Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Wednesday 29th April 2015, time 1300 – 1700 hrs
Trust Conference Room, Warrington Hospital

1300 ***20mins***	***W&HHFT/TB/15/065***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/15/066	***Minutes of the previous meeting held on 25th March 2015***	Paper	
	W&HHFT/TB/15/067	***Action Plan***	Paper	
1310 ***10mins***	***W&HHFT/TB/15/068***	***Chairman's Report***	Verbal	Chairman
1320 ***20mins***	***W&HHFT/TB/15/069***	***Chief Executives Report***	Verbal	Chief Executive

Quality

1340 ***05mins***	***W&HHFT/TB/15/070***	***Verbal Report from the Chair of the Quality Governance Committee***	Verbal	Mike Lynch, Non-Executive Director
1345 ***15mins***	***W&HHFT/TB/15/071***	***Quality Dashboard – 31st March 2015***	Paper	Director of Nursing and Governance / Medical Director
1400 ***15mins***	***W&HHFT/TB/15/072***	***Q4 Infection Control Report***	Paper	Director of Nursing and Governance /Medical Director
1415 ***10mins***	***W&HHFT/TB/15/073***	***Dementia CQUIN update***	Paper	Director of Nursing and Governance
1425 ***10mins***	***W&HHFT/TB/15/074***	***Q4 Complaints Report***	Paper	Director of Nursing and Governance
1435 ***10mins***	***W&HHFT/TB/15/075***	***Medical Staff Revalidation Report 2014/15***	Paper	Medical Director
1445 ***10mins***	***Break***			

People

1455 ***05mins***	***W&HHFT/TB/15/076***	***Verbal Report from the Chair of the Strategic People Committee***	Verbal	Anita Wainwright, Non-Executive Director
1500 ***10mins***	***W&HHFT/TB/15/077***	***Workforce and Educational Development Key Performance Indicators***	Paper	Director of HR & OD
1510 ***20mins***	***W&HHFT/TB/15/078***	***i. Monthly Ward Staffing Report*** ***ii. 6 month Ward Staffing Report***	Papers/ Presentation	Director of Nursing and Governance

Sustainability

1530 ***05mins***	***W&HHFT/TB/15/079***	***Verbal Report from the Chair of the Finance and Sustainability Committee*** ***i. Terms of Reference of the Board Oversight Group - Lorenzo***	Verbal	Terry Atherton, Non-Executive Director
1535 ***15mins***	***W&HHFT/TB/15/080***	***Finance Report – 31st March 2015***	Paper	Director of Finance & Corporate Development

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1550 ***15mins***	***W&HHFT/TB/15/081***	***Corporate Performance Report – 28th February 2015***	Paper	Chief Operating Officer
1605 ***10mins***	***W&HHFT/TB/15/082***	***Radiology Update***	Paper	Chief Operating Officer
1615 ***10mins***	***W&HHFT/TB/15/083***	***Corporate Risk Register***	Paper	Director of Nursing and Governance
1625 ***10mins***	***W&HHFT/TB/15/084***	***Board Assurance Framework 2014/15 and update on progress for 2015/16 against new agreed strategic objectives.***	Paper	Director of Nursing and Governance
1635 ***15mins***	***W&HHFT/TB/15/085***	***Q4 Monitor Quarterly Reporting Compliance Report***	Paper	Director of Finance & Corporate Development
1650 ***10mins***	***W&HHFT/TB/15/086***	***Other Board Committee Reports:*** ***Minutes for Noting:*** ***a) Minutes of the Strategic People Committee 9 February 2015*** ***b) Minutes of the Quality Governance Committee 13 January 2015*** ***c) Finance and Sustainability Committee held on 17 March 2015***	Paper	
	W&HHFT/TB/15/087	***Any Other Business***		
1700 ***ends***		***Dates of next meeting*** *27th May 2015*		

W&HHFT/TB/15/067

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 29th April 2015

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
28/01/2015	TB/15/008	The Director of Nursing and Governance review the reporting of heart failure on the dashboard to see if there was a more appropriate way of showing the position. Any changes would be included in the Quality Dashboards for 2015/16.	The Director of Nursing and Governance May 2015	As part of the refresh of the Quality Dashboard for 2015/16. April 2015 Dashboard will incorporate reporting requirements.	Action ongoing
28/01/2015	TB/15/011	The Director of Nursing and Governance provide an update on progress on End of Life Care at the June or July 2015 Board meeting	The Director of Nursing and Governance - June/July 2015	Identified on the Board work plan – anticipated date September/October 2015	Action Complete

BOARD OF DIRECTORS

WHH/B/2015/ **068**

SUBJECT:	**Chairman's Report**
DATE OF MEETING:	29th April 2015
DIRECTOR:	Chairman

BOARD OF DIRECTORS

WHH/B/2015/ **069**

SUBJECT:	**Chief Executive Report**
DATE OF MEETING:	29th April 2015
EXECUTIVE DIRECTOR:	Chief Executive

BOARD OF DIRECTORS

WHH/B/2015/ **070**

SUBJECT:	**Verbal Report from the Chair of the Quality [Governance] Committee**
DATE OF MEETING:	29th April 2015
DIRECTOR:	Mike Lynch, Non-Executive Director

BOARD OF DIRECTORS

WHH/B/2015/ **071**

SUBJECT:	**QUALITY DASHBOARD (2014/2015) APRIL 2015**
DATE OF MEETING:	29th April 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Simon Constable, Medical Director
LINK TO STRATEGIC OBJECTIVES:	All Choose an item. Choose an item.
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	The Quality Dashboard provides a monthly update on KPIs for 2014/2015 from the:- • CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required). • Quality Contract • Quality Account - Improvement Priorities • Quality Account – Quality Indicators • Sign up to Safety – national patient safety topics • Open and Honest Exception reports are included for non-compliant indicators including. Please note that VTE and dementia are extracted for the purpose of the QDB in advance of submission via UNIFY at months end and may not show compliance with the

	threshold. (VTE – 95% and Dementia – 90%). This will be updated in the May QDB.	
RECOMMENDATION:	***The Board is asked to:*** 1. Note that the data for a number of indicators can change month on month. This applies to incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased. 2. Note progress and compliance against the key performance indicators 3. Approve actions planned to mitigate areas of exception	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1. Key Performance Indicators

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Intelligent Monitoring																			
Banding March 14 = 5	Not set						3						5		CQC Inspection				
Number of elevated risks March 2014 = 1	Not set						2						1		CQC Inspection				
Number of risks March 2014 = 4	Not set						5						3		CQC Inspection				
Safety																			
Mortality																			
HSMR (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	98	98	98		98	98	99		101	102	105		107				107
SHMI (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	109	110	110		110	112	111		112	112	115						115
Total deaths in hospital	Not set		99	89	76	264	74	81	97	252	95	80	133	308	136	84	89	309	1133
Regulation 28 - Prevention of future deaths report	Not set		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Incidents resulting in Moderate, Major or Catastrophic harm																			
Incidents resulting in moderate, major or catastrophic harm	TBC	QC	6	9	6	21	4	5	9	18	6	7	7	20	1	1	0	2	61
Incidents of moderate, major or catastrophic harm under investigation	N/A		1	0	2	3	0	0	2	2	1	0	10	11	7	21	38	66	82

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Falls																			
All falls (approved)	Not set		91	78	87	256	88	76	79	243	71	68	91	230	69	77	86	232	961
Moderate, major and catastrophic harm falls (approved)	<=13 per year	IP	1	3	2	6	1	2	3	6	0	4	0	4	0	0	0	0	16
Moderate, major and catastrophic harm falls (awaiting approval)	N/A		0	0	0	0	0	0	0	0	0	0	2	2	4	2	1	7	9
Major and catastrophic harm falls (approved)	<=2 per year	QC	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Pressure Ulcers																			
Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	IP	1	1	0	2	0	0	0	0	2	0	0	2	0	1	0	1	5
Grade 3 and 4 Hospital Acquired (Unavoidable)	<=10	QC	0	0	0	0	1	0	2	3	0	0	1	1	0	0	0	0	4
Grade 3 and 4 Hospital Acquired (Under review)	N/A		0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
Grade 2 Hospital Acquired	<=101 per year	IP	3	8	2	13	11	3	3	17	9	5	8	22	7	3	4	14	66
Grade 2 Hospital Acquired – stretch target	<=90 per year	IP	3	8	2	13	11	3	3	17	9	5	8	22	7	3	4	14	66

(20% reduction)																			
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Grade 2 Hospital Acquired (under review)	N/A		0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	3	3
% RCA / mini investigation completed	100%	IP	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
% of patients with a pressure ulcer (Community or hospital acquired) (ST)	<=3.99% (November 2014 – March 2015) (median YTD)	C	4.92	3.07 amended	3.73		3.37	5.63 amended	4.95		4.34	5.90	4.65		3.60	5.20	4.59		RM 4.62
Health Care Acquired Infections																			
MRSA	0= green, 1-5=amber, >5 red	QC, IP	0	1	0	1	0	0	1	1	0	0	1	1	0	0	0	0	3
Clostridium difficile	<=26 per year	QC, IP	2	3	2	7	1	7	1	9	3	1	3	7	1	2	5	8	31
MSSA	Not set		1	0	1	2	1	0	0	1	1	1	2	4	2	2	1	5	12
Out of hours transfers	TBC	BK	1	2	5	8	1	5	1	7	3	0	7	10	3	3	1	7	32
Never Events	0 per year	QC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of cardiac arrests in hospital wards, outside A&E, Theatres, CCU and ICU'.	Annual: <75 = G 75 – 85 = A >85 = Red	QC	8	11	7	26	3	13	6	22	5	7	13	25	12	5	6	23	96
Medicines Safety Thermometer % harm free (ST)	TBC	IP	PILOT	PILOT	PILOT		PILOT	PILOT	98.3		99.2	97.4	99.2		Quarterly Reporting	Quarterly Reporting			

