drug use, Alcohol, DV, Mental Health, FGM	100%	No cases reviewed
If a Family Supplementary Section is in notes is the information up to date?	100%	N/A
Evidence of consultation with patient/carer regarding self-care	100%	No evidence in notes
If health risk regarding lifestyle identified, evidence of documented plan of care.	100%	N/A
RAG rating	**98%**	**78%**

Recommendations:
One patient was identified as having hygiene problems this was reported to Safeguarding team.
9/10 had a social assessment at booking in the HHN but required a follow up assessment.

Record Keeping		
	Ward 1	**PNF**
Documented evidence of involvement of patients in their	90%	10%

plan of care		
Documented evidence of discussion with carers regarding their plan of care	NA	N/A
Observation chart present	100%	100%
Observation chart contains name and hosp. number	100%	90%
Each entry is timed	90%	100%
Each entry is dated	90%	100%
Fluid balance chart present	None observed	50%
Fluid balance chart contains name and hosp. number	As above	50%
Each entry is legible	As above	100%
Each entry is timed	As above	100%
RAG rating	**94%**	**78%**

Midwife for Audit and Guideline is working closely with the staff on PNF to improve record keeping.

Safety

	Ward 1	**PNF**
Initial social assessment documented (HHN's)	90%	89%
Falls assessment been completed (PN notes)	NA	50%
If patient identified with mental health needs risk, documentary evidence that psychiatric Team informed (page 3 HHN's)	100%	No cases audited
If risk identified, and referral to the appropriate specialist teams i.e. safeguarding team	100%	As above
Evidence of a care plan	100%	As above
RAG rating	**98.5%**	**70%**

Action
Community midwives and antenatal clinic midwives to be reminded to complete the social risk assessment in the pregnancy hand held notes

Staff on the postnatal floor to be reminded to completed the falls risk assessment for all women on admission to the postnatal floor.

Health Promotion

Is the following information available to patients and visitors?	**Ward 1**	**PNF**
Pelvic floor exercises	NA	100%
Mental health(CAMHS, Connexions, Samaritans)	100%	100%
Smoking Cessation	100%	100%
Alcohol (Aquarius)	100%	100%
Health promotion / education resources	100%	100%
Bladder and Bowel care	No cases	100%
Drug addiction information (poster/Leaflet)	0%	100%
Patient information accessible and visible	100%	100%
PALS	100%	100%
RAG rating	**85.7%**	**100%**

Action

Ward 1 to request posters/leaflets from safeguarding team to display in ward area

Environment

	Ward 1	PNF
Ward profile available and visible to patients	100%	0%
Appropriate weighing facilities (scales)	100%	Available on Ward 1
Appropriate Patient handling Equipment	100%	100%
Ward has supply of soap	100%	0%
Ward has supply of toothpaste	0%	0%
Ward has supply of toothbrushes	0%	0%
Ward has supply of combs	0%	0%
Ward has slide sheets	100%	100%
Authorised abbreviation list on ward or in notes	100%	100%
RAG rating	**67%**	**33%**

Most patients supply their own personal hygiene equipment. Emergency supplies are available in the trust but not required frequently enough to warrant a ward supply.

Action
Consider having a hygiene pack available on the wards
PNF are developing a ward profile leaflet

Uniform Audit

	Ward 1	PNF
Correct uniform (no scrubs)	90%	
Trust/NHS lanyard	100%	
Hair off collar	100%	
Jewellery	90%	
Shoes	100%	
ID badge	100%	
Tights/socks	100%	
Make up	100%	
Nails	100%	
General appearance	100%	
RAG rating	**98%**	**75%**

One midwife pregnant therefore wearing scrubs as no maternity uniform available

Action
One midwife wearing inappropriate jewellery and told to remove it
Staff on postnatal floor reminded of Trust Work Wear Policy

Privacy, Dignity and Respect

	Ward 1	PNF
Are visitors greeted /acknowledged on arrival at ward?	100%	100%

Upon answering the phone, do staff introduce themselves?	50%	0%
Care taken when using telephone to prevent confidential information being shared	100%	100%
Precautions taken to cover computer screen	100%	100%
Room available for private consultation with patients/relatives	100%	100%
RAG rating	**90%**	**80%**

Action
Staff to be reminded to always identify themselves when answering the phone

ENCLOSURE 7

DIRECTORATE REPORT TO THE INFECTION PREVENTION & CONTROL COMMITTEE

Quarterly period	Jan – March 2011
Directorate	Gynaecology
Matron	Jacky Cotton

3. Infection Control Surveillance

1.4 Newly detected cases of colonisation or infection with MRSA

3 in total Jan = 1 Feb = 0 March = 2 cases – all pre admission screens

1.5 Mandatory MRSA & VRE bacteraemia surveillance

None

1.6 Mandatory Clostridium difficile surveillance

None

1.7 Mandatory E coli and MSSA bacteraemia surveillance

None

4. Audit Data

HAND HYGIENE AUDITS (Compliance Scores - Green ≥ 95% Amber 90 – 94% Red ≤ 89%)				
Ward/Dept	**January**	**February**	**March**	**Process used to feed back results to all ward staff**
Ward 7	70%	90%	85%	Graphs on display Discussed at ward meetings
Ward 8	95%	95%	90%	Graphs on display Discussed at ward meetings
Exception Report – action undertaken for compliance scores < 95%				

Other Infection Control Audit Activity – Ward Kitchens (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)			
Ward/Dept	**Date**	**Score**	**Process used to feed back results to all ward staff**
7	16.3.11	95%	Discussed at ward meetings
8	16.3.11	93%	Discussed at ward meetings
Exception Report – key areas of non-compliance & actions taken			

Ward 7

- Dishwasher leaking water – reported to Estates
- Stains to flooring around dishwasher. Issue raised last quarter. Current detergent corroding floor so housekeeping exploring use of different type of detergent.

Ward 8

- Damage to the wall behind the bin. Reported and awaiting tiling of area as wall has been cleaned so often, paint has come off.
- The daily temperature chart is only completed on a morning. Housekeepers working on ward in afternoon also to complete.
- Stains to flooring around dishwasher. Issue raised last quarter. Current detergent corroding floor so housekeeping exploring use of different type of detergent.

7. Patient Environment & Medical Equipment Cleanliness

Quarterly Departmental Environment Audit		
Ward/Dept	**Date Completed**	**Score (%)**
Ward 7	24.3.11	97.4%
Ward 8	25.3.11	94.4%
Colposcopy	4.1.11	100%
Hysteroscopy	4.1.11	100%
EPAU	28.3.11	100%
GOPD	24.3.11	99.26%
Fertility Centre	25.3.11	88.5%
Urogynaecology/preop assessment	31.3.11	94%

Exception Report
Key areas of non-compliance that could not be resolved locally & actions taken

GOPD: 2 walls requiring paint touch up. Estates informed
Fertility Centre – see below

Medical Equipment Cleanliness Audit				
Ward/Dept	**Timeframe/Result**	**January**	**February**	**March**
Ward 7	Date Completed	31.1.11	25.2.11	24.3.11
	Score (%)	97.4%	100%	97%
Ward 8	Date Completed	26.1.11	26.2.11	18.3.11
	Score (%)	100%	100%	88%
Colposcopy	Date Completed	31.1.11	21.2.11	9.3.11
	Score (%)	96%	92%	100%
Hysteroscopy	Date Completed	18.01.11	**.02.11	15.3.11
	Score (%)	100%	100%	100%
Fertility Centre	Date Completed	28.01.11	15.2.11	25.3.11
	Score (%)	100%	96%	85%
Urogynaecology/preop assessment	Date Completed	20.1.11	23.2.11	31.3.11
	Score (%)	98%	98%	98%
GOPD	Date Completed	10.1.11	21.2.11	24.3.11
	Score (%)	100%	100%	100%
EPAU	Date Completed	31.1.11	22.2.11	24.3.11
	Score (%)	100%	100%	100%

Exception Report
Key areas of non-compliance that could not be resolved locally & actions taken

Dusty keyboards still notes in some areas. Remedial action taken.
Shower chair taken out of service in Ward 8.
Urogynaecology: couch to be recovered and still waiting for noticeboard to be put up
Fertility Centre: Blinds in nonclinical rooms need replacement. Fans on bimonthly cleaning contract with Estates. Requires to be done more frequently. Stained ceiling tiles in reception area have been replaced but department feel that whole ceiling area requires replacement to improve aesthetic appearance of reception. Funding not currently available.

Multidisciplinary Environment Inspections		
Ward/Dept	**Date Completed**	**Outcome of Inspection** i.e not deemed to be putting patients at immediate risk
Ward 7	17.2.11	not deemed to be putting patients at immediate risk
Ward 8	15.2.11	not deemed to be putting patients at immediate risk
Colposcopy / Hysteroscopy	18.2.11	not deemed to be putting patients at immediate risk
EPAU	17.2.11	not deemed to be putting patients at immediate risk
GOPD	10.2.11	not deemed to be putting patients at immediate risk
Fertility Centre	24.2.11	not deemed to be putting patients at immediate risk
Urogynaecology/preop assessment	17.2.11	not deemed to be putting patients at immediate risk.
Exception Report **Outstanding actions & any non-compliance that has not been resolved**		
Action plans produced for all areas. All issues raised already identified through other audits and actions in place.		

4. Aseptic Technique Audit 2011

This was a 'snapshot' audit of practice in identified clinical areas
The types of procedures observed included:

- Insertion of PVC
- Insertion of an Urinary Catheter
- Administration of intravenous
- Procedure undertaken i.e.: Drain removal / Biopsy

Ward/dept	Compliance
Ward 8	**100%**
Colposcopy	**94%**
Average Compliance score	**97%**

Recommendations for Practice
Generally compliance with aseptic practice was observed to be very good.
The following issues require further attention/action to raise standards during the performance of aseptic practices at Ward/Department level.

- Ensuring windows are closed prior to the performance of all aseptic procedures and other tasks such as bed making cleaning are not undertaken 30 minutes before procedure.
- Ensuring the correct personal protective clothing is selected and removed at appropriate times during aseptic techniques.
- Hand are decontaminated following any contact with the patient environment with alcohol hand gel if hands are visibly clean

5. Mattress and Pillow Audit

Not due this quarter

Mattress Audit		
Ward/Dept	**Audit Undertaken (Y/N)**	**Date Completed**
7	No	Due Q1 & Q3
8	No	Due Q1 & Q3
2 (ECG bed)	No	Due Q1 & Q3
Pillow Audit		
7	No	Due Q1 & Q3
8	No	Due Q1 & Q3
2 (ECG bed)	No	Due Q1 & Q3
Exception Report – key issues identified & actions taken		

Quarterly meetings being held with Head of Nursing, Ward & Departmental Managers and infection control link nurses to discuss elements of role and audit requirements.

8. High Impact Interventions

No. 2a PVC Insertion						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
8	5	27	N/A	All elements 100% except for March – PPE 90% Documentation 90%	Staff reminded of required standards of practice.	Ward meetings.
EPAU	10	Jan = 10	No data submitted for Feb/Mar. To be discussed with dept manager by Head of Nursing	Score for wearing of PPE had been improving in previous quarter but was non-compliant in Jan. All other areas 100%	Staff reminded of policies & need for PPE	Ward meetings
Fertility Centre	10	Mar = 10	To be discussed with dept manager by Head of Nursing	Score for wearing of PPE was non-compliant and for Documentation only 20%.	Required changes in practise discussed with Link Nurse & dept managers. PVC inserted for short period only so no form required but insertion and removal to be documented in patient care plan.	Department Meeting
No. 2b PVC On-going care						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
8	20	Jan = 10 Feb = 10 Mar = 20	Ward manager reminding staff constantly.	100% compliant in all areas for all 3 months except for 95% for clinical indication in March.	None required	Ward meetings
No. 6a Urinary Catheter Care - Insertion						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
8	5	30	N/A	None. 100% compliant in all areas for all 3 months of Q4	None required	Ward meetings

No. 6b Urinary Catheter Care – On-going care						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
8	20	Jan = 7 Feb = 10 Mar = 10	Ward manager reminding staff constantly.	None 100% compliant in all areas for all 3 months of Quarter 4	None required	Ward meetings

ENCLOSURE 7

Essence of Care Audit
MARCH 2011

Overall RAG ratings for each section: **Red = <60%**
Amber= 60-85%
Green = >85%

Although patients were selected at random, all the patients in the sample on Ward 7 were day cases and so do not require such in-depth assessment on admission. Consequently some of the criteria do not apply. Since the last audit undertaken in September 2010, the audit tool used has been re-evaluated and some amendments made to fully reflect the changes in type of patients being cared for on Wards 7 & 8.

On Ward 8 some of the patients were admitted as emergencies as well as electives.

This audit was carried out in Feb/Mar 2011.10 sets of notes from each ward were reviewed.

Nutrition		
Nutrition	**Ward 7**	**Ward 8**
Nutritional assessment tool completed on admission	100%	100%
If risk identified, has an individual care plan been developed?	100%	100%
If risk identified, Is there evidence the plan has been implemented?	100%	100%
RAG rating	100%	100%
Recommendations: none		

Continence		
	Ward 7	**Ward 8**
Documented evidence of assessment of continence needs on admission	100%	100%
If need identified, evidence of documented plan of care.	100%	100%
If need identified, evidence of implementation of plan of care	100%	100%
If need identified, evidence of evaluation of plan of care	100%	100%
RAG rating	100%	100%
Recommendations: none		

Pressure Ulcers		
	Ward 7	**Ward 8**
Waterlow score documented	N/A	100%
Evidence of Waterlow score reassessment – all patients low risk	N/A	100%
Evidence of evaluation	N/A	N/A
RAG rating	100%	100%
Recommendations: Waterlow not carried out on day case patients. If any risks are identified in pre-op it would be carried out.		

Personal & Oral Hygiene		
	Ward 7	**Ward 8**

Personal/oral hygiene needs assessed on admission	100%	100%
Patients with personal/oral hygiene needs have individualised care plan	n/a	n/a
RAG rating	100%	100%
Recommendations: none		

Communication		
	Ward 7	**Ward 8**
Documented assessment of communication needs	90%	100%
If communication needs identified, evidence of documented plan of care.	N/A	100%
If communication needs identified, evidence of ongoing evaluation	N/A	100%
RAG rating	90%	100%
Recommendations: one patient on ward 7 was admitted to the HDC. No documentation on the current proforma for the HDC with regards to communication needs		

Life Style/Self Care		
	Ward 7	**Ward 8**
Evidence of lifestyle assessment on admission (includes smoking, alcohol intake)	90%	100%
Evidence of ongoing lifestyle assessment	N/A	100%
Evidence of consultation with patient/carer regarding self-care	90%	100%
If health risk regarding lifestyle identified, evidence of documented plan of care.	90%	100%
RAG rating	90%	100%
Recommendations: as above		

Record Keeping		
	Ward 7	**Ward 8**
Documented evidence of involvement of patients in their plan of care	100%	100%
Each entry is timed	100%	100%
Each entry is dated	100%	100%
Each entry dated	100%	100%
Has a name stamp been used or name printed	100%	100%
Is the patients identification on all documents including DOB and registration number	100%	100%
Do all inpatients have a wrist band on with hospital number NHS number surname forename DOB	0%	0%
RAG rating	85.7%	85.7%
Recommendations: No check was made of wrist bands as all notes audited were on patients who had already been discharged. Recommend auditor to do a spot check of inpatients.		