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
VTE																			
% of patients risk assessed	>=95%	QC	95.55	95.92	95.61		95.33	95.30	95.31		95.64	95.91	95.47		95.27	96.83	92.59*		
% of eligible patients having prophylaxis (ST)	100%	QC	92	99.8	93		100	99.6	100		100	100	100		99.83	100	100		
Number of patients who developed a HA VTE	Baseline TBC	QC	7	8	5	20	12	4	3	19	6	4	1	11	Delay due to late coding	Delay due to late coding			50
Number of patients who developed a HA VTE (under review)			0	0	1	1	1	5	4	10	8	2	4	14	2	6			33
% free from harm (ST)		OH	97.3	99.2	97.8		98	96.4	98		97.4	96.5	98		97.2	96.6	98.4		
Catheter Acquired Urinary Tract Infections																			
CA – UTI: Number of catheterised patients who developed a UTI (ST)	<=3 per month <=36 annual	IP	4	2	2	8	2	4	5	11	0	5	1	6	2	2	2	6	31
CA – UTI % of catheterised patients who developed a UTI (ST)	<=0.6% each month	IP	0.76	0.38	0.39		0.40	0.89	0.99		0	0.92	0.19		0.34	0.40	0.36		
Dementia																			
Dementia Assessment % (Part 1)	>=90%	C	94.55	95.69	95.43*		94.26	96.59	92.45		92.70	96.61	96.29		96.93	94.81	97.17		
Dementia Assessment % (Part	>=90%	C	100	100	100*		100	100	91.89		100	100	97.22		96.77	100	95		

2)																			
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Dementia Assessment % (Part 3)	>=90%	C	100	100	100*		100	100	100		100	100	100		100	100	100		
Care Indicators																			
Falls - risk assessment % compliance	>=95%	IP	100	95	95	96.6	98.8	98.9	98	98.7	99	98	99	97	90	100	99.3	96.3	
Waterlow - risk assessment % compliance	>=95%	IP	98	92.7	88.3	93	95.6	93.3	83	90.6	96	98	100	95	91	100	99.3	95.6	
MUST - risk assessment measures	>=95%	IP	57.2	59.4	60	58.9	81.6	71.1	75	75.9	83	83	94	77	60	81.8	93.3	80	
Effectiveness																			
Advancing Quality % compliance (cumulative scores)																			
Acute MI	>=95%	IP, C	100	98.4	98.9		98.4	98.8	99		98.37	97.90	98.15						98.15
Hip and Knee	>=95%	IP, C	95.2	96.5	95		96.4	96.7	96.9		97.23	97.57	97.44						97.44
Heart failure	>=90.2%	IP, C	100	90.9	87.9		83.1	84.3	83.7		84.31	81.42	82.21						81.21
Pneumonia	>=73.9%	IP, C	68.6	72.8	74.4		75.1	76.1	75.2		74.66	73.36	73.85						73.85
Stroke	>=60.4%	IP, C	69.7	61.4	57		58.3	60	60.7		61.76	61.30	58.98						58.98
COPD (data not yet released)	>=50%	IP, C						PILOT	PILOT										
Patient Reported Outcome Measures (PROMS)																			
Hip replacement (Average health gain)	0.44 (latest England average Mar 2014)	IP,QC		Still provisional data													0.41		0.41
Knee replacement (Average health gain)	0.32 (latest England average Mar 2014)	IP,QC		Still provisional data													0.34		0.34
Groin surgery (Average health gain)	0.085 (latest England average Mar	IP,QC		Still provisional data													0.065		0.065

	2014)																		
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Patient Experience																			
Always events (Q1&2 implementation, Q3 data collection)	% completed TBC	IP									84	100	100		100	100	100	100	
Mixed sex occurrences	0	QC	6	3	0	9	0	0	0	0	0	0	5	5	3	6	1	10	24
Friends and family (F&F) test (patients' views)																			
F&F Test. **Star rating**	TBC		4.54	4.5	4.58		4.53	4.6	4.58		4.6	4.61	4.59		4.59	4.55	4.61		
F&F Test Inpatients **Net promoter changed to % recommending Trust – November 2014.**	>=95% (National average changes each month including independent)	OH	76	74	81		76	77	94		95	97	96		96	97			
F&F Test A&E **Net promoter changed to % recommending Trust – November 2014.**	>=88% (National average changes each month)	OH	42	35	41		40	45	82		85	87	84		87	84			
F&F response rate (A&E)	Q1 – >=15% Q4 - >=20%	C	23.08	18.52	20.79	20.75	19.55	17.58	14.51	17.26	13.57	17.86	16.48	15.93	19.74	23.61	22.09	21.80	18.90
F&F response rate (inpatients)	Q1 – >=25% Q4 - >=30% March 2015 achieve >=40%	C	27.32	26.83	34.62	29.55	32.20	30.02	26.39	29.55	32.85	30.99	28.44	30.77	26.69	33.04	40.50	33.28	30.73
Friends and family test (staff views)																			
Staff friends and family question (needing care) (Extremely likely and likely responses from F&F quarterly staff survey)	TBC Q3 Staff survey results. Last year = 65	C				70.9				72				STAFF SURVEY 61					

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3					
Staff F&F place to work (as above)	Q3 Staff survey results. Last year = 60					66.8				67				STAFF SURVEY 59					
Complaints and concerns																			
Number of concerns received	Not set	IP	2	10	6	18	17	10	9	36	9	0	7	15	4	11	6	21	91
Number of complaints received **Please see note below.**	2013/2014 received 422 (No threshold set)	IP	31	38	38	107	51	30	29	110	47	29	32	108	40	53	60	153	478
% of complaints resolved within the agreed timescale	>=94%	IP	94.44	95.24	100	96.51	96.88	100	97.5	98.23	97.92	100	100	99.1	100	100	100	100	98.39

ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Key: YTD = Year to date, ST = Safety Thermometer (monthly point prevalence survey), IC = Inclusion criteria

Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception*(CE), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

2. Exception reporting

SHMI (Summary Hospital-level Mortality Indicator)

Since April 2014, for four 12 month periods, our SHMI has been 'higher than expected'; at 112 for the 12 month periods ending August 2014, October 2014 and November 2014, and 115 for December 2014. The HSMR has risen to 107, which is still 'as expected'. The Trust's crude death rates remain comparable with other Trusts. In August 2014 the trust made a commitment to review the care of all patients who die in our hospitals. Although 100% of deaths are not yet being reviewed (74% in April 2015, to 23rd April) the Medical Director is committed to continuing the Trust's journey towards full compliance and a high level group has developed a new process which will be in place by Q2 2015/16, to better integrate central and local processes, promoting trust wide learning and improvement. In addition to this, we will continue to focus on improvement work around the deteriorating patient, critical care access and end of life care. Work is also progressing around the accurate recording of patients' details including their admission source and comorbidities, which will not only make the mortality ratios more accurate and useful, but improve the quality of our records.

Care Indicators

High Quality Care was a local CQUIN for 2013/2014. The care indicators audit was a process which was developed as part of this CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. The Trust identified this as an important aspect of quality of care and thus agreed to continue monitoring as a Quality Indicator for the Quality Accounts in 2014/2015. The results (random sample) indicate compliance with both Waterlow and Falls, however compliance with MUST although improved at 93.3% still remains an issue. The trust is moving from sampling patients to roll out across all wards. The Patient Safety Champion will be formulating a recovery plan to ensure that all the wards participate in the self-assessment and that completion of MUST risk assessments improve to achieve the required 95% compliance. Nursing care indicators will remain as a Quality Indicator and progress will be reported in the Quality Report next year.

Clostridium Difficile

MRSA bacteraemia

A nil return for was submitted for MRSA bacteraemia in March 2015. The Trust has reported a total of 5 cases for the financial year, 3 of which are hospital apportioned cases.

Clostridium difficile

The Trust reported 6 cases of Clostridium difficile in March 2015, 5 of which were hospital apportioned. The Trust has reported a total of 65 cases for the year, 31 of which are hospital apportioned. This exceeds the permitted threshold of 26 cases. Partnership working with the CCG is taking place to review the cases with a view to exclude some cases from the contractual penalties.

Advancing Quality – Heart failure and Pneumonia

The nursing and medical teams continue to work toward patients with Heart Failure receiving the treatment they require and in the vast majority of patients this is the case. We are working on looking at the fails which are in the main due to patients who were admitted and discharged with a diagnosis of Heart Failure within 24 hours. We are looking to develop a document similar to that used in the pneumonia work stream in support of this. Importantly, it must be noted that concerns were raised at the last AQ meeting that there may be issues with accuracy of recording heart failure patients who may not eventually have heart failure (it would be unusual only to be admitted for 24 hours with this condition). Our most recent data reflects two patients where we did not provide discharge instructions. One of these patients was subsequently found not to have heart failure. Meetings have taken place with AQuA to assist us in resolving these issues. With regards to the slight dip in compliance with Pneumonia there are no significant additional issues to report.

Falls

Our improvement priority for 2014/2015 established a 10% reduction for falls resulting in moderate - catastrophic harm which equates to <=13 falls. The trust can report that whilst we have performed well in reducing the overall number of falls we are disappointed to report that we have failed to achieve the threshold for falls resulting in moderate - catastrophic harm. (As of February we have 16 falls of this severity and 9 awaiting approval). During 2014/2015 the trust has also identified falls as a Sign up to Safety goal. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. This is something that our trust has been working towards over the last few years. Our driver document articulates the trusts strategy for a 30% reduction in moderate falls by 2017. The trust did agree a 10% reduction in falls where moderate harm occurs by March 2015 for stage one of Sign up to Safety but as with the improvement priority we have failed to reach this threshold. As such we will have to concentrate efforts and ensure that we address this shortfall in stage two for 2015/2016. Falls management will also be a priority for the Falls Group and the new Patient Experience Committee. A 10% reduction in all falls and a threshold of <=13 moderate – catastrophic falls has been identified as an improvement priority for 2015/2016.

Mixed Sex Occurrences

DSSA Breach & Sanction Reporting.
There was one breach of same sex accommodation in March 2015. A male patient in ICU/HDU was an unjustified breach. A root cause analysis was carried out and the report has been submitted to Warrington CCG. A financial penalty of £250 was applied.

Complaints

A decision was reached whereby we agreed to count withdrawn complaints as concerns. However unfortunately there was a slight error in that whilst the outcome code was being altered to withdrawn, we had failed to alter the type from formal to concern. The Patient Experience Team has refreshed the data which shows over reporting on the QDB of formal complaints for 2014/2015 – total number of formal complaints received is now 478. This data refresh has resulted in a data change to nine months namely May; July; September; October; November; December; January and February.

4. KPI Updates and clarification

Pressure ulcer (Community or hospital acquired) (ST)

This indicator is in place to monitor progress with the national CQUIN - The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey / Total number of patients surveyed on the day.
The Trust median baseline for October to March 2014 was established at 3.99%. We have agreed improvement value of <=3.99% with commissioners. The Trust is required to show improvement in the period November 2014 to March 2015. The Trust has been over the target of 3.99% with the exception of January with a rate of 3.60%. The main issue is old PU (known as community). Analysis of "old to new" shows that the rate has increased due to the number of old PU's Work being undertaken to identify the patients who are admitted from care homes and directly from home and we will then identify themes e.g. location of PU and long term conditions to share with care homes and GP's. Commissioners have agreed that a report outlining community vs hospital acquired will address any concerns and enable us to achieve.

CQC: Intelligent Monitoring

The 'elevated risk' is:
Whistleblowing (18-7-13 – 29-9-14)

The 'risks' are:
Composite indicator: In-hospital mortality - Cardiological conditions and procedures (01-May-13 to 30-Apr-14)
Composite indicator: In-hospital mortality - Haematological conditions (01-May-13 to 30-Apr-14)
NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)

BOARD OF DIRECTORS

WHH/B/2015/ **072**

SUBJECT:	**Infection Prevention and Control**	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Lesley McKay Associate Director of Infection Prevention and Control	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance Simon Constable, Medical Director	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO2: To be the employer of choice for healthcare we deliver SO3: To give our patients the best possible experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.3 Failure to achieve infection control targets in accordance with the Risk Assessment Framework	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection control activity in quarter 4 (Q4) 2014/15 and highlights the Trust's progress against infection prevention and control key performance indicators. The Trust reported 8 cases Clostridium difficile resulting in a total of 31 cases for the financial year against the annual threshold of 26 cases. The Trust submitted a nil return for hospital reported MRSA bacteraemia resulting in a total of 3 hospital apportioned cases for the financial year against the annual target of zero. The Trust was significantly affected by viral gastroenteritis affecting a large number of wards.	
RECOMMENDATION:	***The Board is asked to:-*** note the contents of the report and the progress made and Support the request for increasing the Antibiotics Pharmacist hours	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	29/04/2015
	Summary of Outcome	Choose an item.

Infection Prevention and Control Report

EXECUTIVE SUMMARY

This report provides a summary of infection control activity in quarter 4 (Q4) 2014/15 and highlights the Trust's progress against infection prevention and control key performance indicators.

The Trust reported 8 cases Clostridium difficile resulting in a total of 31 cases for the financial year against the annual threshold of 26 cases.

The Trust submitted a nil return for hospital reported MRSA bacteraemia resulting in a total of 3 hospital apportioned cases for the financial year against the annual target of zero.

The Trust was significantly affected by viral gastroenteritis affecting a large number of wards.

CONTEXT

The Trust has developed healthcare associated infection (HCAI) reduction action plans for MRSA & MSSA bacteraemias and Clostridium difficile. These action plans are updated quarterly to ensure local and national priorities relating to HCAI are addressed and meet the requirements specified in the NHS Standard Contract for 2014/15.

Monitor uses Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases of Clostridium difficile are taken into account for regulatory purposes. The *de minimis* limit for cases of C. difficile is set at 12. Monitor will assess the Trust for breaches of the Clostridium difficile objective (threshold of 26 cases for 2014/15) each quarter using a cumulative YTD trajectory. Monitor will consider whether the Trust is in breach of its licence if the Care Quality Commission reports serious concerns about Trust performance or third parties raise concerns about infection outbreaks.

HEALTHCARE ASSOCIATED INFECTIONS

CLOSTRIDIUM DIFFICILE

During Q4 the Trust reported 14 cases of *Clostridium difficile, 8* of which were hospital apportioned (appendix 1). Year to date (YTD) the Trust has reported 65 cases of *Clostridium difficile*, 31 of which are hospital apportioned against the financial year threshold of 26 cases. The Trust is 5 cases above planned trajectory at the end of year. Cases are being reviewed with a view to submitting to the CCG for appeal against contractual sanctions.

Weekly surveillance is carried out to identify periods of increased incidence (PIIs) [2 hospital apportioned cases within a 28 day period in a defined location]. A PII was noted (3 cases) on ward A3 during February and March (dates: 16/02/2015, 04/03/2015 & 11/03/2015). Further testing of the 3 Clostridium difficile isolates identified they were the same ribotype. Additional testing was undertaken (DNA fingerprinting) which has shown the cases were indistinguishable therefore indicating transmission has occurred. 2 of the cases occurred in male patients who were located in the same bay and 1 case arose in a female patient in a side room.

A number of actions have been implemented including: hydrogen peroxide vapour decontamination in the areas where the patients were cared for, promotion of hand hygiene and appropriate use of personal protective equipment and a full infection control audit to review infection control standards. There is a plan to complete further environmental cleaning across the ward and to provide targeted training on C difficile. A review meeting will be held once all 3 investigations are completed

It should be noted that both community apportioned cases of Clostridium difficile (toxin positive) and all cases of Clostridium difficile PCR positive/toxin negative (local surveillance only) cared for within the Trust present a background incidence of cases and associated transmission risk.

Discussions have taken place with the CCG in relation to the review process for Clostridium difficile cases. The investigation toolkit has been revised (as per C. difficile objective) and agreed for the next financial year. A CCG representative will be invited to the Trust's internal case review meetings to facilitate consideration of removal of cases from contractual sanctions.

Antibiotic prescribing

The last Antibiotic Point Prevalence Audit (March 2015) identified an overall decrease in antibiotic usage however higher than seen previously for this time of year. A slight decrease in prescribing compliance is noted compared to the previous quarter (appendix 2).

The Infection Prevention and Control Team requested further support/increase in hours to the Antibiotics Pharmacist role to facilitate additional antibiotic ward rounds and to produce an antibiotic prescribing e-learning package. This was approved and supported by the Board however has not yet been implemented.

In addition to the point prevalence audits, antibiotic ward rounds are conducted which identify prescribing non-compliances. Due to wider concerns about antimicrobial resistance and preservation of antibiotics to treat infections, this is a key area requiring greater attention/action. The DIPC is addressing the request for addition hours for the Antibiotics Pharmacist role with the Chief Pharmacist.

BACTERAEMIAS

MRSA bacteraemia

During Q4 the Trust submitted a nil return for hospital apportioned cases of MRSA bacteraemia.

At the end of year the Trust has reported 5 MRSA bacteraemia cases, 3 of which are hospital apportioned against the threshold of zero avoidable infections.

MSSA bacteraemia

During Q4, the Trust reported 14 cases of MSSA bacteraemia, 5 of which were hospital apportioned. Post Infection reviews have been requested for all cases.

At the end of year the Trust has reported 37 MSSA bacteraemia cases, 12 of which are hospital apportioned. This is a positive position compared to last financial year when the Trust flagged as an outlier both regionally and nationally for higher than average numbers of hospital apportioned cases.

E. coli bacteraemias

In Q4 a total of 37 cases were reported. The Medical Microbiologists review all cases of E. coli bacteraemia and the majority of cases are deemed unlikely to be associated with healthcare. At the end of year the Trust has reported 158 cases of E. coli bacteraemia.

OUTBREAKS/INCIDENTS/NEW DEVELOPMENTS

Viral Gastroenteritis

In Q4 the Trust experienced extreme pressures associated with viral gastroenteritis. A total of 17 wards (13 in February) were under surveillance and part or fully closed. Norovirus genotype 2 was identified as the causative organism in the majority of wards. Similar situations were noted in partner organisations with a number of care homes also being closed to admissions.

The Infection Control Nurses worked over and above expected performance working additional hours to support management of the situation whilst simultaneously advising how to safely maximise operational throughput. All the wards were re-opened as soon as it was safe to do so. The Microbiology laboratory is reviewing testing methodology with a view to providing in house testing for gastroenteritis viruses. This will provide more timely results to inform decision making.

Ebola preparedness

The Infection Control Team is continuing work to prepare the Trust for managing suspected cases of Ebola and other viral haemorrhagic fever. The Infection Control Team has worked closely with the Emergency Planning Officer to produce action cards in addition worked with AED on processes for safe management of suspect cases.

Chickenpox exposure *incident*

A chickenpox exposure incident occurred in the Neonatal Unit in January. A sibling developed chickenpox rash within 2 days of visiting the unit and therefore was infectious at the time of visiting. Contact tracing identified significant exposure (>15 minutes) occurred to 7 neonates, parents and staff who were present at the time of the visit. Investigations confirmed all mothers and staff on duty had antibodies to chickenpox and therefore were considered immune. The presence of maternal antibodies indicated conferred immunity to the neonates and no additional prophylaxis was required. The neonates who were

remaining on the unit were isolated for the remainder of the infectious period as a precaution.

The incident was managed with guidance from Public Health England. A patient notification exercise was undertaken. No secondary cases were identified in relation to the incident.

Influenza

Public Health England have advised influenza A activity has increased to levels higher than the last 2 seasons and for most of the decade to 2009. A patient was admitted to the Trust from a care home that was subsequently closed to admissions due to an outbreak of influenza. The patient underwent testing and was confirmed with influenza A. 4 patient contacts nursed in the same bay were commenced on prophylaxis. Investigations confirmed these patients did not contract influenza.