Safety		
	Ward 7	**Ward 8**
Initial social assessment documented on admission	90%*	100%
Psychological ADL documented on admission	90%*	100%
Falls assessment been completed	100%	70%
If patient identified with mental health needs risk, documentary evidence that psychiatric services informed	N/A	N/A
If risk identified, evidence of documented plan of care	N/A	N/A
Care plan evaluated	N/A	N/A
RAG rating	93%	90%

Recommendations: Ensure staff complete manual handling/falls assessment on all patients.
* As above re HDC

Health Promotion		
Is the following information available to patients and visitors?	**Ward 7**	**Ward 8**
Ward Speciality e.g. Gynae related subjects	√	√
PALS	√	√
Health promotion / education resources(e.g. 5 a day)	√	√
Infection control/hand hygiene information	√	√
Smoking Cessation	X	X
Alcohol	X	X
Drug Abuse	x	x
Mental health	√	√
Continence	√	√
RAG rating	66%	66%

Recommendations: Ward managers to ensure range of all leaflets available. Awaiting delivery of new leaflet holders.

Environment		
	Ward 7	Ward 8
At Least quarterly environmental and infection control audits on display on the ward	√	√
Ward profile available and visible to patients	√	√
Staff names are clearly displayed	√	√
Appropriate weighing facilities (scales)	√	√
Height stick available	√	N/A
There is a separate area available for patients to eat meals undisturbed by activities on the ward.	√	√
Appropriate Patient handling Equipment	√	√

Oral hygiene equipment is available	√	√
Personal hygiene equipment is available	√	√
RAG rating	100%	100%

Recommendations: Height stick on ward 7 also used for ward 8.

Privacy and Dignity		
	Ward 7	Ward 8
Are patients/visitors greeted /acknowledged on arrival at ward?	√	√
Upon answering the phone, do staff introduce themselves including staff title?	√	√
Care taken when using telephone to prevent confidential information being shared	√	√
Precautions taken to cover computer screen	√	√
Patients/carers can access an area that safely provides privacy.	√	√
Privacy and dignity of patients is maintained during direct care	√	√
Privacy and dignity is maintained during staff handover.	√	√
RAG rating	100%	100%

Recommendations: none

Comments

Revision of the audit tool and education of staff in completing not applicable responses appropriately has resulted in an improved performance being recorded for Quarter 4. Ward managers feel that this is a truer reflection of the standards on the wards than the results using the previous audit tool in Quarter 2.
For future audits, spot checks to be made of patient identification.

ENCLOSURE 7

DIRECTORATE REPORT TO THE INFECTION PREVENTION & CONTROL COMMITTEE

Quarterly period	Q4
Directorate	Clinical Support
Matron	Tariq Rehman

5. Infection Control Surveillance
NA

6. Audit Data

HAND HYGIENE AUDITS (Compliance Scores - Green ≥ 95% Amber 90 – 94% Red ≤ 89%)				
Ward/Dept	Jan	Feb	March	Process used to feed back results to all ward staff
Theatre and Recovery	100%	95%	100%	Item agenda at staff meetings for feed back, information on infection control notice board
Radiology	90%	100%	100%	Feed back through staff meetings, infection control notice board
Physiotherapy	na		n/a	
Exception Report – action undertaken for compliance scores < 95%				
No Audits were completed for quarter 2, IPC link team in theatres have been identified to ensure all aspects of audits are completed on time for future reports.				

Other Infection Control Audit Activity – Standard Precautions (Compliance Scores - Green ≥ 85%, Amber 76 – 84% Red ≤ 75%)			
Ward/Dept	Date	Score	Process used to feed back results to all ward staff
Radiology			Team Briefs
Physio			Team Briefs
Theatre			Team Briefs
Exception Report – key areas of non-compliance & actions taken			

9. Patient Environment & Medical Equipment Cleanliness

Quarterly Departmental Environment Audit		
Ward/Dept	Date Completed	Score (%)
Theatre	30/03/11	100%
Radiology	25/03/11	97%
Physiotherapy	30/03/11	100%
Exception Report Key areas of non-compliance that could not be resolved locally & actions taken		

Theatres/Recovery
• Cleaning rotas were developed following the environment inspection last Quarter , monitoring however needs to be increased . • Storage rooms re-organised, alternative storage shelving was sought and is now in place for storage of sterile fluids. • New operating mattresses now in place

Medical Equipment Cleanliness Audit				
Ward/Dept	**Timeframe/Result**	**Jan**	**Feb**	**March**
Theatre	Date Completed	**31/01/11**	**28/02/11**	**30/03/11**
	Score (%)	**91.6%**	**100%**	**87%**
Radiology	Date Completed	**25/1/11**	**25/02/11**	**25/03/11**
	Score (%)	**100%**	**100%**	**100%**
Physiotherapy	Date Completed	**20/01/11**		**30/03/11**
	Score (%)	**100%**	**100%**	**100%**
	Date Completed			
	Score (%)			
	Audit Completed			
	Score (%)			
Exception Report **Key areas of non-compliance that could not be resolved locally & actions taken**				
Non compliance due to cleaning rotas are not always signed by all staff, this was discussed at theatre team meeting further improvement sought, in February improvement achieved in theatre following the implementation of cleaning schedules which are being signed off. March only 87% was achieved this was due to cupboards not cleaned on the inside.				

Multidisciplinary Environment Inspections		
Ward/Dept	**Date Completed**	**Outcome of Inspection** i.e not deemed to be putting patients at immediate risk
Radiology	**20/01/11**	**Not deemed to putting patients at immediate**
Theatre	**03/02/11**	**Not deemed to be putting patients at risk**
Exception Report **Outstanding actions & any non-compliance that has not been resolved**		
Action plan report from Radiology presented at the infection control meeting 03/03/11, improvement will be sought in the areas identified Action plan report for theatre presented at the infection control meeting 03/03/11		

Mattress and Pillow Audit		
Ward/Dept	**Audit Undertaken (Y/N)**	**Date Completed**
Exception Report – key issues identified & actions taken		
No Audits have taken place.		

10. High Impact Interventions

No. 2a PVC Insertion						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
Theatre	20 Jan 19 Feb 20 March	59	One incomplete	PPE & Hand Hygiene	Further discussions with medical staff to improve areas of non compliance	Staff Meetings and notice board 88% for Jan Feb score 99% improvement In PPE and hand hygeine 88% score for March, this is due to one anaesthetist not adhering to hand hygiene and PPE

No. 6a Urinary Catheter Care - Insertion						
Ward	**Target No. obs per month**	**No. obs in Quarter**	**Reason Target not met**	**Areas of Non-Compliance identified**	**Action Taken in response to non-compliance**	**Process used to feedback results to clinical staff**
Theatre	20 Jan 20 Feb 20 March	60				100% compliance fpr the quarter

None of the above audits took place in quarter 2

SUBJECT :	NHSLA Risk Management Standards Project
REPORT BY :	Jane Owen
AUTHOR :	Michelle Walsh

CONTEXT AND BACKGROUND FOR REPORT

This report aims to demonstrate progress made towards compliance with the NHSLA Risk Management Standards for Acute Trusts and the CNST Clinical Risk Management Standards for Maternity Services.

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

To note feedback from the NHSLA assessors at recent informal visits to assess progress with Level 2 Acute and Maternity Standards.

Collection and review of evidence is ongoing for a level 2 assessment.

There remains concern about progress made towards a Maternity assessment at Level 3 in quarter one of 2012-13.

RECOMMENDATIONS

To note the content of this report.

NHSLA Risk Management Standards Project – May 2011

1. Acute Risk Management Standards

1.1 Level 1

The action plan following the level 1 assessment will be updated to include a small number of amendments to policies required following the informal visit on Wednesday 11th May 2011.

The majority of minor amendments are required to ensure policy and practice remains aligned. It is expected that some discrepancies are only identified as more staff become engaged with the development and implementation of the processes.

1.2 Level 2

An informal visit with the assessors took place on Wednesday 11th May 2011 to assess progress with Level 2. The main focus of the day was on Standards 2, 3 and 4. General feedback from the assessor suggested that progress has been made, but a lot of work is still required if the Trust is to be assessed in September 2011.

In relation to Standards 2 and 3, the assessor felt the format of evidence presented worked well, and she gave feedback to suggest how to present complete individual case studies of compliance that demonstrates the process from start to finish. Work will continue to ensure evidence templates are fully completed in preparation for an assessment.

In relation to standard 4, the assessor identified some issues with record keeping and completeness of records, for example:

- Missing or inadequate signature, date and/or time of entry
- Missing observations, such as respiration rate
- Incomplete documentation of discussions and provision of information for patients, e.g. the name of an information leaflet provided during the consent process not documented
- Checklist left blank, instead of documenting N/A
- Inadequately designed or out of date forms in use.

It should be noted that the majority of casenotes that were deemed non-compliant were usually due to one of the above errors, rather than consistently poor record keeping standards.

Further work is therefore required to find fully compliant casenotes for the assessment. These issues also highlight further work required to raise staff awareness of the content of key policies.

Notes from the visit, including actions, have been circulated to staff and will be reviewed at the next Standard Leads meeting on 8th June 2011.

A second informal visit with the assessor has been provisionally booked for Monday 25th July 2011 to cover standards 1 and 5 and revisit standard 2.

1.3 Level 3

Directorate Audit Plans for 2011-12 are due to be presented to the Clinical Governance Committee for final approval at the June 2011 meeting. The programmes will be checked by the Clinical Governance Directorate with input from the NHSLA Standard Leads to ensure all the audit requirements for Level 3 are included.

In addition to Directorate audits, a number of audits will be required from corporate services, for example from Human Resources and Clinical Governance teams. A corporate audit plan will be developed by June 2011 to facilitate this.

1.4 Financial Implications

The cost per quarter for delaying a Level 2 Assessment is £6,322.50. The last opportunity to be assessed against the 2011-12 standards is February 2012.

2. Maternity Clinical Risk Management Standards

2.1 Level 1

The action plan following the level 1 assessment will be updated to include a small number of amendments to policies required following the informal visit on Thursday 12th May 2011.

The majority of minor amendments are required to ensure policy and practice remains aligned. It is expected that some discrepancies are only identified as more staff become engaged with the development and implementation of the processes.

2.2 Level 2

An informal visit with the assessors took place on Thursday 12th May 2011 to assess progress with Level 2. The main focus of the day was on Standards 2, 3 and 4. General feedback from the assessor suggested that progress has been made, but further improvements in documentation are still required.

Compliant casenotes were identified during the visit and the Maternity Directorate will now consolidate evidence for Quarter 1 (Dec 10 – Feb 11) and continue to review casenotes for Quarter 2 (Mar 11 – May 11).

Of the casenotes deemed non-compliant, some of the causes included:

- name of the lead professional not recorded on the front of the green handheld records
- missing observations
- lack of documentation of discussion with women
- recording results on electronic records as well as on paper
- documenting all minimum requirements of a management plan.

Notes from the visit, including actions, have been circulated to staff and will be reviewed at the next Standard Leads meeting on 8th June 2011.

A second informal visit with the assessor has provisionally been booked for Wednesday 27th July 2011 to cover standards 1 and 5 and the remaining criteria in standard 3.

Going forward, it is felt important to maintain a balance between the time spent identifying compliant casenotes for the assessment and the time spent teaching and educating staff to improve practice. The Maternity Directorate have implemented a number of strategies to provide feedback to staff and increase opportunities for teaching, some of which include:

- feedback at PROMPT training, attended by all midwifery staff
- newsletter and posters of key practice points
- guideline of the week notice board
- allocating topics to Band 7 midwives to champion and engaging Supervisors of Midwives
- teaching by example while on clinical shifts
- monthly progress meetings.

2.3 Level 3

There remains concern about progress made towards a level 3 assessment in quarter one of 2012-13. The majority of annual audits are below 75% by a margin that will make it very difficult to average 75% across the year. 3/4 continuous audits are not achieving 75% on a monthly basis.

2.4 Financial Implications

The cost per quarter for delaying a Level 2 Assessment is £153,176.50. The last opportunity to be assessed against the 2011-12 standards is March 2012.

ENCLOSURE 9

SUBJECT :	Monitoring and Assurance of Compliance against the Care Quality Commission (CQC) Essential Standards
REPORT BY :	Jane Owen
AUTHOR :	Michelle Walsh

CONTEXT AND BACKGROUND FOR REPORT

This report provides a summary of assurance of compliance against the Care Quality Commission Essential Standards for 2010-11, and identifies improvements to the process for ongoing monitoring and reporting arrangements for 2011-12.

KEY ISSUES FOR THE BOARD'S CONSIDERATION AND DECISION

For 2011-12, Directorates will continue to implement the CQC Essential standards in day to day practice and will contribute evidence as required; however, the responsibility of completing the CQC Provider Compliance Assessment forms has been moved from individual Directorates to the Clinical Governance Team.

The Board of Directors will be made aware of compliance progress throughout the year, via the monthly CGC minutes and a year-end report will again be produced to confirm the status of assurance for 2011-12. Any Trust-wide non-compliances identified during the year will be escalated to the Board by the Director of Nursing, Midwifery and Operations.

RECOMMENDATIONS

To note the content of this report and consider the proposed reporting arrangements in light of the Quality Governance requirements.

Monitoring and Assurance of Compliance against the Care Quality Commission (CQC) Essential Standards

1. Assurance of Compliance during 2010-11

The Trust was licensed without conditions with the CQC in April 2010.

2010-11 was the first year of ongoing monitoring of the new CQC Essential Standards. Directorates were asked to review compliance quarterly and report compliance to the Clinical Governance Committee (CGC). Some individual areas of non-compliance were reported and remedial actions developed, but no Trust-wide non-compliance was identified. The quality of evidence varied across Directorates; this has also been identified through a recent internal audit. Improvements have been made to the monitoring process for 2011-12, see section 2 below.

The Trust received an unannounced planned visit by the CQC on 13th April 2011. All 16 essential standards were reviewed by CQC assessors visiting clinical and non-clinical areas of the Trust, talking to patients and staff. The provisional feedback from this visit was very positive with only minor comments made. Four Provider Compliance Assessment (PCA) forms and other documentary evidence were supplied, as requested by the CQC, and this too received a positive response. The formal written report from the CQC is due imminently.

2. Monitoring Compliance during 2011-12

Responsibility for producing Trust-wide PCA forms for each of the 16 Essential Standards will now be held centrally by the Clinical Governance Team, who will liaise with Directorates for supplementary evidence. As mentioned above, four PCA forms have already been completed; the remaining 12 are to be completed by July 2011. All 16 PCA forms will then be circulated to Directorates, who will be asked to provide any additional evidence from within their departments. If applicable, the Clinical Governance team will also develop and monitor action plans for any reported non-compliances.

CQC compliance is a standing agenda item at CGC. CGC will also receive the Quality Risk Profile (QRP) approximately monthly, to identify and prioritise potential risks of non-compliance, as determined by external information held by the CQC about the Trust. The CQC updates the QRP monthly, with the exception of May, September and January to enable them to carry out a regular evaluation of the information provided by the QRPs. The Trust QRP

has been improving over the last few months, and the next update is expected to improve further as a result of the recent CQC visit.

The Board of Directors will be made aware of compliance progress throughout the year, via the monthly CGC minutes and a year-end report will again be produced to confirm the status of assurance for 2011-12. Any Trust-wide non-compliances identified during the year will be escalated to the Board by the Director of Nursing, Midwifery and Operations.

Birmingham Women's

NHS Foundation Trust

SUBJECT :	Annual Report of the Director Of Infection Prevention & Control April 2010 – March 2011
REPORT BY :	Jane Owen DIPC
AUTHOR :	Several contributors

CONTEXT AND BACKGROUND FOR REPORT

This has been presented and discussed at the April Infection Control Committee.

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

- For the eighth year in succession no infections in two of the three categories subject to Department of Health mandatory surveillance.
- There has been one case of Clostridium Difficile in July 2010.
- Active programme of Infection Control Audit, focusing on areas of high risk to this Trust.
- Active programme of environmental inspections has been enhanced
- Improved performance in hand hygiene audits.
- Provision of hand hygiene facilities at the Point of Care throughout the Trust.
- MRSA screening of elective and emergency Gynaecology patients, all admissions to the Neonatal Unit, and high-risk Maternity cases maintained.
- Excellent rating on Patient Environment maintained.
- Training programme in Infection Prevention & Control successfully delivered, including extensive hand hygiene training.
- No breaches identified during our unannounced visit by South Birmingham PCT in 2010
- Trust compliant with Code of Practice for the prevention and control of healthcare associated infections contained in The Health and Social Care Act 2008.

RECOMMENDATIONS

To discuss and note the achievements. relating to infection prevention and control described in this report

ANNUAL REPORT OF THE DIRECTOR OF INFECTION PREVENTION & CONTROL

April 2010 – March 2011

Blitz the Bugs……….

The Trust takes Infection Prevention & Control very seriously

We are committed to ensuring that our staff, patients and visitors are protected from healthcare associated infections

Please help us to maintain our high standards by:

- ✔ **Washing your hands or using alcohol hand gel on entering and before leaving wards and departments**
- ✔ **Helping us to keep our hospital clean and tidy**
- ✔ **Not visiting patients if you are unwell with signs of an infection (such as diarrhoea, vomiting, fever or flu like symptoms)**
- ✔ **Letting us know if you have any questions or concerns regarding infection prevention and control or standards of cleanliness**

………… It's in all our hands

Birmingham Women's NHS Foundation Trust
Working together to beat infection

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PART 1: INTRODUCTION

EXECUTIVE SUMMARY

- For the eighth year in succession no infections in two of the three categories subject to Department of Health mandatory surveillance.
- There has been one case of Clostridium Difficile in July 2010.
- Active programme of Infection Control Audit, focusing on areas of high risk to this Trust.
- Active programme of environmental inspections has been enhanced
- Improved performance in hand hygiene audits.
- Provision of hand hygiene facilities at the Point of Care throughout the Trust.
- MRSA screening of elective and emergency Gynaecology patients, all admissions to the Neonatal Unit, and high-risk Maternity cases maintained.
- Excellent rating on Patient Environment maintained.
- Training programme in Infection Prevention & Control successfully delivered, including extensive hand hygiene training.
- No breaches identified during our unannounced visit by South Birmingham PCT in 2010
- Trust compliant with Code of Practice for the prevention and control of healthcare associated infections contained in The Health and Social Care Act 2008.

INTRODUCTION

Birmingham Women's NHS Foundation Trust has always been committed to protecting patients from healthcare-associated infections (HCAIs). Once again we are pleased to report evidence of continuing high standards of Infection Prevention and Control at all levels within the Trust, together with the successful achievement of almost all objectives set for the Infection Control Team (ICT). In November 2010 we underwent an unannounced inspection by South Birmingham PCT of our performance against the Hygiene Code. No breaches of the Hygiene Code were found,

For the eighth consecutive year there were no MRSA bacteraemia infections subject to Department of Health mandatory surveillance. However for the first time in over 5 years, the trust reported one case of Clostridium Difficile in July 2010. A full review of the case was undertaken and lessons have been learnt and shared. The trust continues to implement a range of stringent infection prevention measures that have been in place for many years . Mandatory infection surveillance encompasses only a small proportion of the overall burden of healthcare associated infections (HCAIs), and it is important to note that our much more extensive internal infection surveillance continues to show satisfactory performance in preventing a much broader range of HCAIs. This excellent performance is no reason for complacency. We continue to raise awareness of specific risks around HCAIs with our staff, and to promote and monitor good clinical practice to minimise the risk of HCAI for our patients.

We believe that this report underlines our success and ongoing commitment in providing excellent standards of infection control and environment cleanliness.

DESCRIPTION OF INFECTION CONTROL INFRASTRUCTURE

All staff members at Birmingham Women's Hospital have a responsibility to themselves, patients, visitors and other staff to maintain high standards of Infection Control. However some staff have specific responsibilities defined in their job descriptions, and they are recorded here.

The Infection Control Team
Jane Owen, Director of Infection Prevention & Control
Julie Suviste, Infection Control Nurse Specialist
Samantha Bullingham, Infection Control Nurse
Charlotte King, Infection Control Lead for Neonatal and Maternity Services
Jim Gray, Consultant Microbiologist
Mitul Patel, Consultant Microbiologist

Matrons
Jenny Henry, Head of Midwifery
Justine Jeffrey, Clinical Manager, Delivery Suite
Michele Emery, Head of Nursing, Neonatal Services
Jacky Cotton, Head of Nursing, Gynaecology Directorate

Other Clinical Services
Emily Hartwell, Pharmacy
Louise Hopton, Occupational Health Nurse
Gael Peters, Operating Theatre Manager

Corporate Services
Pam Cooper, Head of Facilities
Gail Alexander, Hotel Services Coordinator
Roger Bengough, Assistant Estates Manager
Rosey Monaghan, Decontamination Lead
Cath Roper, Risk Manager

STATEMENT BY THE BOARD OF DIRECTORS

The Board of Directors is committed to maintaining the Trust's excellent reputation and rating in relation to the prevention and control of healthcare-associated infections (HCAIs). Effective prevention and control of HCAIs has to be embedded into everyday practice and applied consistently by everyone. The Board recognises it has an important role in ensuring that appropriate and adequately resourced arrangements for infection prevention and control are in place, and in monitoring standards through an assurance framework and knowledge of the annual infection control programme.

As part of the regular reporting and assurance to the Board the Director of Infection Prevention and Control (DIPC) presents an annual report and programme of work as well as quarterly Directorate reports from the matrons.

These reports provide information and assurance on issues affecting infection prevention and control across the Directorates and demonstrate the infection control is an integral part of the Directorate's activities.

In January 2010, a weekly patient safety report, produced by the medical director, was introduced. Two of the nine metrics reported are MRSA and Clostridium Difficile. The " Friday metrics" are circulated to all staff , the PCT and our governors. This has raised the profile of the trust's performance against these indicators.

The Trust's strategic objective of improving the quality, reputation and safety of our services is underpinned by infection prevention and control.

Objective: To maintain infection control standards and compliance with the Hygiene Code.

An assurance framework exists for each principal objective of the Trust that includes assessment of the principal risks, key controls, assurances on controls and arrangements for Board reporting (including provision for reporting gaps in controls and/or assurance).

By this means the Board of Directors takes collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks, and is assured that sufficient resources are available to secure the effective prevention and control of HCAI.

PART 2: THE REPORT OF THE INFECTION CONTROL TEAM

ACHIEVEMENTS OF THE INFECTION CONTROL TEAM

PRIZES & AWARDS

MEMBERSHIP OF NATIONAL COMMITTEES

Jim Gray

- Expert Adviser, British National Formulary for Children (BNF-C)
- Member, Guidelines Development Group, National Institute for Health & Clinical Excellence: Donor breast milk banking short clinical guideline
- Member, NETSCC, HTA Pharmaceuticals Panel
- Member, Guidelines Development Group, National Institute for Health & Clinical Excellence: Antibiotics for early onset neonatal infection

Mitul Patel

- Member, Guideline Development Group, The management of acute bloody diarrhoea potentially caused by VTEC (E coli O: 157) in children. Health Protection Agency, RCPCH and RCGP

EDITORSHIPS

Jim Gray

- Associate Editor, Journal of Paediatric Infectious Diseases
- Paediatric Section Editor, International Journal of Antimicrobial Agents
- Assistant Editor, Journal of Hospital Infection

PUBLICATIONS

Peer-reviewed publications

1. Daniels J, **Gray J**, Pattison H, Gray R, Khan KS on behalf of the GBS Collaborative Group. Intrapartum tests for group B streptococcus: accuracy and acceptability of screening. Br J Obstet Gynaecol 2011;118:257-65.
2. **Gray J**, Patwardhan SC, Martin W. MRSA infections in obstetrics: a review. J Hosp Infect 2010;75: 89-92.
3. Kaambwa B, Bryan S, **Gray J**, Milner P, Daniels J, Khan K, Roberts TE. Cost-effectiveness of rapid tests and other existing strategies for screening and management of early onset group B streptococcus during labour. Br J Obstet Gynaecol 2010; 117:1616-27.
4. **Gray J**, Ali O, Dawood R, Robertson S, Strauss R, Walton S. Consensus guideline for the management of common bacterial skin infections in primary care. Guidelines 2010; 51: 437-41.
5. **Gray J, Patel M**, Turner H, Reynolds F. MRSA screening on a Paediatric ICU. Arch Dis Child. Doi:10.1136/adc.2010.185785.
6. Ismail AQ, **Gray J**, Anthony. M. An investigation of possible routes of transmission of group B streptococci to humans outside the neonatal period. J Hosp Infect 2011;77:184-5.
7. **Gray J**, O'Donoghue B. Bacteraemia with meticillin-sensitive *Staphylococcus aureus* in an English children's hospital. J Hosp Infect. doi: 10.1016/j.jhin.2011.02.006.
8. **Gray J, Patel M.** Management of antibiotic resistant infection in the newborn. Arch Dis Child Fetal Neonatal Ed. In press.

9. **Gray J**. GUM_02_001 Interpreting Laboratory Tests. In Department of Health e-Learning for Healthcare. E-HIV-STI. 2010.

Book chapters

1. **Gray J**, Hextall A. Vaginitis. In: Cardozo L, Statskin D (eds.) Textbook of female urology and urogynecology, 3rd edn. Informa UK, London.2010, pp.544-53.
2. **Gray JW**. POCT for infectious diseases. In Price CP, St John A, Kricka LJ (eds.) Point-of-care testing. Needs, opportunity and innovation, 3rd edn. Washington DC: AACC Press 2010, pp. 447-65.
3. **Gray J**, Robinson D. Lower urinary tract infections: simple and complex. In: Cardozo L, Statskin D (eds.) Textbook of female urology and urogynecology, 3rd edn. Informa UK, London.2010, pp.530-43.

PRESENTATIONS AT SCIENTIFIC MEETINGS

1. **Gray J**, Bullingham S, Dyer N, Room J. Rapid root cause analysis to investigate the sources of cases of hospital-acquired rotavirus (HARV). Poster presentation at the 28th Annual Meeting of the European Society for Paediatric Infectious Diseases, Nice, 5-8 May 2010.
2. **Gray J**, Sime M, Sahni M, Rasiah SV. MRSA on a neonatal unit (NNU): admission screening or surveillance cultures? Poster presentation at the 28th Annual Meeting of the European Society for Paediatric Infectious Diseases, Nice, 5-8 May 2010.
3. Lyttle M, **Gray J**, Berry K. Assessment of potential benefits in the paediatric population with point of care testing in pandemic H1N1 influenza. Oral presentation at the 28th Annual Meeting of the European Society for Paediatric Infectious Diseases, Nice, 5-8 May 2010.
4. Room J, **Gray J**. Elective Surgical MRSA Screening in a Paediatric Hospital. Poster presentation at the 3rd Congress of the European Academy of Paediatric Societies, Copenhagen, October 23-26 2010.
5. Room J, **Gray J**, **Patel M,** Thomas C. PVL-producing US 300 MRSA Outbreak on a Paediatric Burns Unit. Poster presentation at the 3rd Congress of the European Academy of Paediatric Societies, Copenhagen, October 23-26 2010.
6. Lyttle M, **Gray J**, Berry K. Assessment of potential benefits in the paediatric population with point of care testing in pandemic H1N1 influenza. Poster presentation at the College of Emergency Medicine Conference, Learning from Each Other. Civilian and Military Emergency Care, Birmingham, September 13-15 2010.
7. Patwardham S, **Gray J**, Martin W. MRSA Screening in Obstetrics. Poster presentation at the 30th annual meeting of the Society for Maternal-Fetal Medicine, San Francisco, February 7-12 2011.
8. Lyttle M, **Gray J**, Berry K. Assessment of potential benefits in the paediatric population with point of care testing in pandemic H1N1 influenza. Poster presentation at the 1st Annual West Midlands CEM Conference, Birmingham,19th January 2011.
9. **Gray J**. *Clostridium difficile*: can we be better at diagnosis? Invited lecture at Society for Applied Microbiology Spring Meeting, Stratford upon Avon, 16 April 2010.
10. **Gray J**. Microbiology of Donor Milk Banking. Invited lecture at UKAMB Milk Banking Conference, Solihull, 8 October 2010.

11. **Gray J**. Infection Prevention & Control on the Burns Unit. Now & into the Future. Invited lecture at the 7th International Conference of the Hospital Infection Society, Liverpool, 10-13 October 2010.
12. **Gray J**. European strategies to contain antibiotic resistance & promote appropriate antibiotic prescribing in paediatric care. Invited lecture at the 3rd Congress of the European Academy of Paediatric Societies, Copenhagen, 23-26 October 2010.
13. **Suviste J**. **Bullingham S**, Coley C, King C. Blitzing Bug's at Birmingham Women's Hospital. Poster presentation at the International Forum on Quality and Safety in Healthcare, Amsterdam 5-8 April 2011.
14. **M Patel**. Neonatal infections: Learning from each other's experience. Invited presentation. P.S. Medical College, Gujarat, India. May 2010
15. **M Patel**. Making sense of antifungal guidelines. Presentation at West Midlands Microbiology Meet, Oct 2010
16. Johansen L, Sharif K, Mirza DF, **Patel M et. al.** CMV PCR is indicated in symptomatic children whereas routine EBV PCR screening is necessary in effective management of post-intestinal transplant patients. British Society for Paediatric Gastroenterology, Hepatology and Nutrition annual meeting. Jan 2011

AWARDS
Julie Suviste

- Regional winner (Central/East of England) - Cepheid Infection Control Nurse Award 2010

INFECTION SURVEILLANCE

1. ALERT ORGANISM-BASED SURVEILLANCE

BACKGROUND

The Infection Control Team prospectively records all new laboratory isolates of key alert organisms (that is microorganisms that are important causes of healthcare associated infections).