The staff uptake of influenza vaccination for this year was 78%. Due to concerns about vaccine efficacy and the high number of cases seen this year, consideration is required on how to promote vaccination for the forthcoming influenza season.

Code of Practice on prevention and control of infection

The Department of Health has published a draft revision to the Code of Practice on prevention of healthcare associated infections. A gap analysis has been conducted against the draft document and the action plan updated (appendix 3). The most significant change relates to criterion 3 and the requirement to ensure appropriate antibiotic use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.

NEXT STEPS

Further work is required to:-

- Ensure provision of Antibiotics Pharmacist Hours

RECOMMENDATIONS

The Board is asked to support the requirement for additional Antibiotics Pharmacist Hours.

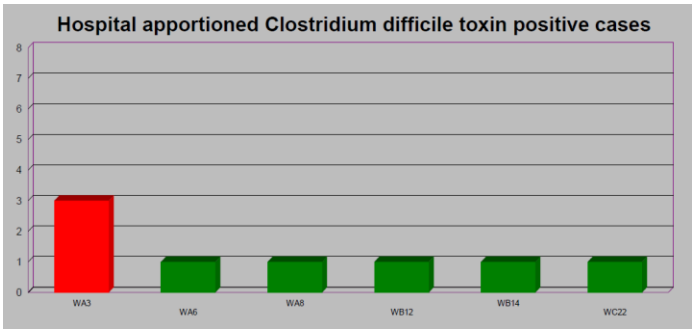
CONCLUSION

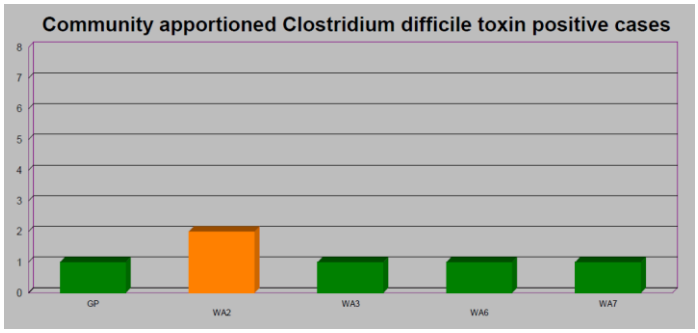
The Board is asked to note the contents of the report and the progress made.

Appendix 1 - HCAI Surveillance data April 2014 – March 2015

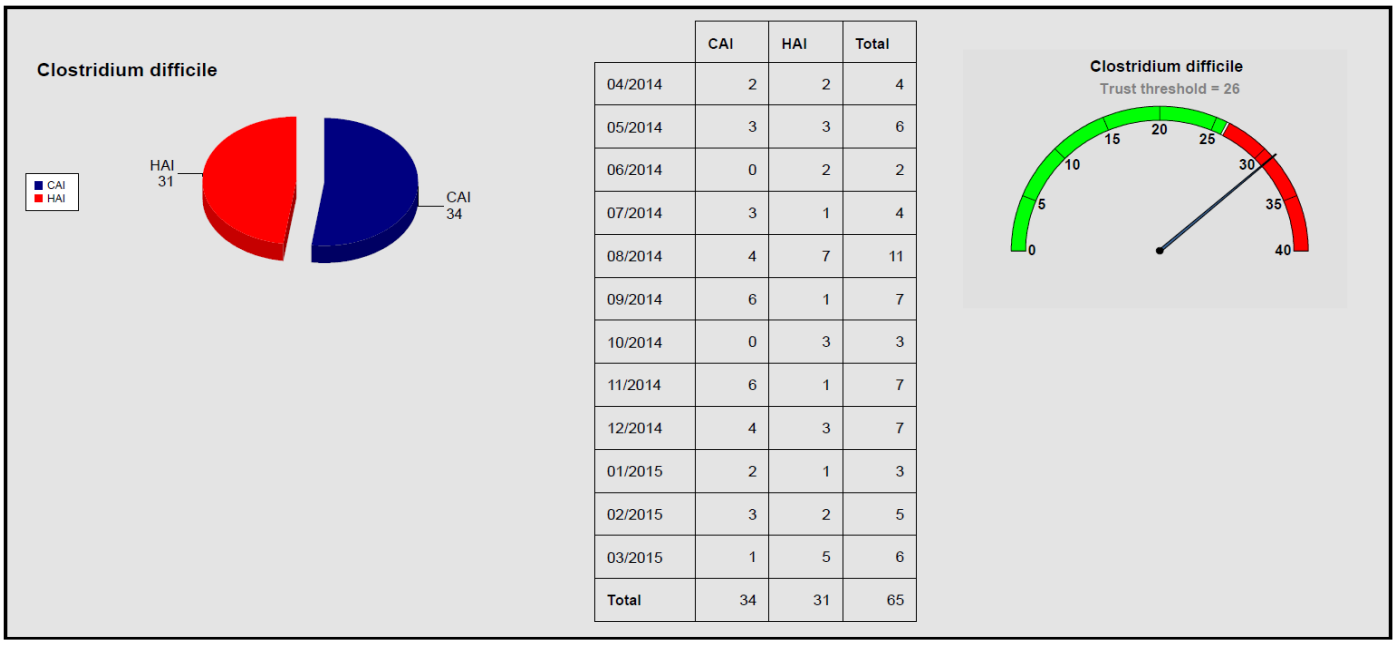
CLOSTRIDIUM DIFFICILE

Q4 Clostridium difficile toxin positive* cases by location when detected





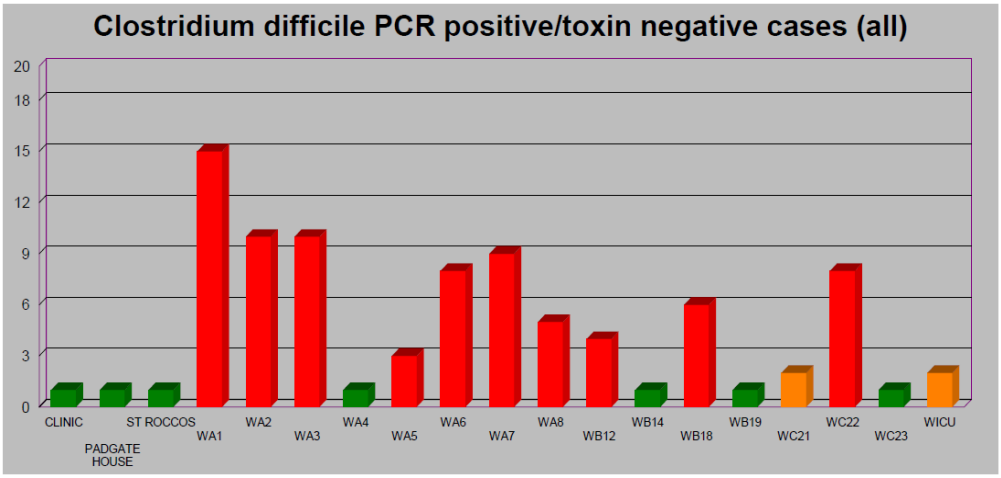
Clostridium difficile year to date position



	CAI	HAI	Total
04/2014	2	2	4
05/2014	3	3	6
06/2014	0	2	2
07/2014	3	1	4
08/2014	4	7	11
09/2014	6	1	7
10/2014	0	3	3
11/2014	6	1	7
12/2014	4	3	7
01/2015	2	1	3
02/2015	3	2	5
03/2015	1	5	6
Total	34	31	65

Clostridium difficile PCR positive/toxin negative cases by location when detected (April 2014 – March 2015)

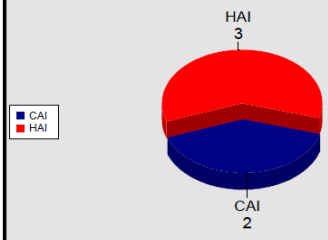
(Local surveillance only)



BACTERAEMIAS

MRSA bacteraemias

MRSA Blood Cultures

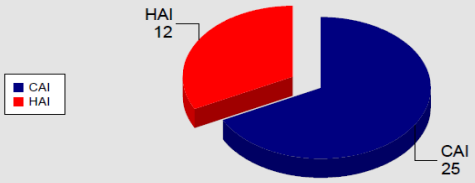


	BLOODSTREAM			Total
	CAI	HAI	Total	
05/2014	0	1	1	1
09/2014	1	1	2	2
12/2014	0	1	1	1
02/2015	1	0	1	1
Total	2	3	5	5

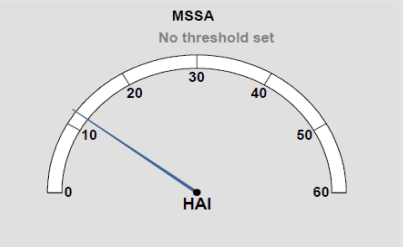
Annual Threshold

MSSA bacteraemia

MSSA blood cultures



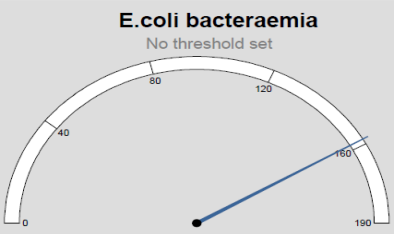
	CAI	HAI	Total
04/2014	4	1	5
05/2014	3	0	3
06/2014	0	1	1
07/2014	0	1	1
08/2014	3	0	3
09/2014	1	0	1
10/2014	2	1	3
11/2014	2	1	3
12/2014	1	2	3
01/2015	5	2	7
02/2015	1	2	3
03/2015	3	1	4
Total	25	12	37



E Coli Bacteraemia

E Coli blood cultures

	Total
04/2014	16
05/2014	14
06/2014	10
07/2014	20
08/2014	18
09/2014	11
10/2014	11
11/2014	12
12/2014	9
01/2015	18
02/2015	15
03/2015	4
Total	158



Appendix 2 - Antibiotic Point Prevalence Audit Results April 2015

The quarterly point prevalence audit of compliance with the trust antibiotic formulary was carried out on 30th and 31st March 2015 across Warrington and Halton hospitals. This was the April audit, but was carried out a week early due to the Easter bank holiday weekend.