Staphylococcus aureus is an important cause of HCAI in all groups of patients. Meticillin-resistant *S. aureus* (MRSA) are strains that are resistant to flucloxacillin and other commonly-used antibiotics. They are especially important because infections with MRSA are inconvenient and expensive to treat, and because in hospitals where MRSA is prevalent it tends to add to the overall burden of healthcare associated infections.

Klebsiella and *Enterobacter* are usually the most common hospital-associated opportunistic nosocomial Gram-negative pathogens seen on our NNU. Although the majority of cases detected are asymptomatic, their occurrence is a useful measure of patient-to-patient transmission of a wide range of bacteria.

Pseudomonas and *Acinetobacter* are Gram-negative bacteria that are important because they are often multiply antibiotic-resistant and they occur almost exclusively as healthcare-associated pathogens. These bacteria have a different epidemiology to *Klebsiella* and *Enterobacter* in that they can be

associated with deficiencies in environmental cleanliness, as well as direct patient-to-patient spread.

In recent years the range of potentially important Gram-negative bacteria on NNUs has increased: during 2010/11 we introduced enhanced screening of neonates to monitor the acquisition of these bacteria and to facilitate earlier intervention in the event of a possible outbreak. One impact of this approach is that surveillance will have detected more babies on the NNU colonised with Gram-negative bacteria, and therefore numbers are not directly comparable with previous years.

METHODS

Alert organism-based surveillance is undertaken by prospective collection of Microbiology laboratory data by the Infection Control Team.

In the case of MRSA, the ICT makes a thorough assessment of each new case. This includes determining the likely origin of the MRSA using the following definitions:

- Originating at BWNFt: Patient admitted to BWH at least 48 hours before MRSA first identified *and* no risk factors for prior colonisation with MRSA *or* previous negative microbiology results from the affected site(s).
- Originating elsewhere: Patient already known to be colonised with MRSA *or* patient transferred from, or employed in, a hospital where MRSA is prevalent *and* no previous negative microbiology results from the affected site(s). Infections in babies judged to be vertically transmitted are categorised according to the origin of the maternal infection.
- Uncertain origin: Cases that do not fulfil either of the above definitions.

MRSA cases are also assessed on the reason why swabs were collected (screening or because infection is suspected).

RESULTS

Annual numbers of cases of colonisation or infection with *S. aureus* for the past five years are shown in Table x.1. Numbers of cases in babies were lower than in previous years, whilst cases in adults women were comparable to recent years.

Table 1: Annual numbers of cases of colonisation or infection with *S. aureus* according to patient group over the past four years

	No. of cases of colonisation or infection with *S. aureus* in:			
	NNU	Other babies	Obstetric mothers	Gynaecology
2010/11	63	44	73	32
2009/10	77	66	57	28
2008/09	123	57	50	36
2007/08	106	83	74	46
2006/07	68	68	100	46
2005/06	105	85	114	54

The evolution of screening for MRSA means that numbers of cases of colonisation or infection detected in 2010/11 are not fully comparable with those in previous years. Results are presented in the same format as last year, but note that the Gynaecology results will be skewed as a result of introduction of screening of emergency admissions during the last year (Table x.2). It is also noted that rationalisation of the screening programme for Maternity services has, as predicted, had no effect on case ascertainment.

Again, no cases of MRSA were considered to have been definitely acquired at BWH in 2010/11: 34 were deemed to have been acquired elsewhere, and in two cases a source could not be assigned with certainty.

Table 2: Occurrence of various epidemiological categories of MRSA colonisation and infection during the past three years

Reason for test	No. of cases in patient category								Total nos. of cases	
	NNU babies		Other babies		Maternity		Gynaecology			
	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11
Routine screen	0	1	0	0	9	6	16	19	25	26
Non-routine screen	0	0	3	1	0	1	0	0	3	2
Suspected infection	0	0	1	3	3	4	2	1	6	8
TOTALS	0	1	4	4	12	11	18	20	34	36

The numbers of cases of infection or colonisation with klebsiella and enterobacter in NNU babies were comparable to the previous year (Table x.3): these results were unaffected by the change in screening procedure refrred to earlier. The number of cases of *P. aeruginosa* was substantially increased. This was partly due to enhanced surveillance, but the specific matter of pseudomonas being found in taps and water is discussed in the Untoward Incidents chapter.

Table 3: Occurrence of *Klebsiella* and *Enterobacter* spp. in NNU patients in the past three years

	No of isolates of:			
	Klebsiella	*Enterobacter*	*Acinetobacter*	*Pseudomonas*
2010/11	12	9	1	37
2009/10	16	2	1	18
2008/09	21	22	3	9
2007/08	26	16	2	8

Numbers of cases of colonisation or infection with *P. aeruginosa* are also recorded for Maternity and Gynaecology patients. There were 15 isolates of *P. aeruginosa* in Gynaecology patients in 2010/11, which is comparable to previous years: 10, 7, 22, and 14 cases in the years 2009/10 to 2006/07. Amongst Maternity patients *P. aeruginosa* was isolated from 6 mothers and no babies in 2010/11, compared with 8 mothers and 2 babies in the previous year.

CONCLUSIONS

Although far more comprehensive than many hospitals' programmes, the limitations of our surveillance programme in that denominator data are not used to determine rates of infection have been noted in previous Annual Reports. Nevertheless it can be concluded that:

- MRSA remains tightly controlled in our hospital.
- MRSA screening has made it easier to identify whether MRSA was acquired within or outside the Trust. However, it has had little effect on overall case ascertainment: in particular extension of the screening programme to include emergency gynaecology admissions has had minimal impact.
- Numbers of cases of colonisation or infection with *Staphylococcus aureus* remain at a lower level.
- The most important change detected by organism surveillance has been increased numbers of previously unusual Gram-negative bacteria on the NNU.

RECOMMENDATIONS

- Revised MRSA screening strategy is working well, although case ascertainment rates remain low: there may be an opportunity to rationalise screening further once the results of the national audit planned for May 2011 are available.
- Work is ongoing to investigate and control Gram-negative bacteria on the NNU.

2. CONDITION-BASED SURVEILLANCE

2.1 National surveillance through mandatory reporting to the Health Protection Agency

BACKGROUND

The Department of Health mandatory infection surveillance schemes encompass three infections:

- Bacteraemia with meticillin-resistant *Staphylococcus aureus* (MRSA)
- Bacteraemia with glycopeptide-resistant enterococci (GRE)
- *Clostridium difficile*-associated diarrhoea in over-2 year olds

RESULTS

For the eighth consecutive year there were no bloodstream infections with either MRSA or GRE. We did however report one case of presumed *C. difficile*-associated diarrhoea in July 2010. The patient had self-limiting diarrhoea and was *C. difficile*-positive by PCR, but toxin-negative by enzyme immunoassay. A root cause analysis (RCA) was undertaken on this case, which identified some issues with movement of patients with possible infectious diarrhoea and around antibiotic stewardship. All actions arising from this RCA have been completed.

ENHANCED SCREENING FOR GNB USING RECTAL SWABS ON NNU

BACKGROUND

Gram negative organisms resistant to commonly used antibiotics are a growing threat to hospitalised patients globally. We have seen more instances of colonisation with Gram-negative bacteria with unusual antibiotic resistances on the NNU in recent months. There are anecdotal reports of other local NNU having same problem.

A screening programme using oropharyngeal secretions (OPS) and endotracheal secretions (ETS) is already in place on the NNU.

An enhanced screening programme for screening for resistant gram negative organism using rectal swab has been implemented on the new NNU.

METHOD

Rectal swabs are collected at the time of admission to the unit and once in a week throughout the patient's in-patient stay. The target organisms are: gentamicin resistant *Enterobacteriaceae*, ESBL producing *Enterobacteriaceae* and *serratia marcescence* (GNB of interest: **GNBi**)

RESULT

Table: 1 GNBi isolated from screening specimens including rectal swabs during the first 6-month period (1st Sept 10 to 28th Feb 11) on the new NNU

Organism	From any specimen	First isolated in rectal swab	Isolated only from rectal swab	Isolated from other specimen
Gent R *E coli*	6	3	1	2
Gent R *Klebsiella*	2	2	2	0
Gent R *Morganella*	1	1	0	1
ESBL *E coli*	4	2	2	0
Serratia marcescence	8	3	2	1
TOTAL	**21**	**11**	**7**	**4**

- A total of 21 GNBi were isolated from 21 cases from all clinical and screening specimens during the first 6 months period.
- Rectal swab was the first specimen to grow GNBi in 11 cases.
- In 7 out of these 11 patients, rectal swab was the only positive specimen that was growing the GNBi during their in-patient stay.
- In 4 out of the 11 cases, the same organism was isolated from other specimens e.g. ETS/ OPS, including one blood culture, later during their in-patient stay.
- In addition to above organisms, *P. aeruginosa* colonisation was also identified in 9 cases; a detail of which has been discussed in 'untoward incidents'.

CONCLUSION

- Rectal screening enabled early recognition of colonisation with GNBi in 11 out of 21 cases.
- Seven of those 11 cases, where rectal swab was the only positive specimen, would have passed through the NNU without notice.
- Enhanced screening has helped monitor the changing epidemiology of GNB on NNU

RECOMMENDATION

- To continue rectal screening and keep under review

INFECTION CONTROL AUDITS

BACKGROUND

In order to comply with the duties detailed in the Health and Social Care Act (2008) *Code of Practice for the Prevention and Control of Health Care Associated Infections and related guidance* Trusts need to ensure that they have an active audit programme in place to monitor compliance with key infection prevention and control policies. Audits are a useful measure of general compliance with clinical practices and can also help to identify where further action, resources or education may be required. However it is important to note that audits can only reflect the practice observed at the time and observational audits can be subject to bias by the auditor or those being audited.

The audit programme for 2010/2011 was identified in the Trust Infection Control Annual Programme and agreed by the Infection Control Committee.

Audits have continued to focus on key clinical practices and environmental standards. This year clinical departments have taken the lead in undertaking monthly audits of cleanliness and environmental standards, hand hygiene compliance and the Department of Health Saving Lives – High Impact Interventions.

Audits completed this year include:
Clinical Practices

- Hand Hygiene Compliance
- Safe Sharps Practice
- Standard Precautions
- Isolation Practices
- Aseptic Practice
- High Impact Interventions

Environmental Standards

- Multidisciplinary Environment Inspections
- Hand Hygiene Facilities
- Department led Environmental Audits
- Department led Medical Equipment Cleanliness Audits

- Mattress & Pillow Audits
- Ward and Main Kitchen Inspections

METHODS

The majority of audit tools used are based on the Infection Control Nurses Association (ICNA) *Audit tools for monitoring infection control standards* or nationally recognised audit tools i.e. Department of Health Saving Lives – High Impact Interventions. The ICNA defines scores of 85% and above as compliant, whilst scores of 80-84% are partially compliant.

Collation of audit results is either undertaken by the Infection Control Nursing Team or by individual Departments, this is dependent upon the audit. The responsibility for dissemination of results and follow-up of any issues identified remains the responsibility of Heads of Nursing and Midwifery or designated Infection Control Leads. Audit results and actions taken are detailed in the Directorate Matron Reports to the Infection Control Committee.

RESULTS

An overview of the audit results is provided below.

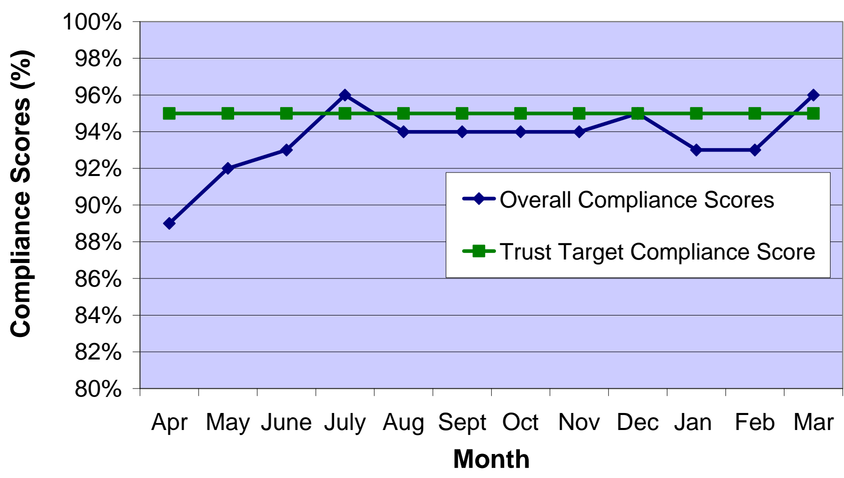
Hand Hygiene Compliance

Clinical areas undertake monthly observational audits of hand hygiene compliance which focus on the World Health Organisations "Five moments of hand hygiene" and the key elements of "Bare Below the Elbows". Compliance scores are entered into an electronic database and overall scores are generated for each Directorate, Department and individual staff disciplines.

Scores are displayed in clinical areas on dedicated Infection Control notice boards for staff and public information.

The Trust compliance target is 95% and above. Overall compliance scores have continued to increase this year with scores consistently at or above 93% for the majority of months this year, a score of 96% was recently achieved in March. High standards of hand hygiene compliance remains a priority for the Trust with Clinical Directorates being responsible for ensuring actions are undertaken to improve and sustain compliance in their areas. Hand Hygiene training is included in all Infection Control education sessions for all relevant staff and is promoted as part of Infection Control awareness days and ad hoc sessions throughout the year, which are aimed at staff, patients and the public.

Overall Trust Compliance Scores



Hand Hygiene Facility Audit

An audit of hand hygiene facilities was undertaken in all clinical areas throughout the Trust. The overall compliance score was 92% compared to 88% in 2009/2010.

Key issues identified related to non-intact sealant, evidence of build up of alcohol gel or soap residue around nozzles of dispensers, or missing drip trays . All issues have been addressed and are monitored locally during department level environmental audits.

Hand Hygiene Facilities – Inpatient Departments									
Dept/Ward	**1**	**3**	**4**	**7**	**8**	**TC**	**NNU**	**DS**	**BC**
Score	91%	95%	95%	91%	91%	91%	100%	95%	82%

Hand Hygiene Facilities – Outpatient Departments										
Dept	**ACU**	**EPAU**	**FM**	**Rad**	**Physio**	**Wd 2**	**ANC**	**Gynae OPD**	**Colp**	**DAU**
Score	82%	91%	82%	95%	95%	96%	86%	100%	95%	100%

Safe Handling and Disposal of Sharps

Safe handling and disposal of sharps is key to preventing inoculation injuries. Compliance with practice was assessed in 19 areas during Quarter 3. Scores were above 90% in 17 areas and the overall Trust compliance score was 95%. The main themes identified were:

- Lack of use of the temporary closure mechanism on sharps containers when not in use.
- Visual posters detailing the correct management of inoculation injuries were not displayed in all areas, however on questioning staff knowledge was very good.

Safe sharps practice and management of inoculation injuries continues to be included in all infection control training sessions at induction and during annual Infection Control updates. It was also targeted during our Infection Control awareness week in June.

Standard Precautions

Standard precautions are key principles of infection prevention and control practice and encompass several different aspects (including hand hygiene, use of personal protective equipment, decontamination processes, management of blood and bodily fluids and management of linen and waste). Compliance with practice was audited in 19 areas in Quarter 2 with outpatient clinical areas also included this year. 5 areas scored lower than 85%, key areas that required further action included:

- Ensuring that all staff know where to locate personal protective equipment in their areas; including protective eye wear and disposable face masks.
- Ensuring all staff are knowledgeable about the products used for all decontamination processes.
- Ensuring spillage kits are available and within use by dates in all clinical areas.

Isolation Practices

Compliance with isolation policy was undertaken in Quarter 2. Due to the low number of patients often requiring isolation, the audit was undertaken over a 6 week period, to gain a sufficient number of observations to reflect practice. The audit focused on all key elements of the Trust Isolation Policy.

Compliance with policy was observed to be very good, with patients being isolated promptly, appropriately and with key isolation practices in place.

Throughout the year capacity of isolation facilities has been observed to be sufficient within the Trust. The isolation facilities available in the Neonatal Unit have now increased and are usually sufficient for demand. However following risk assessments involving the ICT, cohort nursing has still been necessary on occasion due to the numbers of babies colonised with specific organisms, patient dependency or staffing.

Department of Health – Saving Lives: High Impact Interventions

High Impact interventions (HII's) are audit compliance tools (Care Bundles) which relate to key clinical procedures and aim to reduce any variation in practice. They are based on the latest evidenced based guidance and provide a means for clinical staff to measure local compliance of clinical procedures against nationally agreed standards.

Participation in the individual auditing programmes by clinical areas has improved this year and a central electronic database has been produced by Informatics and the Infection Control Nursing Team to improve collation and dissemination of results.

Compliance with the individual Care Bundles is generally very good, however some individual departments need to focus on ensuring that documentation records for the care of peripheral venous devices are fully completed.

Aseptic Practice

Elements of aseptic practice are monitored via the audit of High Impact Interventions. In addition clinical areas were requested to undertake more detailed audits of aseptic non-touch technique practice throughout Quarter 4, using an audit tool based on the policy for Aseptic and Aseptic non-touch technique.

64 completed audit forms were returned from 9 clinical departments. Compliance with policy was reported to be very good with individual department scores ranging between 86% and 100%. Key issues identified by the audit will be reinforced during ongoing education programmes delivered by the Infection Control Nursing Team.

Environmental Audits

Department based audits that assess environmental standards and cleanliness of medical equipment continue to be led by Department Managers. Performance and any unresolved issues are included in the Quarterly reports to the Infection Control Committee produced by the Heads of Nursing and Midwifery (Matrons).

Formal mattress and pillow audits are also completed in all clinical areas, these are performed quarterly in Delivery Suite and the Birth Centre and a minimum of 6 monthly in all other clinical areas.

Environmental Inspections 2010/11

BACKGROUND

The Health and Social Care Act (2008) Code *of practice for the NHS on the prevention and control of health care associated infections and related guidance* Criterion 2 identifies the need to: *"Provide and maintain a clean and appropriate environment which facilitates The prevention and control of healthcare associated infections".*

In July 2010 an environmental Inspection framework was developed and agreed by members of the Infection Prevention and Control Committee. This is now the standard proforma that is used and applied to all the Environmental Inspections done in clinical areas.

METHOD

An Environmental Inspection visit is carried out in all clinical areas on an annual basis (as a minimum) by the Environmental Inspection Team. This consists of:

- Lead
- Matron
- Infection Control Nurse

- Facilities/housekeeping Lead

The audit tool '*Observational Tool for Quality Walkabout Patient Environment'* is used as a framework for the visits.

RESULTS

The Environmental Inspection Team determines the outcome of the inspection dependent on the findings. Results are deemed as:

1. EIT inspection visit reveals no problems
2. EIT inspection visit reveals problems NOT deemed to be putting patients at immediate risk
3. EIT inspection visit reveals problems THAT ARE deemed to be putting patients at immediate risk

Where the EIT visit reveals problems that are deemed to be putting patients at immediate risk this information is escalated to the DIPC on the same day and a decision will be made on precautions to be put in place i.e. special measures.

Since July 2010 there have been 17 inspections that have been undertaken. Two off the Inspection visits were found deemed to be putting patients at immediate risk, Delivery Suite and the Birth Centre. Following the inspections the issues/problems identified were escalated to all team members including the DIPC an action plan was formulated and a revisit to both areas was scheduled. These areas are now in process of rectifying any outstanding issues raised during the visits.

RECOMMENDATIONS

Recommendations for 2011/12 are:

- To develop a robust system to enable common themes/problems that are occurring across the Trust
- Review the current observational audit tool.
- Develop the tool to make it more specific for use in the out-patient areas and Theatre settings.

Ward Kitchen Audits

Quarterly unannounced inspections are undertaken by the Infection Control Nursing Team and the Facilities Manager. The main aim is to monitor environmental standards within ward kitchens and assess compliance with the Food Hygiene policy**.**

Results have continued to be good throughout the year with overall compliance scores ranging between 84% in Quarter 1 to 90% in Quarter 4. Areas of non-compliance can vary but in general relate to cleanliness of areas that are difficult to access, i.e. beneath and behind appliances, storage of inappropriate or surplus items in the kitchen, and lack of labelling of food items stored in ward based refrigerators. Department Managers are responsible for ensuring action is taken in response to any issues identified.

Ward Kitchen Compliance Scores 2010/2011				
Quarter	Q1	Q2	Q3	Q4
Score	89%	83%	78%	90%

The Infection Control Team also participate in quarterly inspections of the Trust main kitchen in conjunction with the Catering Manager to monitor practice and environmental standards. The main and ward kitchens are also subject to annual inspections undertaken by Environmental Health, the ICT are normally invited to accompany them during their visits.

CONCLUSIONS

A robust proactive audit programme has continued throughout the Trust this year, encompassing the monitoring of environmental standards and individual clinical practices. In general audit scores remain very good and reflect the high standards of practice in all clinical areas. The Multidisciplinary Environment Inspections have continued to be extremely useful and effective in maintaining and further improving our high standards throughout the Trust. The reporting mechanisms in place help to ensure that prompt action is taken if any areas of concern are identified.

RECOMMENDATIONS

- To review our audit programme to ensure that this continues to reflect the requirements of the Health and Social Care Act 2008.

- To incorporate the new national Quality Improvement Tools within our audit programme following their launch which is expected in April this year.

- To review auditing of the High Impact Interventions and incorporate any of the newly published tools which are relevant to our Trust.

ANTIMICROBIAL PRESCRIBING

BACKGROUND

Good antimicrobial stewardship depends on a number of factors, including:

- Selection of agents that give effective and reliable cover against the expected pathogens.
- Selection of agents that are safe for our group of patients: this is an especially important consideration in this Trust, where a large proportion of our patients fall into groups that are at high risk of harm from drugs, such as pregnant, breastfeeding, and neonates.
- Selection of agents that minimise the risks of antibiotic resistance and nosocomial infections such as *Clostridium difficile* and MRSA.
- Antibiotics prescribing for the shortest effective time.

The antimicrobial prescribing policy for neonates in this Trust fulfils all the above criteria.

The antimicrobial prescribing policy for adults has to strike a balance between patient safety and promotion of antimicrobial resistance. As a result, we place fewer restrictions on use of cephalosporins during the antenatal period; however, new guidelines promote reduced use of cephalosporins in every other group.

METHODS & RESULTS

Updated antibiotic prescribing policies for Maternity Services, Gynaecology and the Neonatal Unit were approved last year.
This year an A4 size laminated and coloured 'quick reference' guide has been published and put on every ward for easy access. This has been well received by medical staff, with positive feedback and encouraging audit results.

The pharmacist's role includes the monitoring of the antimicrobial prescribing across the trust. This is based on current antibiotics guidelines.
An annual audit was carried out and the results showed that in the majority (93%) of cases the antibiotics were prescribed appropriately, guidelines were followed where possible; microbiologist was contacted when needed and record keeping, especially for duration of treatment, was somehow poor.
Antimicrobial prescribing is now a regular feature of junior doctors' induction program.

CONCLUSIONS & RECOMMENDATIONS

An early audit, straight after the introduction of the new guidelines showed good results, however antibiotic prescribing ought to be reassessed during the year to ascertain compliance.
In addition, further training has been put together by the pharmacist and the microbiologist, for nurses and midwives, to help understanding infectious diseases and antibiotic drugs use.
If well attended and received the training should result in better prescribing, monitoring and health outcomes for patients.

INFECTION CONTROL POLICIES

BACKGROUND

The Trust has in place all the core Infection Control Policies identified in The Health & Social Care Act 2008, as well as additional policies specific to the needs of this Specialist Trust. All Infection Control Policies are available for any staff member to view on the Trust intranet.

OUTCOMES

The following Infection Control Policies were reviewed, and updated as required:

- Policy for the control of *Clostridium difficile*
- MRSA screening policy
- Policy for the control of infections with varicella zoster virus (chickenpox and shingles)
- Guidelines for the management of needlestick injuries and mucous membrane exposures to blood & body fluids (inoculation injuries)

- Cleaning, disinfection & decontamination policy
- Isolation policy
- Aseptic and aseptic non-touch technique policy
- Introduction to infection control and arrangements for reporting of infections
- Policy for the prevention & control of tuberculosis
- Policy for the control of MRSA
- Marking of patient's case notes who represent an infection control hazard
- Procedure for handling used linen
- Notes on the control of individual of individual infections diseases

In addition the following new Infection Control Policies were produced and approved:

- Policy for the control of respiratory viruses in the hospital
- Policy for the control of diarrhoea and vomiting in the hospital
- Policy for the Laboratory Investigation & Surveillance of Healthcare Associated Infections

RECOMMENDATIONS

That the Infection Control Team continues to ensure that existing Infection Control Policies are in date, and that new policies in response to local or national demands are produced in a timely manner.

PART 3: THE REPORTS OF OTHER KEY SERVICES

FACILITIES

BACKGROUND

Cleaning services are provided by the Hotel Services function, which forms part of Facilities Directorate. Cleaning is undertaken by an extremely dedicated in house team of Housekeepers and Housekeeping Supervisors. The majority of cleaning is undertaken between 07.30 and 20.00 hours, however a 24 hour service is provided to the Delivery Suite and Birth Centre.

The Trust now employs 48.6 wte Housekeepers and 3.4 wte Housekeeping Supervisors.
The Hotel Services Department have successfully grown a team of bank workers that can be called upon to cover staff shortages

All Housekeepers assist with meal and beverage services, as a result they are trained to the basic food hygiene standard; they receive annual hand hygiene/infection control training and undertake the NVQ level two Basic Cleaning course.

METHODS

Cleaning services are provided throughout the hospital, the level and frequency of service is documented in work schedules which are on public display. All work schedules are compliant with the National Cleaning standards.

The Trust adopts the National Colour Coding system for cleaning cloths, mops etc and all waste is segregated and stored in designated areas away from public view.

In addition to scheduled work the Housekeeping department undertake special cleans, usually as part of a refurbishment or building programme where the entire area receives a thorough deep clean prior to re-occupation.

All clinical areas have disposable curtains and the Housekeeping team change as necessary or upon the date of the annual change.

Standards of cleanliness and general environment are monitored on a daily basis by Housekeeping Supervisors. Room cleaning checklists are completed for high risk; high turnover areas like Birth centre and Delivery Suite to ensure standards are maintained despite the quick turnover.

Ward cleanliness checklists are completed on a weekly basis for specific pieces of equipment such as Ice makers and beds

A new contract has been established for monthly deep cleaning of Ice makers in line with EHO recommendations

Each clinical area has an Infection Control/Housekeeping notice board specifically designated for the display of Infection Control and Housekeeping information, relating to that specific ward or department.

Monthly quality control reports are completed by the Housekeeping Supervisors, these are then sent to the relevant Ward manager or Department head for comment/action as required and a copy id displayed on the Infection Control/Housekeeping notice board.

The Facilities team are actively involved in the design and development of all building work and refurbishment programmes, this provides an excellent opportunity to influence the design and layout of areas and to ensure cleaning, storage and waste handling services are included in any design.

The Facilities team are active members of the Infection Control Committee and Infection Control Task Force participating in regular site inspections. This team has proved to be invaluable as a means of maintaining good communication/access to Ward Managers, Service heads, Director for Infection, Prevention and Control and the Infection Control team.

RESULTS

- Deep clean and maintenance programme for all Delivery rooms implemented
- New Neo natal unit opened and cleaning processes adjusted to meet manufacturers recommendations for the new floors and other furnishings
- Dedicated storage space created for clean linen, consumables and cleaning equipment in the new Neo natal unit and also designed into the new Midwifery unit plans
- Further patient bathrooms converted to wet rooms and hands free taps installed
- Water birth room refurbished
- Improved waste segregation and introduction of new waste stream for offensive waste
- Ceiling tiles replaced on an on going basis, and patch painting undertake
- Junk removal and general de cluttering throughout.
- Waste traps and shower wastes cleaned out on a regular basis by dedicated member of staff.
- Waste hold area on Delivery suite refurbished, floor and wall surfaces replaced to reduce infection control risks from damaged surfaces
- Changing facilities for Catering staff and Housekeeping staff refurbished.

CONCLUSIONS

The general standard of cleanliness and the condition of the patient environment has been maintained over the last 12 months. However there are some patient areas in need of upgrade and redecoration ante natal clinic in particular

Working relationships across clinical and non clinical teams have been strengthened and the relationship between Facilities and Infection Control continues to be extremely healthy and supportive.

RECOMMENDATIONS

- To maintain the current level of investment in Housekeeping and maintenance services.

- To maintain an on going programme of re upholstering of patient furniture and removal of clutter

- To maintain the programme of Infection Control/Environmental inspections in all patient areas

- To consider increasing the level of painting and redecoration service provided to patient areas in order to maintain the appearance of the environment and ensure surfaces are in a good condition to clean and maintain.

MATERNITY SERVICES DIRECTORATE

BACKGROUND

The Directorate team, with the support of local link workers and the ICT, has made good progress against the objective set for this period.

Objectives for 2010/2011

- To secure resources to ensure a bed/mattress replacement programme is in place
- To maintain resource for housekeeping services
- To continue with the quarterly audits and regular environment inspections
- To continue to fund link midwives within the clinical area
- To monitor the adherence of compliance for all high impact interventions
- To provide targeted hand hygiene education
- To improve compliance with MRSA screening

METHOD

Hand hygiene audits and environmental audits continue within all clinical areas. Changes to cleaning systems and reallocation of tasks to specific staff groups have been implemented. Targeted teaching for hand hygiene has improved compliance amongst staff groups that had consistently lower levels of compliance.

Environmental inspections provided disappointing results for the intrapartum areas. New systems for cleaning each of the areas have been implemented

regular weekly spot checks are carried out by the leads for IC to ensure that standards are maintained.

A maintenance programme for the intrapartum area was organised to address some minor estate issues that were identified during environmental inspections. Delivery beds were also serviced and repairs carried out in the last quarter of this year. Disposable curtains continue to be successfully utilised within the directorate.

MRSA screening compliance continued to challenge the Directorate for the majority of this period. Targeted teaching and a new system implemented in the post natal area have provided assurance to the Trust during the last quarter.