1. **Number of patients audited**

	Warrington hospital	**Halton hospital**	**Total**
% of inpatients seen on day of audit	92% (377/411)	100% (30/30)	92.3% (407/441)
% of inpatients prescribed antibiotics on day of audit	33.7% (127/377)	10% (3/30)	32% (130/407)
Number of antibiotics prescribed at time of audit	160	3	163

2. **Overall antibiotic prescribing**

32% of inpatients were prescribed at least one antibiotic at the time the audit was carried out.

This is a decrease in antibiotic prescribing from last quarter (January 2015) when 40% of patients were on antibiotics, however the trust is still experiencing higher use of antibiotics than normal for the time of year; previous audits carried out in April showed 24.8% of patients on antibiotics in April 2014, 30% in 2013 and 24% in 2012.

All patients had the allergy section of their prescription chart completed.

3. **Compliance with the formulary**

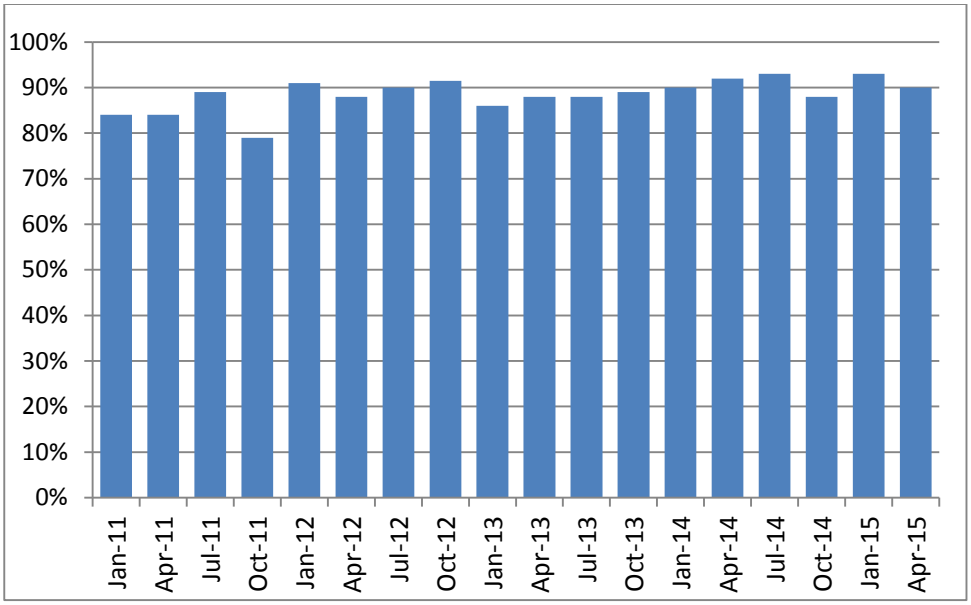
Overall compliance with the antibiotic formulary this quarter was 90%. This compares to compliance of 91.7% across the trust last quarter.

Compliance at Warrington hospital was 89% this quarter. Compliance at Halton hospital was 100%, however only 3 antibiotics were prescribed at the time of the audit.

Compliance within unscheduled care was 90% this quarter (119/132).

Within scheduled care compliance was 84% (22/26) this quarter as compared to 80% last quarter.
Within WCSS compliance was 100% but only 1 patient was audited in WCSS due to medical outliers on C20 at the time of the audit.

Compliance with the antibiotic formulary per quarter since January 2011



Compliance with the formulary by ward

Ward	Compliance Oct 2014	Compliance Jan 2015	Compliance April 2015
A1	85% (11/13)	100%	89% (16/18)
A2	90% (9/10)	100%	92% (12/13)
A3	60% (3/5)	87% (13/15)	100%
A4	88% (7/8)	83% (5/6)	83% (5/6)
SAU	N/A	75% (3/4)	50% (1/2)
A5	86% (12/14)	93% (14/15)	72% (8/11)
A6	84% (16/19)	81% (13/16)	89% (8/9)
A7	100%	87% (14/16)	82% (14/17)
A8	86% (12/14)	93% (14/15)	100%
A9	100%	100%	93% (14/15)
FMN unit	100%	80% (4/5)	75% (3/4)
B14	83% (5/6)	89% (8/9)	50% (2/4)
B18	100%	100%	85% (6/7)
C21	100%	94% (16/17)	100% (7/7)
C22	100%	90% (9/10)	100% (6/6)
CCU	50% (1/2)	100%	100% (2/2)
CMTC	0% (0/2)	50% (1/2)	N/A

Wards with less than 90% compliance are highlighted in red.

B19, ITU, B1 (Halton) and C20 have had 100% compliance with the formulary in the last 9 months.

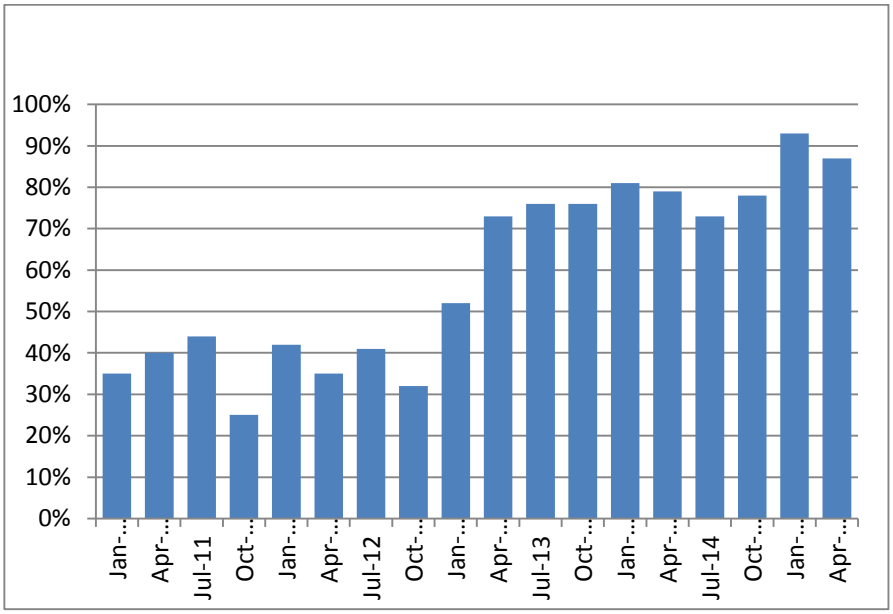
A2, A9, C21 and C22 have had over 90% compliance for the last 9 months.

4. Documentation of indication for antibiotics

One patient was given intravenous antibiotics without a clear indication documented on the drug chart or in the notes.

5. Documentation of review date or stop date

87% of antibiotics which were prescribed for over 24 hours had a documented stop or review date. The improvement in this area is detailed below.



Summary

32% of patients were prescribed antibiotics at the time of the audit; this is the highest rate of antibiotic prescribing seen for the last 4 years in the April audit.

There was 90% compliance with the trust formulary, and as per last quarter there was an improvement in review date/stop dates on prescriptions or in the notes for antibiotics. 87% of antibiotics that were prescribed for more than 24 hours had been reviewed or had a stop date documented.

14 patients were given antibiotics which were not as per the formulary. 10 patients were under unscheduled care consultants and 4 patients were under scheduled care consultants.

Action Points

Results of this audit will be fed back to DIGG meetings and to the Antimicrobial Management Steering Group (AMSG). Letters to individual consultants will continue to be sent regarding specific areas of non-compliance.

Microbiologist/Antibiotics Pharmacist ward rounds will also continue.

Rachel Cameron, Antibiotics Pharmacist, April 2015.

Health and Social Care Act 2012

Code of Practice for health and adult social care on the prevention and control of infections and related guidance

Action Plan 2015 - 2016

Key to colour coded assessment

Evidence available at the time of assessment shows that the outcome is met

Evidence available at the time of assessment shows that the outcome is mostly met, or there is not sufficient evidence to demonstrate that the outcome is met. The impact on people who use services, visitors or staff is low. The action required is minimal.

Evidence available at the time of assessment shows that the outcome is mostly met, or there is not sufficient evidence to demonstrate the outcome is met. The impact on people who use services, visitors or staff is medium. The action required is moderate.

Evidence available at the time shows that the outcome is at risk of not being met or there is no available evidence that the outcome is met. The impact on people who use services, visitors or staff is high. Action is required quickly.