Mattress audits have been completed bi-annually and replacement bed, cot and resuscitaire mattresses are available within the Directorate to ensure rapid replacement. Intrapartum bed mattresses are audited quarterly.

Collating evidence for the high impact interventions has been challenging. Documentation changes in the labour and birth record and a new HDU booklet were introduced in December 2010 to address audit requirements. A review of equipment has begun and financial support for changes to consumables will be explored to improve compliance with catheterisation.

Housekeeping has been maintained and is currently being reviewed with a plan to increase the resource during the forthcoming financial year.

Monthly directorate meetings continue and are attended by the ward managers and/or the link midwife. The monthly audit results are discussed at this meeting and problems/actions to address poor levels of compliance are explored. Infection control remains a standing item on the agenda for the Maternity Managers meeting.

RESULTS

- Hand hygiene compliance has improved in all areas
- All mattresses are audited and replaced promptly
- Financial support to maintain the use of disposable curtains was secured.
- New cleaning systems to provide assurance have been implemented and are proving highly effective.
- Compliance with high impact interventions is improving, in particular documentation.
- Maintenance programme for the intrapartum areas was completed.
- Feedback from the patient tracker units regarding the cleanliness of the environment is positive
- Compliance with MRSA screening has been achieved.
- Delivery beds serviced and repaired.
- Local meeting with link midwives/managers continue.

CONCLUSIONS

The Directorate has continued to perform well against the audit targets.

MRSA screening compliance is now achieved and the Directorate has continued to provide financial support for all of the identified projects.

The IC links have continued to raise the profile of infection control within the Directorate and the Directorate are pleased to report that all of the objectives set have been achieved.

RECOMMENDATIONS

- To maintain resources to ensure a bed/mattress replacement programme is in place
- To increase resource for housekeeping services
- To maintain compliance with all IC audits
- To maintain the funding for link midwives within the clinical area
- To provide an additional Midwife IC link for the Directorate
- To monitor the adherence of compliance for all high impact interventions
- To provide targeted hand hygiene education if levels of compliance fall
- To maintain compliance with MRSA screening

NEONATAL SERVICES DIRECTORATE

BACKGROUND

The Neonatal Directorate has had a challenging year ensuring that the highest standards of infection control and prevention were maintained. We have continued to work very closely with the Infection Control Team to monitor and limit any incidence of infection.

The Neonatal Unit relocated to our brand new purpose built space on the 8th September 2010. The environment is modern, clean and spacious. However there have been on going concerns following the isolation of pseudomonas aeruginosa from the automatic taps.

We now have six single rooms where we can isolate babies with organisms that cause concern. This has been helpful as we have seen an increase in gram negative multi resistant organisms this year.

Throughout the past year considerable activity has been undertaken to monitor and improve all areas with the potential to cause infection.
Hand Hygiene continues to be at the top of our infection control agenda. Training is mandatory and regular sessions are held by Charlotte King, Neonatal Infection Control Lead, to ensure that staff is up to date
Mattress audits have been completed, on a six monthly basis, both of adult and cot/incubator mattresses.

Antibiotic prescribing continues to be closely monitored within the Directorate on daily ward rounds and also by Dr M Patel, Consultant Microbiologist who attends weekly grand ward rounds on Mondays. There is a Neonatal Formulary, which was reviewed in February 2011, available on the intranet which gives antibiotic prescribing advice. Changes to antibiotic policy have been made throughout the year in response to incidents concerning babies.

Other audits have been completed in compliance with the yearly audit programme including aseptic non touch technique, assessing the environment, high impact interventions, medical equipment cleanliness, waste management, sharps management and standard precautions.

New initiatives

Plastic reusable injection trays are now in use to provide a clean area for the making up and administration of intravenous antibiotics. Each baby has his/her own tray to prevent cross infection. The trays are cleaned with a detergent wipe before and after use. They replace disposable cardboard trays which were not fit for purpose.

Disposable sterile packs for the insertion of long intravenous lines have been purchased. These have been a huge success with medical and nursing staff as everything is in one sterile pack saving time and reducing the risk of cross infection. We are now investigating cost effectiveness of similar packs for umbilical arterial and venous line insertion.

In October 2010 Dr Patel commenced a weekly rectal swab screening programme for all babies on the Neonatal Unit specifically to look for gram negative organisms. This has been successful and has now been incorporated into our routine screening programme.

Following review of practice and the literature between neonatologists and microbiologists our practice of screening oropharyngeal secretions in babies requiring oxygen was stopped. There has also been a reduction in screening endotracheal secretion to three times per week instead of daily. In both these cases it was felt that the rectal screening programme had superseded them. Assessed competency based training in Aseptic Non Touch Technique (ANTT) has commenced for all members of the medical and nursing staff to ensure that our practice is of the highest standard.

Results or outcomes

There have been no cases of MRSA bacteraemia or C Dificile in the Directorate this year. There was one baby with asymptomatic colonisation of MRSA detected on routine screening. This baby was isolated to prevent the spread to other patients.

All babies admitted to the Directorate are routinely screened for MRSA. Mothers admitted to Transitional Care are also routinely screened for MRSA. All new members of staff are also screened.

Results of Hand Hygiene Audits have been variable. Although we have had some excellent hand hygiene audit results we have failed to consistently achieve the benchmark of 95% compliance. Numerous interventions have been put in place this year to achieve the benchmark. We have now launched an on line infection control power point presentation that clinical staff can undertake at the cot side. This has a video of correct hand washing technique embedded within it. This is then followed by a compulsory questionnaire which is returned to the Infection Control Lead. We hope this will highlight any problem areas of compliance and understanding.

Results of Environmental Audits have raised minor issues but are not showing cause for concern. Settlement cracks have developed in some of the internal walls.

Medical equipment audits have been disappointing with equipment found to be dusty. A new system is now in place where damp dusting of equipment is carried out at night. A more robust cleaning schedule for clinical trolleys has also been instigated.

High Impact Intervention Audits have been undertaken and show good results many achieving 100% compliance. However, achieving the required number of observations for each audit has proved to be challenging. These audits have to be undertaken in the clinical area when a procedure is occurring and nurses have expressed difficulty in completing them. Next year we are piloting a self assessment audit in an attempt to increase the number of observations achieved.

CONCLUSIONS

Good progress has been made this year but this will be accelerated in 2011 - 2012 to ensure all audit results are compliant with targets.

RECOMMENDATIONS

- To continue to actively support the prevention and control of infection within the Directorate
- To support the Infection Control Audit Programme.
- To continue to develop robust action plans within the multidisciplinary team to improve the hand hygiene audit results to achieve and maintain a minimum of 95% compliance.
- To continue to work with the nurses and Infection Control Team to develop High Impact Intervention Audits.

GYNAECOLOGY SERVICES DIRECTORATE

BACKGROUND

Cleanliness and monitoring of infection control and prevention measures have continued to be a high priority during 2010-11 within the Gynaecology Directorate. No areas were required to relocate during the year so staff have been able to consolidate practice within existing areas. Ward and departmental managers and their staff have worked extremely hard during the year to maintain a clean and pleasant environment for patients and to ensure regular audits are undertaken to provide assurance.

Ward and departmental managers have prioritised the maintenance and enhancement of the clinical environment. Disposable curtains are replaced either as required or as a minimum annually and window blinds are used in all areas. Furniture used in patient areas has been regularly maintained and is either recovered or replaced if any damage is noted which could compromise adequate cleaning. A system has been implemented on the inpatient wards to identify when equipment has been cleaned and is ready for use and also when bed spaces have been cleaned and prepared for the next patient.

All patients admitted to the wards are now screened for MRSA isolates. Patients for elective procedures are screened at their preoperative assessment visit and patients admitted as an emergency are screened on admission. This latter procedure was implemented from April 2010 in advance of the National requirement for all patients to be screened by December 2010.

Hand hygiene continues to be very high profile and is audited regularly. Results of the audits are publically displayed on designated infection control notice boards in ward areas. Hand gel is available at point of care.

Assurance of the standards of cleanliness and actions taken to reduce the risk of infection is provided through an annual audit programme developed by the Infection Control Nurse Specialist. It has continued to be challenging for ward managers to ensure all required audits are undertaken in a timely manner. A particular challenge is monitoring of High Impact Interventions relating to peripheral venous cannulae and catheters and ensuring sufficient numbers of observations have been undertaken. The majority of peripheral venous cannulae are inserted in other departments prior to arrival on the ward and so target figures have been adjusted accordingly.

The role of link nurse in clinical areas has strengthened and many of the audits are now led by these nurses.

Senior nursing staff actively participate in the Infection Control Committee and the Infection Control Taskforce which has ensured infection prevention and control maintains a high priority. The Head of Nursing provides quarterly Directorate reports to the Infection Control Committee, summarising audit activity and results, any concerns and relevant action plans.

Staff within Gynaecology are required to attend annual mandatory training in Infection Prevention and Control Updates provided by Infection Control Nurse Specialists and attendance is monitored closely by Ward and Departmental managers.

A revised antibiotic formulary for the Directorate has been implemented by microbiologists and pharmacists.

Infection control is a standing item on the agenda of Gynaecology Clinical Improvement Group which meets every 6 weeks.

METHODS

The Infection Control taskforce now undertake regular Environment Inspections. A timetable is developed for the year and each clinical area is inspected by a team from the Taskforce at least annually. In addition, senior nurses in the Directorate undertake additional inspections using the same format and audit tool on a quarterly basis.

Ward and departmental managers ensure that the many audits as described in the Infection Control Annual Audit Programme are undertaken in a timely manner and the Head of Nursing collates all the results in the quarterly Directorate reports. . Action plans have been developed where compliance does not meet the agreed standard. The following methods have been implemented

- Hand hygiene audits are undertaken on inpatient wards on a monthly basis.
- Antibiotic usage is closely monitored. On a weekly basis any patients who have been an inpatient for over 6 days or are known to have required therapeutic antibiotics or who have been readmitted with potential wound or other infection are reported to the Infection Control Team. A Consultant microbiologist then assesses the patient's care to ensure the antibiotic prescription is timely and appropriate.
- Readmission of any patients with a wound infection is reported on the Datix incident reporting system. The Infection Control team are informed and they will under a review of the patient's care to see if there were any preventable factors identified.
- Nursing staff complete forms monitoring peripheral venous cannulation from insertion to removal and this is filed in the patient's healthcare records.
- Nursing staff also monitor and record specific interventions relating to care of catheters
- Mattress and pillow audits are completed 6 monthly and if any defects are identified either during the audit or during routine checking whilst bed making, covers or the actual mattresses are replaced as required.
- Ward managers ensure regular audits of cleanliness of medical equipment and the patient environment undertake.
- Senior nursing staff undertake an environment inspection on a quarterly basis
- Audits have been undertaken with Facilities and Infection control staff on sharps management, waste management, standard precautions and environment.

RESULTS

There were no cases of Clostridium difficile or MRSA, MSSA, Eschericia Coli bacteraemias in the Directorate during the year. Several incidences of MRSA isolates were detected on routine screening of patients.

Hand hygiene audits showed generally good levels of compliance, particularly amongst nursing staff and compliance figures have improved during the year. Ward 8 achieved 95% compliance on 4 occasions, 90% compliance on 4occasions, 85% compliance on 2 occasions and 80% compliance on 2 occasions .

Ward 7 achieved 95% compliance on 2 occasions, 90% compliance on 5 occasions and 85% compliance on 3 occasions. The other 2 months were below 85%

This was due mainly to non compliance by medical staff including anaesthetists on ward rounds, particularly preoperatively. Two particular ongoing issues identified here were ensuring staff are "bare below the elbow" particularly during ward rounds and ensuring that clinicians clean their hands after being in contact with patient bed space even if they have not been in direct contact with the patient. Consultant medical staff are regularly reminded of their responsibilities at Consultant Education Meetings.

Results of both Environmental audits and Standard Precautions Audit reflect the hard ongoing work of staff with only minimal areas of non-compliance which are addressed by the ward/departmental managers as soon as they are noted.

CONCLUSIONS

It is evident that staff continue to take great pride in maintaining the cleanliness and appearance of the patient environment in the Gynaecology Directorate.

Formal monitoring and reporting mechanisms within the Directorate have been consolidated and this has supported all staff in maintaining this as a high priority.

Results in hand hygiene audits, whilst generally improving, have not been as consistent as the Directorate would wish. In 2008/09, the agreed standard of 95% compliance overall was only achieved on one occasion. During 2009/10 it was achieved on 5 occasions and in 2010/11 it was achieved on 6 occasions Ward managers are continually working with staff to challenge any non-compliance observed on an ongoing basis to ensure further improvements in the forthcoming year.

RECOMMENDATIONS

- Continue to feedback results of hand hygiene audits to all staff groups
- Nursing staff to challenge other clinicians who are noncompliant with "bare below the elbows"
- Continued education about hand hygiene responsibilities to all staff groups.
- Raise awareness of staff of results and need to comply with policy for hand hygiene.
- Continue current monitoring processes to provide assurance of effective infection prevention.
- Continue close working relationship with Infection Control Team.

CLINICAL SUPPORT SERVICES DIRECTORATE

BACKGROUND

The Associate Director for Clinical Support and the Operating Theatre Manager have lead responsibility for infection control in the Clinical Support Directorate. They work very closely with department managers and the Infection Control Team to ensure high standards of cleanliness within clinical areas are maintained.

Over the past year the directorate has continued to manage the decontamination service provided by BBraun. Monthly service review committee meetings are held to ensure service delivery is effective and an internal BBraun user group are held to discuss non-conformances.

The areas of focus for this financial year have included:

- Hand hygiene compliance

- Standards of environment and equipment cleanliness
- High impact intervention

OUTCOMES

Results in hand hygiene audits, whilst generally improving, have not been as consistent as the Directorate would wish. The Directorate achieved an overall compliance of 93.4%. Radiology achieved 100% on 6 occasions and was below 90% on 3 occasions. Theatres achieved 95% and above on 3 occasions and achieved 90% and below on 3 occasions. Results of these audits are fed back to staff at staff meetings and audit information is displayed on designated infection control notice boards.

Following the Environmental Audits and Medical Equipment Audits, robust cleaning rotas have been developed and are being closely monitored. Storage rooms have been re-organised, and alternative shelving has been erected for the storage of sterile fluids in Theatres.

High Impact Intervention Audits have also been undertaken in Theatres although it is not a true refection of overall activity for PVC insertion (currently undertaken using 2 individuals).

Urinary catheter insertion audits consistently achieve 100%.

Turnaround times for the decontamination service have been reviewed and adjusted from 8 to 24 hours for most sets.

CONCLUSION

Despite audits being inconsistently completed at the beginning of the year, departmental managers have worked hard to ensure standards of cleanliness are maintained and appropriate action has been taken to reduce the risk of infection.

Further work is required in the forthcoming year to ensure staff compliance and to ensure audits are consistent and meet target levels.

RECOMMENDATIONS

- To continue to improve the consistency of hand hygiene audits to ensure results achieve and maintain a minimum of 95% compliance.

- To progress all Environmental and Equipment action plans ensure all results are compliant with targets.

- To continue to work with the Infection Control Team to develop additional High Impact Intervention Audits.