Criterion 1 - Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status/ Action required	RAG
1.1a ✓	Appropriate monitoring and management arrangements should ensure that:- A registered provider has an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and controls such risks	• Infection Control Policy	April 2015	MP SC	ICNs	Achieved	
1.1b	There is a clear governance structure and accountability that identifies a single lead for infection prevention and cleanliness and be accountable directly to the head of the registered provider	• Medical Director appointed DIPC from 01/04/2015 • IPC Assurance Framework	• March 2015	SC SC	SC ICNs	Achieved	
1.1c ✓	The mechanisms are in place by which the registered provider ensures that sufficient resources are available to secure the effective prevention and control of infection, including:- • implementation of an infection prevention and cleanliness programme	• Infection Control Sub-Committee programme 2015 - 2016	• March 2015	SC	ICNs	Achieved	

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status/ Action required	RAG
	• infection prevention and cleanliness infrastructure • the ability to detect and report infections;	• IPC Assurance Framework • Surveillance information system to extract and analyse data (Crystal reports) • Weekly PII report • Laboratory alert organism list	• March 2015			Review of surveillance systems required	
1.1d ✓	Relevant staff contractors and other persons whose normal duties are directly or indirectly concerned with providing care receive suitable and sufficient information on, and training and supervision in, the measures required to prevent and control the risks of infection.	• Induction/Mandatory/consultant/ e-learning training packages • Contractor infection control Information leaflet • Temporary Staffing: Nursing and Midwifery Policy including Local Induction for Permanent and Temporary Staff	• April 2014 • 2013 • June 2012	SC	WJ/ICNs LMcK KD	Achieved Less than 85% attendance recorded at Training sessions	
1.1e ✓	Assurance is in place to ensure that key policies and practices are being implemented appropriately.	• Audit programme in place • Reporting to Infection Control Sub-Committee (ICSC) • ICNA trust wide audit report	• March 2012 • As dated minutes from ICSC • March 2014	SC	ICNs	Achieved	
1.1f	A decontamination lead is designated	• SW is the nominated Decontamination lead • Decontamination Group Terms of reference		MP	SW	The decontamination group has not met since July 2014	

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status/ Action required	RAG
1.1g	A water safety group and water safety plan are in place	• Water Safety Group Terms of reference • Water Safety Plan	• April 2014	SW	GC		
1.2	A registered provider should ensure that it has: • made a suitable and sufficient assessment of the risks to the person receiving care with respect to prevention and control of infection; • identified the steps that need to be taken to reduce or control those risks; • recorded its findings in relation to the first two points; • implemented the steps identified; • put appropriate methods in place to monitor the risks of infection to determine whether further steps are needed to reduce or control infection	• Infection risk assessment guidelines • Monthly review of the Risk Register	September 2012	SC	ICNs	Achieved	
1,3	The DIPC in NHS Provider organisations should: • provide oversight and assurance on IPC to the Trust board. They should report directly to the board but are not required to be a board member • be responsible for leading the organisation's infection prevention team • oversee local prevention and control of infection policies and their implementation	• Quarterly Board reports	• As dated	SC	ADIPC	Achieved	

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status/ Action required	RAG
	• be a full member of the ICT and antimicrobial stewardship committee and regularly attend its infection prevention meetings • have the authority to challenge inappropriate practice and inappropriate antibiotic prescribing decisions • have the authority to set and challenge standards of cleanliness • assess the impact of all existing and new policies on infections and make recommendations for change • be an integral member of the organisation's clinical governance and patient safety teams and structures and water safety group • produce an annual report and release it publicly as outlined in *Winning ways: working together to reduce healthcare associated infection in England*	• DIPC Annual report					
* 1.4 is only applicable to adult social care							
1.5a	Activities to demonstrate that infection prevention and cleanliness are an integral part of quality assurance should include: • regular presentations from the DIPC and/or the ICT to the board • a trend analysis for infections, antimicrobial resistance and antimicrobial prescribing and	• Quarterly Board reports	• As dated	SC	ADIPC	Achieved	

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status/ Action required	RAG
	compliance with audit programmes						
1.5b	Quarterly reporting to the NHS board by clinical directors and matrons (including nurses who do not hold the specific title of 'matron' but who operate at a similar level of seniority and who have control over similar aspects of the patient or the patient's environment). • monthly cleanliness scores (unless this is done via the estates and facilities team); • annual PLACE scores plus monthly scores (where this is agreed practice); • Information taken from the organisation's self-assessment using the NHS Premises Assurance Model (NHS PAM) • Monthly review of antimicrobial prescribing decisions • Observations taken from board level or other staff "walk rounds"	• Matrons reports to Infection Control Sub Committee • Via Estates and Facilities reports to Infection Control Sub Committee • Via Estates and Facilites reports to Infection Control Sub-Committee • Estates and facilities undertake PAM assessment	• As dated	SC	ADIPC	Achieved	
1.5c	A review of mandatory and voluntary surveillance data, including antimicrobial resistance (drug-bug combinations), outbreaks and serious incidents;	• Monthly/weekly surveillance reports • Datix reporting of healthcare associated infections • Root cause analysis of MRSA/MSSA and healthcare related E Coli bacteraemia and Clostridium difficile infections • SUI investigation reports	As dated	SC	ADIPC	Achieved	
1.5d	Evidence of appropriate action taken to deal with occurrences of infection including,	• SBAR reports • RCA meeting action notes	• As dated	SC	ADIPC	Achieved	

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status/ Action required	RAG
	where applicable, root cause analysis and/or post infection review						
1.5e	An audit programme to ensure that policies have been implemented;	• Audit timetable	• Completed audits	SC	ADIPC	Achieved	
1.6	In accordance with health and safety requirements, where suitable and sufficient assessment of risks requires action to be taken, evidence must be available on compliance with the regulations or, where appropriate, justification of a suitable better alternative.	• Health and Safety Policy • Personal Protective Equipment • Legionella Policy • COSHH Policy • RIDDOR Policy	• July 2014 • March 2012 • November 2013 • July 2014 • In production	SC	HW	Achieved	
1.7	1.7 The infection prevention and cleanliness programme should: ▪ set objectives that meet the needs of the organisation and ensure the safety of service users, health care workers and the public ▪ identify priorities for action; ▪ provide evidence that relevant policies have been implemented; ▪ report progress against the objectives of the programme in the DIPC's annual report	• Committee Work plan 2014 - 2015 • Action Plans (MRSA/MSSA/CDT/HSCA) • ICNA Audit report • DIPC annual report	• March 2014 • Quarterly review • March 2014 • June 2014	SC	ADIPC	Achieved Review of revised PAS cleaning specification is in progress	
1.8	An infection prevention and cleanliness infrastructure should encompass: ▪ in acute healthcare settings, an ICT	• Infrastructure revised	• March 2014	SC	ADIPC	Achieved	

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status/ Action required	RAG
	consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and cleanliness), other healthcare workers and appropriate administrative and analytical support, estates and facilities management and adequate information technology – the DIPC is a key member of the ICT; ▪ in acute settings, have a multidisciplinary antimicrobial stewardship committee to develop and implement the organisation's Antimicrobial stewardship programme drawing on Start Smart Then Focus (SSTF); ▪ 24-hour access to a nominated qualified infection control doctor (ICD) or consultant in health protection/communicable disease control. The registered provider should know how to access this advice	• PHE 24 hour access in relevant policies • On-call Consultant Microbiologist	• As per policies • Rotas			May need to review SSTF	
1.9	There should be evidence of joint working between staff involved in the provision of advice relating to the prevention and control of infection; those managing bed allocation; care staff and domestic staff in planning service user referrals, admissions, transfers, discharges and movements between departments; and within and between health and adult social care facilities.	• Transfer and discharge policy • Internal transfer forms under review • Outbreak e-mails • ICNs attend bed meetings on weekdays • Bed bureau assessment forms	• October 2013 • January 2013	SC	ADIPC	Achieved	

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status/ Action required	RAG
1.10	A registered provider must ensure that it provides suitable and sufficient information on a service user's infection status whenever it arranges for that person to be moved from the care of one organisation to another, of from a service user's home, so that any risks to the service user and others from infection may be minimised. If appropriate, providers of a service user's transport should be informed of any infection status.	• Information Governance Policy under review • Discharge and Transfer policy • SBAR internal transfer form • Update to transfer documentation requested from Community Healthcare Trust	•	SC	ADIPC	Achieved Updates to district nurse referral forms requested from Community Trust	

Criterion 2 - Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
2.1a ✓	With a view to minimising the risk of infection, a provider of care should ensure that: It designates leads for environmental cleaning and decontamination of equipment used for diagnosis and treatment (a single individual may be designated for both areas).	• GC – lead for cleaning. • SW – decontamination lead	Decontamination Group Terms of Reference	SW	GC	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
2.1b ✓	In healthcare, the designated lead for cleaning involves directors of nursing, matrons and the ICT or persons of similar standing in all aspects of cleaning services from contract negotiation and service planning to delivery at ward and clinical level.	• Cleaning monitoring reports are emailed to Ward Managers and Housekeepers • Matrons are required to report standards of cleanliness on their monthly reports to the Infection Control Sub-Committee (ICSC) • PLACE assessments • Facilities reports to Infection Control Sub-Committee	• Monitoring reports • ICSC Agendas • PLACE report • ICSC Agendas	SW	GC JmcG MAn	Achieved	
2.1c ✓	In healthcare, matrons or persons of a similar standing have personal responsibility and accountability for delivering a safe and clean care environment	• Matron reports to Infection Control Sub-Committee • E-mails to Facilities regarding cleanliness standards	• ICSC Agendas	KD	ADNs	Achieved	
2.1d ✓	The nurse or other person in charge of any patient or resident area has direct responsibility for ensuring that cleanliness standards are maintained throughout that shift	• Roles and responsibility document - Task Team/nursing staff • Included in Mandatory training	• Cleaning Policy October 2014	KD	ADNs	Achieved Review PAS specification 2014	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
2.1e ✓	All parts of the premises in which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition	• PPM Policy • Monitoring of cleanliness • Spot check audits • Task and Finish group meetings • PLACE inspections • Backlog maintenance programme	• October 2013 • Monitoring reports • Audit reports • PLACE reports	SW	GC JMcG	Achieved	
2.1f ✓	The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is readily available on request.	• Cleaning Manual • Cleaning schedules for all areas including Ward kitchens and all areas of the Trust	• Cleaning Policy October 2014 • Cleaning Frequencies	SW	GC JMcG	Achieved	
2.1g	There is adequate provision of suitable hand washing facilities and antibacterial hand rubs where appropriate.	▪ Hand wash sink audit –upgrade of some facilities required - Estate Plan to be agreed ▪ Hand rub audit weekly	▪ Audits ▪ Hand hygiene audit reports	SW	GC/ ADNs	Achieved	
2.1h ✓	There are effective arrangements for the appropriate cleaning of equipment used at the point of care, for example hoists, beds and commodes - these should be incorporated within appropriate cleaning, disinfection and decontamination policies.	▪ Decontamination policies ▪ Mattress cleaning SOP ▪ Commode cleaning guidance ▪ Wheelchair cleaning specification ▪ Laundering arrangements hoist slings	▪ March 2013 ▪ February 2014	SW	KW	Achieved	
2.1i	The storage supply and provision of	▪ Policy in place.	▪ October 2013	SW	MA	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	linen and laundry are appropriate for the level and type of care.	▪ Review of local washing machine NNU practices in progress					
2.2	The environment' means the totality of a service user's surroundings when in care premises or transported in a vehicle. This includes the fabric of the building, related fixtures and fittings, and services such as air and water supplies. Where care is delivered in the service user's home, the suitability of the environment for that level of care should be considered.						
2.3	The development of local policies should take account of infection prevention and cleanliness advice given by relevant expert or advisory bodies or by the ICT, and this should include provision for liaison between the members of any ICT and the persons with overall responsibility for the management of the service user's environment.						

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
2.3	Policies should address but not be restricted to: • Cleaning Services • Building and refurbishment including air handling systems • Waste management • Laundry arrangements for the correct classification and sorting of used and infected linen; • Planned preventative maintenance • Pest Control • Management of drinkable and non-drinkable water supplies • Minimising the risk of legionella and other water supply and building related infections e.g. *Pseudomonas aeruginosa* and aspergillus by adhering to national guidance; • Food Services (including food brought into the care setting by service users staff and visitors)	• Cleaning Policy • Waste Policy and guidelines • Laundry Policy • Policy • Policy • Covered within the Legionella policy • Legionella Policy and Water Safety Plan • Food policy	• October 2014 • November 2013 • October 2013 • June 2012 • March 2013 • October 2013 • November 2013 • Draft 2014	SW	GC JMcG MAn	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
2.4 ✓	The arrangements for cleaning should include: • clear definition of specific roles and responsibilities for cleaning • clear, agreed and available cleaning routines • sufficient resources dedicated to keeping the environment clean and fit for purpose • consultation with ICTs or equivalent local expertise on cleaning protocols when internal or external contracts are being prepared • details of how staff can request additional cleaning, both urgently and routinely	• Cleaning Policy • Frequencies • Task & Finish group minutes • Capital projects (ICN a member of the group) • Terminal Cleaning Guidelines	October 2014 July 2012	SW	MA	Achieved For discussion in light revised PAS specification	
2.5 ✓	The decontamination lead should have responsibility for ensuring that policies exist and that they take account of best practice and national guidance. ▪ Decontamination of the environment including cleaning and disinfection of the fabric, fixtures and fittings of a building (walls, floors, ceilings and bathroom facilities) or vehicles	• Cleaning Policy	October 2014	SW	MA/ADN	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	▪ Decontamination of linen – including correct classification and sorting of used linen (e.g. soiled and fouled linen, infectious linen, heat labile linen) and disinfection of linen; ▪ Decontamination of equipment – including cleaning and disinfection of items that come into contact with the patient, but are not invasive devices (beds, commodes, mattresses, hoists and slings) examination couches ▪ Reusable medical devices should be reprocessed at one of the following three levels:- —sterile (at point of use); —sterilised (i.e. having been through the sterilisation process); —clean (i.e. free of visible contamination)	• Laundry Policy • Decontamination Policy • Synergy contract	March 2013	SW SW SW	DGM GH GH		
2.6 ✓	The decontamination policy should demonstrate that: • it complies with guidance establishing essential quality requirements and a plan is in	• Decontamination Policy	• March 2013	SW	GH	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	place for progression to best practice • decontamination of reusable medical devices takes place in appropriate facilities designed to minimise the risks that are present • appropriate procedures are followed for the acquisition, maintenance and validation of decontamination equipment • staff are trained in cleaning and decontamination processes and hold appropriate competences for their role; • a record-keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems	• Synergy contract • Pre-purchase questionnaire • Endoscopy training records and competency assessments • JAG accreditation achieved					
Note: Undertaking the actions in NHS PAM's Self-Assessment Question S14 "safe and compliant with well managed systems in relation to: Decontamination Processes" will assist organisations in ensuring they have the correct assurance in place with regards to decontamination.							

Criterion 3 - Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status	RAG
3.1	Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic. These systems draw on national and local guidelines, monitoring and audit tools such as NICE Clinical guidelines, Start Smart then Focus in secondary care (SSTF)	• Prescribing advice is included in the Trust Antibiotic Formulary • Antibiotic ward rounds are conducted (ICU & Clostridium difficile cohort ward daily - weekdays) • Consultant Microbiology and Antibiotic Pharmacist weekly ward rounds (A3; A4) • Quarterly Point Prevalence Audits • Monitoring of dispensed high risk antibiotics		SC	ZQ TN RC	Plan in place to increase ward round activity May need to review SSTF	
3.2	Where appropriate, providers should have in place an antibiotic stewardship committee responsible for developing and implementing the organisation's stewardship programme. Membership of this committee will vary dependent on the setting but should include representation from microbiology/infectious diseases, pharmacy and the organisations' director of infection prevention and control or equivalent.	• Antimicrobial Steering Group (AMSG) minutes • AMSG Terms of Reference • DIPC Quarterly reports to Trust Board		SC	ZQ TN RC	Improvements to attendance required. Complicated by clinical commitments	

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status	RAG
	The committee should report antimicrobial stewardship activities to the Trust board via the organisation's Director of Infection Prevention and Control or equivalent.						
3.3	Providers should develop a local antimicrobial stewardship policy based on national guidance (including the BNF and NICE) that takes account of local antibiotic resistance patterns. Guidance should cover diagnosis, treatment and prophylaxis of common infections and prescribers should be encouraged to record allergy status, reason for antimicrobial prescription, dose and duration of treatment. Adherence to prescribing guidance and compliance with in hospital post-prescribing review at 48-72 hours should be monitored and audited on a regular basis, with data fed back to prescribers and incorporated into patient safety reporting systems to Boards and Commissioners.	• Trust Antibiotic Formulary • Point prevalence audits • Point prevalence audit data included in DIGGs		SC	ZQ TN RC	Review of PPAs to include 48-72 hour reviews	
3.4	Providers should have access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 24 hours.	• 24 hour on call service for Microbiology • Investigation methodology results in greater than 24 hours timescale for some results		SC	ZQ TN RC		

Criteria	Definition	Evidence	Evidence Verified and Date	Exec. Lead	Op. Lead	Current Status	RAG
	Prescribers should have access to a suitably qualified individual who can advise on appropriate choice of antimicrobial therapy						
3.5	In secondary care providers should report local antibiotic susceptibility data (drug-bug combinations) and information on antimicrobial consumption to the national surveillance body. Surveillance information should be communicated back to prescribers in primary and secondary care and used by the stewardship committee or equivalent to monitor local resistance patterns, guide local prescribing policy and improve prescribing quality	Consumption data reported to stewardship committee but that is the endpoint - needs developing if it is to be used to improve prescribing quality but would need IT/data analyst support for this.		SC	ZQ TN RC		
3.6	Providers should ensure that all prescribers receive induction and training in prudent antibiotic use	F1 training programme		SC	ZQ TN RC	Plan to develop an e-learning package	

Criterion 4 - Provide suitable accurate information on infections to service users and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
4.1	Information for service users and visitors should be developed with local service user representative organisations, which could include Local Health watch and Patient Advice and Liaison Services (PALS).	• All information leaflets are reviewed by the Communications Team • Public Health England information leaflets in use	Information leaflets	SC	ICNs	Review programme in place	
4.2a	General principles on the prevention and control of infections and key aspects of the registered provider's policy on infection prevention and control, which takes into account the communication needs of the service user.	• Trust Website • Notice board information top ten tips • Foreign language translation service	• 2014 • December 2014 • As required	SC	CH ICNs	Achieved	
4.2b	The role and responsibilities of particular individuals such as carers, relatives and advocates in the prevention and control of infection, to support them when visiting service users.	• Trust Website • Notice board information top ten tips • Review of NICE Quality Standard 61 in progress	• 2014 • December 2014	SC	ADNs	Achieved	
4.2c	The importance of appropriate use of antibiotics;	All outpatients collecting prescriptions for antibiotics are given advice on dose, duration, completing the course. Inpatients - not audited and not currently recorded if this information is provided (no signature box on antibiotics section for		SC	ZQ TN RC		

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
		counselling					
4.2d	Supporting service user awareness and involvement in the safe provision of care	▪ Trust Website ▪ Notice board information top ten tips ▪ Review of NICE Quality Standard 61 in progress ▪ Wash your hands signs in toilets and patient areas ▪ Reporting symptoms of diarrhoea notice	▪ 2014 ▪ December 2014	SC	ICNs	Achieved	
4.2e	The importance of compliance by visitors with hand hygiene.	▪ Signage at ward entrances ▪ Notice board information top ten tips	▪ December 2014	SC	ICN	Achieved	
4.2f	The importance of compliance with the registered provider's policy on visiting.	▪ Trust Website ▪ Notice board information top ten tips ▪ Viral gastroenteritis signage updated	▪ 2014 ▪ December 2014 ▪ December 2012	SC	ICN	Achieved	
4.2g	Reporting failures of hygiene and cleanliness.	▪ Corporate signage introduced	▪ March 2010	SW	MAn	Achieved	
4.2h	Explanation of incident/outbreak management.	▪ Policy in place ▪ Signage at entrances on doors ▪ Information leaflets	▪ December 2012	SC	ICN	Achieved	
4.3	Materials from European Antibiotic Awareness Day (EAAD) and other campaigns could be used to develop information on	▪ Trust Participation in EAAD	Annually November	SC	ZQ TN	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	appropriate antibiotic use.				RC		
4.4a	A registered provider should ensure that: Accurate information is communicated in an appropriate and timely manner.	▪ Infection risk assessment guidelines ▪ Liaison with community infection control team ▪ Critical Care Indicator function on the Patient Administration system ▪ Infection risk flag on ICE laboratory system	▪ September 2012	SW	DGM	Achieved	
4.4b	This information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection.	▪ Infection risk assessment guidelines ▪ Liaison with community infection control team ▪ Critical Care Indicator function on the Patient Administration system ▪ Infection risk flag on ICE laboratory system ▪ Intra hospital transfers discussed with bed management team re-isolation and screening for CPE/VRE	▪ September 2012	SW	MM	Achieved	
4.4c	Where possible information accompanies the service user	▪ Transfer form accompanies patient in case notes		SW	MM		
4.5	Provision of relevant information across organisational boundaries is covered by the regulation requirement 'cooperating with other providers'.	▪ Infection control discharge summary to PCT ICNs ▪ Pre-admission MRSA screening for elective cases. Letters to GPs		SC	ICNs	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	Due attention should be paid to service users confidentiality as outlined in the national guidance and training material.						