- Continue with current monitoring processes to provide assurance of effective decontamination.

- Educate medical staff in the advantages of wearing PPE within the anaesthetic area.

- Implement stricter controls for audit process of PVC insertion by introducing daily snapshot of activity. Named individual will take responsibility for this role.

- Support training for 2 members of theatre staff to undertake infection control link nurse course.

MICROBIOLOGY DEPARTMENT

The Microbiology Department has unconditional accreditation with CPA (UK) Limited. It underwent a full inspection in March 2011 at which feedback from the Assessor was positive.

The Department has Standard Operating Procedures describing the communication and investigation of hospital infection control-related issues. There is also an infection control policy entitled *Laboratory Investigation & Surveillance of Healthcare associated Infections Policy* that defines the role of the Microbiology Department in the investigation and surveillance of healthcare-associated infections.

PART 4: OUR STAFF

OCCUPATIONAL HEALTH

BACKGROUND

The Occupational Health service is provided to Birmingham Women's Hospital by a Service Level of Agreement with the University Hospital Birmingham. The purpose of the service is to promote and protect the health and well being of staff in the workplace. This contributes to the protection of patients and staff from the acquisition and transmission of some infectious diseases.

METHODS

Health Assessment prior to employment (previously known as Pre-employment screening)

This is undertaken for all new staff. It includes screening and when indicated immunisation for the following infectious diseases.

Screening	
EPP workers (practitioners of invasive procedures)	**All Health Care Workers**
Hepatitis B	Hepatitis B
Hepatitis C	Measles
HIV	Rubella
	Varicella
	TB

Immunisation Clinics

Clinic sessions have been provided for in employment testing and immunisation.

Seasonal flu (which included H1N1)

16 sessions were provided across the Trust including some dedicated clinics for high risk areas. 304 employees were immunised against seasonal flu, this was an increase from the previous year. The initial uptake was poor however when the number of flu cases in the population became high more staff members took up the opportunity to be vaccinated.

Doctors	Nurses & Midwives	Prof & Tech	Snr Mgt	A & C	Ancillary	AHP	Total
35	76	70	13	62	36	12	304

Inoculation/splash Injuries

Advice on the management and follow-up of inoculation/splash injuries is provided on a daily basis and during the induction of all staff members. Occupational Health and Control of Infection ran an inoculation injuries awareness day in June, staff were given information and advice about inoculation injuries, a short quiz identified knowledge gaps.

60 injuries were reported in the Trust. There is also evidence of other unreported and untraceable incidents.

Doctors and Surgeons reported 45% (27) of incidents and were the largest reporting staff group
Nurse and Midwives reported 36% (22) of the incidents

Delivery Suite & Delivery suite Theatres reported 55% (33) of injuries
Gynae Theatres reported 21% (13) of injuries.

The causes of injuries were
Hollow bore needles 31%
Non – hollow needles 26%
Splash Injuries 13%
Surgical Instruments 23%
Others 7%

CONCLUSIONS

- More incidents were reported this year; this may be due to a better reporting system and a better awareness of the importance of reporting injuries.
- Occupational Health and the Control of Infection team have carried out an audit of injuries; this has been report elsewhere in the report.
- Evidence gathered from the reported injuries indicates that the implementation of sharp safe devices could reduce nearly one third of the injuries.
- Improved use of personal protective equipment particularly eye protection could reduce a number of the splash injuries.
- Injuries caused by suture needles and surgical instruments may indicate that there is a training issue that needs to be addressed.

RECOMMENDATIONS

1. **Prevention of injuries should continue to be a priority; this may be achieved by:**
   - ❖ Continue to ensure displays of information at Ward and Department level are appropriate and up to date
   - ❖ A further focus week in conjunction with Control of Infection
   - ❖ Review of Inoculations Injury audit, issues raised from this should be actioned.

2. **Uptake of flu vaccinations**
   - ❖ Frontline staff need to be encouraged to take up the flu vaccination
   - ❖ High risk areas need to be targeted with dedicated sessions
   - ❖ Staff should be encouraged to take up the vaccination at the first possible opportunity

TRAINING & EDUCATION

BACKGROUND

Training and education in infection prevention and control is central to the effective prevention and control of healthcare associated infections. It is also necessary to ensure compliance with the NHSLA standards and requirements of the Health and Social Care Act 2008. The Health Act places key emphasis on ensuring that prevention and control of health care associated infection (HCAI) is embedded into everyday practice, with staff demonstrating consistent high standards and awareness of infection control.

RESULTS

The Infection Control Team (ICT) continues to contribute to a comprehensive training programme to all disciplines of staff throughout the Trust. We continue to adopt a multi-faceted approach to deliver education, which includes formal presentations, informal training in clinical areas, infection control awareness weeks and regular staff newsletters. The Infection Control Training Needs Analysis (TNA) defines levels of training for all disciplines of staff and is part of the Trust Mandatory and Statutory Training policy.

All training sessions are updated at least annually to reflect national and local policy or initiatives and also include feedback of audit results or emphasis on individual policies as required.

Attendance is recorded centrally on the education database (OLM system), quarterly reports are provided by Human Resources to Directorate Leads who are responsible for monitoring the uptake of training and ensuring that all staff attend relevant training sessions in line with the Infection Control TNA.

Our Infection Control awareness week was held in June 2010, this involved the launch of our '*Blitz the Bugs ….. It's in all our hands'* campaign. Staff participated in quizzes based on key infection control practices, with safe management of sharps and inoculation injuries targeted during the week. Representatives from Occupational Health and Synergy Healthcare were also available throughout the week to provide advice and education to staff.

All Departments now have identified link practitioners, who have taken on increased responsibility this year in leading the locally led audit programmes. Forums have now been established in both Maternity and Gynaecology Directorates, which provide an opportunity for the Infection Control Nurses and the link practitioners to meet on a regular and more formal basis.

CONCLUSIONS

A comprehensive training programme continues to be provided by the Infection Control Team, providing a wide range of educational activities. Hand hygiene continues to be a key element in all Infection Control training sessions at induction, as part of update training programmes and in response to local audit results.

RECOMMENDATIONS

To further develop the structure of the Maternity and Gynaecology forums to provide an informative and educational framework for the link practitioners.

PART 5: OUR PUBLIC

REPORT OF INFORMATION PROVIDED TO THE PUBLIC

BACKGROUND

The Trust is committed to providing information on healthcare-associated infections to the people we serve. This is included in public displays throughout the hospital, Infection Control awareness days and an information leaflet which describes what the Trust is doing to prevent and control healthcare associated infections, which is sent out to patients with all appointment or booking information.

OUTCOMES

Throughout the year a number of initiatives have been completed to provide information and raise awareness of Infection Prevention and Control:

- Launch of our 'Blitz the Bugs' campaign to reinforce and communicate key Infection Control messages to the public.
- Regular update of the Infection Control information board which is displayed in main reception for public access.
- Continued display of information at Ward and Department level on Infection Control notice boards, including key Infection Control messages and audit results of hand hygiene compliance, environmental cleanliness standards and High Impact Interventions.
- Production of an abbreviated version of the Trust Annual Report, highlighting the key points from the full report that would be of interest to our staff and our public.
- Our Infection Control Focus Week took place in June 2010. This involved displays, quizzes, an opportunity to test individual hand hygiene technique using the ‘Glo & Tel’ hand inspection unit and a chance for the public to meet the Infection Control Nurses and Infection Control Leads.
- Updates on Infection Prevention and Control in the Trust newsletter – Women’s Progress.
- Further development of our sections on the Trust Internet site and Intranet pages.

RECOMMENDATIONS

Continue to develop and update the information that is displayed throughout the Trust.

Ensure our patient information leaflets meet the requirements of the Health and Social Care Act 2008, and the needs of our users.

PART 6: ASSURANCE

COMMITTEES & REPORTING

INFECTION CONTROL COMMITTEE

The Infection Control Committee met on the following dates:

22 April 2010
22 July 2010
21 October 2010
13 January 2011

INFECTION CONTROL TASK FORCE

This group operated regularly throughout the year, with the focus more on environmental inspection than on meetings. A new Observation Tool and Action Report Form were introduced in June 2010, and a more detailed report of the inspection programme is included elsewhere in this report.

CLINICAL GOVERNANCE GROUP

Quarterly reports were made to the CGG in April 2010, July 2010, October 2010 and January 2011.

THE CARE QUALITY COMMISSION AND COMPLIANCE WITH THE HYGIENE CODE

The Care Quality Commission (CQC) has registered, and therefore licensed, Birmingham Women's NHS Foundation Trust to provide services. The essential standards of quality and safety that must be met for registration include a requirement that patients are cared for in a clean environment where they are protected from infection (that is that we comply with the Hygiene Code).

This Annual Report of the Director of Infection Prevention & Control provides evidence of compliance against each of the ten criteria of the Hygiene Code.

RESPONSES TO GUIDANCE & DIRECTIVES FROM THE DEPARTMENT OF HEALTH & OTHER BODIES

- *The Health & Social Care Act 2008 (Revised December 2010)*
  A further revised Hygiene Code again contained few changes that were relevant to the acute sector. As in recent years, the Annual Programme for Infection Control 2010-11 follows the format of the Hygiene Code, and includes actions that have been identified to ensure ongoing compliance with the Code.

- *Department of Health Water Sources and Potential for Infection from Taps and Sinks Gateway 14720 27 August 2010*
  This alert highlighted the risks associated of bacteria being transmitted from taps and sinks, a matter that became of importance following the opening of the new Neonatal Unit in September 2010 (see Untoward Incidents chapter).

- *NHS West Midlands Serious Incidents (SI) reporting Policy and Procedure*
  Infection-related incidents are managed and reported in accordance with this document.

- *NHS West Midlands minimum data set toolkit for healthcare associated infections*
  The Infection Control Team began reporting these data in November 2010.

- *Extension of DH Mandatory Surveillance of bloodstream infections to include meticillin-sensitive Staphylococcus aureus (MSSA) and E.coli*
  The Infection Control Team has had arrangements in place to report bloodstream infections with MSSA on the national hcai website since January 2011. Guidance on reporting of *E. coli* infections is still awaited. The Trust has decided that all bloodstream infections with MSSA and *E. coli* will be investigated by root cause analysis. All clinical staff have received a letter outlining their responsibilities in preventing and responding to these infections.

PROGRESS AGAINST INFECTION CONTROL PROGRAMME 2009-2010

Criterion 1	Systems to manage & monitor the prevention & control of infection

Subject	Objective	Priority	Lead individual	Target date	Status at end of Q4
Decontamination Lead	See under Criterion 2				
Audit programme	Undertake audit of key infection control policies & practices • Standard Precautions • Isolation Policy • Safe Handling & Disposal of Sharps • Hand Hygiene Facilities • Aseptic Technique	HIGH	JS Matrons	March 2011	Completed
	Undertake audits to ensure environmental standards are maintained: • Medical equipment cleanliness • Environmental and cleanliness standards • Ward Kitchens • Mattress & Pillows • Waste Management	HIGH	Matrons/ HoN's/HoM's GA/PC	On-going	Completed
Multidisciplinary Environment Audits (IC Task Force)	Agree a programme of audits for the year	HIGH	JO	April 2010	Completed
Hand Hygiene Compliance	Establish a working group to lead on improving and sustaining hand hygiene compliance at all clinical areas Implement actions at local level and provide exception reports where compliance falls below 95%	HIGH HIGH	JO & Matrons Dept Managers/ Matrons	May 2010 On-going	Completed

High Impact Interventions	Continue to undertake audits of high impact interventions. • Central venous devices • Peripheral venous devices • Urinary catheters • Ventilator Care Improve ownership of programme in clinical areas	HIGH HIGH	Matrons/JS Matrons	On-going	Completed
	Review Care Bundle for Cleaning & Decontamination & incorporate into audit programme		Matrons/JS		Completed
Audit feedback and action plans	Develop ownership at Department/Directorate level . Ensure systems are in place to feed back/review audit results, produce action plans & re-auditing where required.	HIGH	Matrons/ Ward & Dept Managers	July 2010	Completed
	Explore the use of IT systems to support collation and feedback of Trust wide audit data	Moderate	JS/IT Dept	July 2010	Completed
Infection Control Resources at Department Level	Establish a system to provide support and education to department based IC Link practitioners	Moderate	JS/ Dept Managers	June 2010	Completed.
Local infection surveillance	Continue to participate in mandatory MRSA bacteraemia surveillance	HIGH	JG	Ongoing	Completed
	Continue to participate in mandatory *C. difficile* surveillance				
	Continue to participate in mandatory GRE bacteraemia surveillance				
Infection Prevention & Control Committee	Undertake annual review of membership & terms of reference	Moderate	JG/JO	July 2010	Completed
MRSA screening	Review experience of screening of obs screening	HIGH	JG	April 2010	Completed
	Introduce screening of emergency Gynaecology admissions	HIGH	JC	April 2010	Completed

Criterion 2	Clean & appropriate environment

Subject	Objective	Priority	Lead individual	Target date	Status at end of Q4
Decontamination	Review the management of decontamination, taking account of three roles defined in the Hygiene Code: • Decontamination Lead • Lead for Cleaning • Lead for Decontamination	HIGH	JO	June 2010	Completed
	Review cleaning, disinfection and decontamination policy to ensure that requirements under 2.1, 2.5 and 2.6 of the Hygiene Code are addressed.	HIGH	JG/JS	May 2010	Completed
	Mattresses Ensure that Ward Managers understand and execute their responsibilities in relation to: • Ensuring staff awareness of the Mattress Policy • Having in place a system for local regular mattress checking	HIGH	Matrons	Sept 2010	Completed
Hand hygiene & uniform policy	Reinforcement of key messages via the Trust ‘ Blitz the Bugs’ campaign • Hand Hygiene • ‘Bare below the elbows’	HIGH	JS	June 2010	Completed

Criterion 3	Suitable & accurate information on infections to service users and their visitors

Subject	Objective	Priority	Lead individual	Target date	Status at end of Q4
Patient & public information	Launch ‘Blitz the Bugs campaign’	HIGH	JS	May 2010	Completed
	Develop promotional material for display at hospital and ward entrances promoting as part of ‘Blitz the Bugs’ campaign	HIGH	JS	June 2010	Completed
	Review and update the information on the IC information Board in main reception	Moderate	JS	August 2010	Completed
	To have at least one Infection Control Focus week throughout the year	Low	JS/CK	Sept 2010	Completed
Ward notice boards	Review information displayed at ward level to ensure that it is consistent and reflects requirements	Moderate	JS/ Matrons	July 2010	Completed
System for reporting breaches of hygiene & cleanliness	Review current process for collating & reporting of information on cleanliness breaches	Moderate	JO	September 2010	Completed
	Implement any actions arising from the above review	Low	GA	December 2010	Completed
Website & Trust Intranet	Ensure all information is renewed and updated as required	Moderate	JS	On-going	Completed

Criterion 9	Infection Control Policies

Subject	Objective	Priority	Lead Individual	Target date	Status at end of Q4
Antibiotic prescribing	Develop and implement systems for monitoring and reporting antimicrobial use	HIGH	MP	September 2010	Completed
C. difficile diagnosis	Monitor impact of changes to laboratory methods for *C. difficile* testing via quarterly reporting to ICC	HIGH	JG	Ongoing	Completed
Policy on control of acinetobacter & other antibiotic-resistant Gram-negative bacteria	Produce new Infection Control Policy	Low	JG	September 2010	Completed
Policies on control of respiratory viruses and diarrhoeal infections	Produce new Infection Control Policies	Moderate	JG	June 2010	Completed

Criterion 10	HCWs are free of, and protected from exposure to, infections, and that staff are suitably trained

Subject	Objective	Priority	Lead individual	Target date	Status at end of Q4
Medical staff training	Develop and implement new means of training in infection control	HIGH	JG	June 2010	Completed
	Develop and implement new means of training in antimicrobial prescribing	HIGH	MP	June 2010	
Training & development of IC Nurses	Ensure that ICNSs have appropriate PDPs	HIGH	JO	March 2011	Completed
Monitoring of training	Ensure training uptake is monitored	HIGH	Matrons	July 2010	Completed
Reduction of sharps injuries	Undertake an appraisal of the feasibility, likely effectiveness and costs of using Safety-Engineered Sharp Devices at Birmingham Women's Hospital	Moderate	JG/JS	January 2011	Completed

INFECTION CONTROL RISKS

BACKGROUND

The infection control risk register was successfully transferred onto the Trust's new Datix Risk Register during 2009/10.

RESULTS & CONCLUSIONS

There are currently 13 infection control risks on the risk register, with no risk scoring greater than 12. 8 risks were closed during the year, and 2 risks were added.

All infection control risks are reviewed on a quarterly basis by the Infection Control Committee, which reports to the Clinical Governance Committee. Any important risk-related matters can also be brought to the attention of the Clinical Governance Committee via the quarterly Infection Control Report.

RECOMMENDATIONS

Although there has been progress in ensuring that the infection control risk register remains a 'live' document, further work is required to ensure that it reflects the current risks with respect to HCAI.

APPENDIX 1: TABLE REFERENCING THIS REPORT AGAINST THE HEALTH & SOCIAL CARE ACT 2008: *CODE OF PRACTICE*

Code of Practice criterion	Section of Report						
	Part 1	Part 2	Part 3	Part 4	Part 5	Part 6	Appendix 2
1: Have in place & operate effective management systems for the prevention & control of HCAI	√	√	√	√		√	√
2: Provide and maintain a clean and appropriate environment		√	√				
3: Provide suitable and sufficient information on HCAI to the patient, the public, and other service providers					√		
4: Ensure that patients with an infection are identified promptly and managed appropriately		√	√			√	√
5: Gain the cooperation of staff, contractors & others in preventing & controlling infection				√			
6: Provide adequate isolation facilities		√	√				
7: Secure adequate access to laboratory support							
8: Have and adhere to policies for the prevention of HCAI		√	√	√		√	
9: Staff are free of, and protected from, infection and are suitably educated				√			

APPENDIX 2 - UNTOWARD INCIDENTS

Patients unknowingly exposed to a case of open tuberculosis (TB)
On 14 April 2010 the Trust was informed that a woman who had been an inpatient on Ward 5 from 17-18 February 2010 had been diagnosed as having open TB. It was confirmed that the case was coughing at the time of her admission to the Women's Hospital. Three women and their babies had same-bay contact with the case. An Outbreak Control Group was established to manage the incident. All of these were contacted and referred to their local chest clinic for follow-up: none were found to have evidence of having contracted TB.

Increased prevalence of alert Gram-negative bacteria (including *Pseudomonas aeruginosa*) on the new Neonatal Unit (NNU)
In preparation for the move to the new NNU in September 2010, the routine surveillance of babies was extended to include rectal swabs. The reasons for this were:

a) Concern that there may be a decline in infection prevention and control standards due to staff being unfamiliar with their new working environment;
b) International, national and local evidence of increasing antibiotic resistance in Gram-negative bacteria on NNUs; and
c) Knowledge that the gastrointestinal tract is often the first site of colonisation with these bacteria.

By November 2010 it became clear that there a number of Gram-negative bacteria were being isolated from babies on the NNU at a higher than expected frequency, including *Serratia* spp., antibiotic-resistant *E. coli*, and most importantly *Pseudomonas aeruginosa*. Between November 2010 and March 2011 two babies died of sepsis with *P. aeruginosa*. An outbreak control group was established to manage the issue, the first meeting being on 18 November 2010. Actions have been taken in relation to the general increase in Gram-negative bacteria, and specifically in relation to the increase in *P. aeruginosa*.

General measures

- Promotion and increased monitoring of hand hygiene
- Regular environmental inspections to identify and correct areas of poor infection control practice.
- Environmental sampling (unrevealing apart from detection of *P. aeruginosa* in sinks and taps (see below).
- Changed antibiotic policy to ensure that babies were treated with agents active against the prevalent nosocomial pathogens.

Measures specifically in relation to *P. aeruginosa*
It was established early on that taps were a possible source of these bacteria. In accordance with recent DH guidance (see chapter Responses to guidance & directives from the Department of Health & other bodies) staff and visitors were asked to use alcohol gel after hand washing. This, and other measures such as using sterile water to bath babies, led to a reduction in the number of

babies acquiring *P. aeruginosa* to a lower, but not normal level. PALL bacterial filters were then applied to all taps in clinical areas, which appears to have been associated with a reduction in rates of acquisition of *P. aeruginosa* to the long-term expected rate.

Extensive investigation of the electronically-operated hands-free taps in conjunction with the manufacturer has so far not resolved the issue. However, a number of observations have been made:

- There is evidence of contamination of the cold water supply with *P. aeruginosa*, and of a direct inverse relationship between taps usage rates and the amount of bacteria in the water.
- Moreover, the amount of water usage on the NNU was far below the expected level.
- The inner parts of the taps are largely free from *P. aeruginosa*.
- The plastic flow straighteners on the ends of the taps were the most consistently contaminated past of the system.

We are currently investigating whether the presence of *P. aeruginosa* is primarily a problem of the water supply being contaminated, compounded by the low level of water usage, or whether there is a fundamental design fault with the taps.

Isolation of group A streptococci (GAS) from three maternity cases
Three women were identified to have infection with GAS, all of whom had delivered in the Birth Centre between 20-21 February 2011. An Outbreak Control Group met on 4 March 2011 to manage this incident of possible hospital acquisition of GAS. Control measures included screening hospital and community-based staff for carriage of GAS, which was unrevealing. Typing results of the three isolates of GAS became available later, which showed that they were unrelated. This incident was therefore not an outbreak of infection.

Diarrhoea and vomiting

Only a small number of staff reported symptoms of diarrhoea and vomiting during the year: all of these reports affected only small numbers of staff in the same clinical area. There were four instances in total which occurred on the Neonatal Unit and affected between 2-4 members of staff. There was one instance of diarrhoea and vomiting which affected 4 patients on Ward 8, when patients were successfully cohort nursed in a 4 bedded bay whilst affected. None of the episodes had any impact on the operation of the hospital.

ENCLOSURE 13

SUBJECT :	Corporate Objectives – 2011/12
REPORT BY :	Steve Peak - Chief Executive
AUTHOR :	Steve Peak - Chief Executive

CONTEXT AND BACKGROUND FOR REPORT

This paper sets out the draft corporate objectives for 2011/12 for consideration by the Board of Directors.

KEY ISSUES FOR BOARD OF DIRECTORS' CONSIDERATION AND DECISION

The objectives have been established following the planning process and consideration of the key issues facing the organisation. Each objective is set within the context of the Trust's strategic objectives:

- Attain & maintain top quartile quality & safety outcomes where comparisons exist by 2013/14
- Deliver at least 5% productivity improvements each year for the next three years
- Deliver at least 1% net growth year on year for the next three years
- Maintain current service portfolio
- Develop partnerships where necessary to achieve the above

For each objective there are a set of deliverables, timescales or milestones and an identified lead Director.

The draft has been presented to and considered by the Member's Council, at its meeting on 17th May 2011. Council was broadly content with the objectives proposed; however, there was a suggestion that the Board consider whether an objective related to engagement with emergent GP consortia, given the expected move to GP Consortia commissioning, should be added.

ENCLOSURE 13

RECOMMENDATIONS

The Board is invited to:

- Consider and approve the corporate objectives for 2011-2012
- Agree a process for sharing within the organisation
- Note the requirement for reporting progress on a quarterly basis

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Strategic objectives 2011/12 – 2014/15

Objective One
Attain & maintain top quartile quality & safety outcomes where comparisons exist by 2013/14

Objective Two
Deliver at least 5% productivity improvements each year for the next 3 years

Objective Three
Deliver at least 1% net growth year on year for the next 3 years

Objective Four
Maintain current overarching service portfolio – Gynaecology, Neonatal, Maternity, Laboratory and Clinical Genetics

Strategic Objectives Supported by The Trust's Organisational Development programme:

Staff engagement & reward/recognition
Leadership development
Service Line Reporting/Management
LEAN principles
Seek where possible innovative partnerships to achieve strategic objectives
The BWH patient care pledge

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Target Strategic Objectives	Annual Corporate objective	Key success factors	Key dates	Lead(s)
One - Attain & maintain top quartile quality & safety outcomes where comparisons exist - 2013/14	Embed our standardised patient feedback approach to facilitate improvements in patient services	• Directorate level reports • Board/Members' Council reports • Colleague recognition awards • Information for 2012/13 planning	Monthly - April Monthly/Qrtly Monthly Ongoing	JO
	Continue to develop our safety & quality agenda through: • The development of the Friday metrics. • Continuation of the current Board & Governor safety walkabouts • Maintain infection control standards and compliance with The Hygiene Code 2008 • The introduction of the Board level Quality & Safety dashboard & report • Continue to implementing the use of the NPSA toolkit for all relevant cases • Quality Accounts published	• Actions from safety walkabout published • Zero MRSA and C Diff cases • Post operative infection rates requiring in-patient re-admission from 1.7% to 0.7% or below • Quality & safety dashboard	Ongoing Quarterly Monthly April 2012	PT SPk PT/JO PT/JO
	Corrected Neonatal mortality rate from 3.9 per thousand births (12 month rolling average) to 3.5	▪ Extended Consultant presence on the NNU ▪ Administration of surfactant within 1 hour of birth for babies under 28 weeks gestation ▪ Consultant presence for inborn births before 25 weeks for resuscitation when required by the Trust's early care guideline	Ongoing	PT
	Implement the BWH Pledge	▪ Board sign off ▪ Specific training events ▪ Included in PDP & Board appraisals	April Ongoing Ongoing	NS

		▪ Features within staff induction	Ongoing	

Target Strategic Objectives	Annual Corporate objectives	Key success factors	Key dates	Lead(s)
One - Attain & maintain top quartile quality & safety outcomes where comparisons exist - 2013/14	Corrected Still birth rate from 4.1 per 1000 births (12 mth rolling average) to 3.8	▪ Surgical safety checklist implemented for elec/emerg c/s ▪ Increasing fetal growth restriction detection to 35%	Ongoing	PT
	Maintain inpatient gynaecology satisfaction levels in top 20% for all Trusts	Respond to patient feedback following the introduction of the feedback system	Ongoing	JO
	Improve Gynaecology outpatient satisfaction levels from an average position when compared nationally to a top 20% position	▪ Implement actions from previous plan following the 2010 survey ▪ Develop a plan based upon the feedback received through the new patient feedback system	March 2012	JO
	Improve maternity good to excellent satisfaction rates from an average position for all Trusts to a top 20% position	Develop a plan based upon the feedback received through the new patient feedback system	Sept 2011	JO
	Unscheduled returns to theatre to fall from 30 cases per annum (0.6% of all cases) to 25 cases in a 12 month period (0.5% of cases)	• Surgical Safety Checklist in place • Audit meetings	March 2012	PT
	Normal delivery rate from 61% to 65%		March 2013	JO
	Maintain current miscarriage rate following CVS and Amniocentesis of 0.53% and 0.7%		March 2012	PT
	Maintain unconditional CPA, HTA and HEFA accreditation for our labs and services	Accreditation	Ongoing	PT
	Increase Breast feeding initiation on transfer to Health Visitors to 70%	Baby Friendly level 3 status to raise the profile of breast feeding within the Trust	March 212	JO
	Maintain early pregnancy booking at >90%		Ongoing	JO
	Fertility rates through Fertility Centre to rise from 38% to 45%		March 2014	PT

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	Greater than 95% of In-patients requiring continue to be screened for VTE		Ongoing	PT
Target Strategic Objectives	**Annual Corporate objective**	**Key success factors**	**Key dates**	**Lead(s)**
One - Attain & maintain top quartile quality & safety outcomes where comparisons exist - 2013/14 Two - Deliver at least 5% productivity improvements each year for the next 3 years	Revise the current draft IM&T strategy to achieve a signed off final version with agreed & timed actions for 2011/12	• Agreed IM&T Strategy signed off by the board • Action plan for 2011/12 & 2012/13 • Delivery of agreed actions	July 2010 March 2012	JB JB
	Achieve CNST level 2 for Maternity and acute standards	• Project Plan milestones	Nov 2011	JO/ PT
	Implement Lorenzo IT programme	▪ Early adopter status - care plans ▪ Request/results module implemented	March 2012	JB
One - Attain & maintain top quartile quality & safety outcomes where comparisons exist - 2013/14 Two - Deliver at least 5% productivity improvements each year for the next 3 years Three - Deliver 1% net growth year on year for the next 3 years	Implement the maternity capital scheme to: ▪ Facilitate improvements in the environment & increase the capacity to move to 8000 births ▪ Improve the patient care environment within fetal medicine outpatients	▪ Project updates at Board ▪ Recruitment to business case levels ▪ Delivery bookings increased ▪ Completed scheme	Jan 2012	NS/JO
	All CQUINs are delivered as per the targets	▪ Quarterly monitoring in place and feedback via the Board ▪ All CQUINs delivered	Quarterly March 2012	JO/PT JO/PT
	Achieve a year end surplus of at least £400k and a year end FRR of 3	• Planned productivity and income schemes delivered • SLM embedded	March 2012 Ongoing	All JB
	Continue with the Trust's OD programme • Listening into Action • Reward & recognition • Leadership development • Service Line Reporting/Management	Appraisal rates at >85% Range of specific engagement events Monthly & annual recognition awards Long service awards Social events	Ongoing	All

	• LEAN principles	Agreed LEAN projects (Newton) Directorate & Board financial reporting Staff survey results		

Target Strategic Objectives	Annual Corporate objective	Key success factors	Key dates	Lead(s)
One - Attain & maintain top quartile quality & safety outcomes where comparisons exist - 2013/14 Three - Deliver 1% net growth year on year for the next 3 years	Continue to develop Directorate action plans to build upon the Trust's agreed academic strategy	▪ Recruitment numbers to portfolio studies are increased ▪ Maintain the number of national grants held	Ongoing	SPk
	Ensure that Governors receive the appropriate training and development to support them in their updated roles in relation to the current Health Bill	▪ Specific needs assessment carried ▪ Tailored training and development sessions ▪ Feedback form Governor colleagues on the success of the development	March 2012	SPs