Criterion 5 - Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
5.1	Registered providers excluding personal care providers, should ensure that advice is received from suitably informed practitioners and that, if advised, registered providers should inform their local health protection unit of any outbreaks or serious incidents relating to infection in a timely manner.	▪ Infection Control Policy ▪ Notification Policy ▪ Major outbreak Guidelines ▪ CCDC – e-mail ▪ Minutes from investigation meetings	▪ May 2012 ▪ December 2012 ▪ January 2013	SC	ICN	Achieved	
5.2	Arrangements to prevent and control infection should demonstrate that responsibility for infection prevention and control is effectively devolved to all groups in the organisation involved in delivering care.	▪ Divisional Infection Control Groups ▪ Infection Prevention and Control Link Staff Group ▪ CDAG ▪ Job description statement	▪ Meeting minutes	SC	ADN	Achieved	

Criterion 6 - Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
6.1	A registered provider should, so far as is reasonably practicable, ensure that its staff, contractors and others involved in the provision of care co-operate with it, and with each other, so far as is necessary to enable the registered provider to meet its obligations under the Code.	▪ Mandatory training programme (taught and e-learning) for Trust employed staff ▪ Infection Prevention and Control Link Staff Group ▪ Policies state giving access to contractors as appropriate ▪ Programme of audit to assess compliance ▪ Contractor information leaflet		SC SC	WJ DGM ADN ICN	Attendance figures recorded are <85% DIPC directive to improve attendance at mandatory training	
6.2	Infection prevention and control would need to be included in the job descriptions and be included in the induction programme and staff updates of all employees (including volunteers). Contractors working in service user areas would need to be aware of any issues with regard to infection prevention and control and obtain 'permission to work'.	▪ Added to all job descriptions ▪ Induction and Mandatory Training programme ▪ Contractor information leaflet ▪ Local Induction Checklist ▪ Volunteer training provided		SC	HR	Achieved	
6.3	Where staff undertake procedures, which require skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently.	ANTT Policy Competency framework is being established for CVC, peripheral cannulation, urinary catheterisation, wound care blood cultures.	March 2012	SC	WJ	Competency framework under consultation	

Criterion 7- Provide or secure adequate isolation facilities.

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
7.1	A healthcare registered provider delivering inpatient care should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection.	▪ Cohort Ward operational policy ▪ Side rooms facilities audit ▪ MDRO policy ▪ VHF policy ▪ Regional Infectious Diseases Unit ▪ High Secure Infectious Diseases Unit (National)	▪ January 2013 ▪ May 2014 ▪ April 2014 ▪ September 2014	SW	DGMs	Achieved.	
7.2	Policies should be in place for the allocation of patients to isolation facilities, based on a local risk assessment. The assessment could include consideration of the need for special ventilated isolation facilities. Sufficient staff should be available to care for the service users safely.	▪ Isolation Policy ▪ VHF policy ▪ TB policy ▪ MDRO guidelines ▪ Notification policy ▪ Regional Infectious diseases unit ▪ Direct observation policy in production ▪ Close liaison with Patient Flow team to optimise side room access	▪ February 2013 ▪ September 2014 ▪ March 2010 ▪ April 2014 ▪ December 2012	SW	DGMs	Achieved	
7.3	Registered providers of accommodation should ensure that they are able to provide or secure facilities to physically separate the service user from other residents in an appropriate manner in order to minimise the spread of infection.	▪ Liaison with Patient Flow Managers		SW	DGMs	Achieved	

7.4	Care homes (Intermediate care) are not expected to have dedicated isolation facilities for service users but are expected to implement isolation precautions when a service user is suspected or known to have a transmissible infection.	▪ Local protocol for the intermediate care setting.		SW	DGMs		

Criterion 8 - Secure adequate access to laboratory support as appropriate

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
8.1	A registered provider should ensure that laboratories that are used to provide a microbiology service in connection with arrangements for infection prevention and control have in place appropriate protocols and that they operate according to the standards required by the relevant national accreditation bodies.	▪ CPA accreditation	Copy of Accreditation letter	SW	ZQ TN GM	Achieved	
8.2	Protocols should include:- ▪ A microbiology laboratory policy for investigation and surveillance of healthcare associated infections ▪ Standard laboratory operating procedures for the examination of specimens ▪ Timely reporting	• Reporting via Co-Surv • SOPs	List of SOPs held in the laboratory	SW	ZQ TN GM	Achieved	

Criterion 9 - Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
9.1	A provider should, in relation to preventing, reducing and controlling the risks of infections, have in place the appropriate policies concerning the matters mentioned in (a) to (y) below. All policies should be clearly marked with a review date.			SC	ICNs		
9.2	Refers to a guidance table on required policies in the appendix						
9.3	Any registered provider should have policies in place relevant to the regulated activity it provides. Each policy should indicate ownership (i.e. who commissioned and retains managerial responsibility), authorship and by whom the policy will be applied. Implementation of policies should be monitored and there should be evidence of a rolling programme of audit and a date for revision stated.	▪ Ownership details listed ▪ Policies and guidelines all follow specified Trust policy/guideline format ▪ Review date included on all policies ▪ Audit programme in place	As listed A-Y below	SC	ICNs	Achieved	
a)	Standard infection control precautions		October 2012	SC	ICNs	Achieved	
	Hand Hygiene Policy		May 2012	SC	ICNs	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	Personal Protective Equipment		March 2012	SC	ICNs	Achieved	
b)	Aseptic technique ANTT policy		March 2012	SC	ICNs	Achieved	
c)	Outbreaks of communicable infection		January 2013	SC	ICNs	Achieved	
d)	Isolation of service users with an infection		February 2013	SC	ICNs	Achieved	
e)	Safe handling and disposal of sharps		November 2011	SC	CE	Achieved	
f)	Prevention of occupational exposure to blood borne viruses, including prevention of sharps injuries		November 2011	SC	CE	Achieved	
g)	Management of occupational exposure to blood borne viruses and post-exposure prophylaxis		November 2011	SC	CE	Achieved	
h)	Closure of rooms Wards, Departments and premises to new admissions		January 2013	SC	ICNs	Achieved	
i)	Environmental disinfection policy	Terminal Cleaning guidelines Cleaning Policy	July 2012 October 2013	SW	MAn JMcG	Achieved	
j)	Decontamination of reusable medical devices		March 2013	SW	GH	Achieved	
k)	Single use medical devices		March 2013	SW	GH ICNs	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
l)	Antimicrobial prescribing		November 2014	SC	ZQ/TN	Achieved	
m)	Reporting of Infection to Public Health England and Mandatory reporting of Healthcare associated infection to Public Health England	Notification Policy Mandatory reporting Policy	 March 2013	SC	ICNs	Achieved	
n)	Control of outbreaks and infections associated with specific alert organisms						
	MRSA Policy		May 2014	SC	ICNs	Achieved	
	Clostridium difficile		October 2012	SC	ICNs	Achieved	
	Glycopeptide resistant enterococci	MDRO guidelines	April 2014	SC	ICNs	Achieved	
	Carbapenem resistant organisms	MDRO guidelines		SC	ICNs		
	Acinetobacter and other antibiotic resistant bacteria	MDRO guidelines	April 2014	SC	ICNs	Achieved	
	Viral haemorrhagic fevers	Guidelines	September 2014	SC	ICNs	Achieved	
	CJD and other human prion disease	Policy requires revision	December 2010	SC	ICNs	requires review	
	Relevant policies for other specific alert organisms						
	TB and MDR TB	Policy requires revision	March 2010	SC	ICNs	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	Respiratory viruses						
	Pandemic Influenza		January 2013	SC	ICNs	Achieved	
	Chickenpox and Shingles		October 2012	SC	ICNs	Achieved	
	RSV		February 2013	SC	ICNs	Achieved	
	Diarrhoeal viruses	Viral gastroenteritis guidelines	December 2012	SC	ICNs	Achieved	
o)	Handling of instruments and devices in procedures carried out on known or suspected CJD patients and on patients known to be at risk of CJD (including disposal/quarantine procedures)	Policy requires revision	December 2010	SW	GH/ ICNs	Achieved	
p)	Safe handling and disposal of waste	Policy/guidelines	November 2013	SW	MAn	Achieved	
q)	Packaging, handling and delivery of laboratory specimens	Guidelines requires revision Laboratory Users' Handbook (Pathology)	July 2010 November 2012	SW	GM ICNs	Achieved	
r)	Care of deceased patients	Policy being revised	February 2011	SW	ICNs	Achieved	
s)	Use and care of invasive devices						
	Peripheral Venous Cannulation.		January 2013	SC	AR	Achieved	
	Adult Central Venous Access Devices		March 2011	SC	AR	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	Peripheral inserted catheters (midlines)		October 2013	SC			
	Intravenous drug administration. Excluding Neonatal Unit		August 2013	SC	AR	Achieved	
	Trust Policy Adult Venepuncture		January 2011	SC	AR	Achieved	
	Male catheterisation policy		March 2013	SC	RCo	Achieved	
	Female catheterisation		April 2013	SC	RCo	Achieved	
	Intermittent Self Catheterisation		February 2014	SC	RCo	Achieved	
	Supra-pubic catheter removal and reinsertion		July 2013	SC	RCo	Achieved	
t)	Purchasing, cleaning, maintenance and disposal of equipment Medical Devices Policy	Pre-purchase questionnaire electrical equipment Need to identify purchase of non-electrical items Pre-purchase questionnaire medical devices	April 2012	SW	AP	PPQ circulated for use	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
u)	Surveillance and data collection	Alert organism monthly reports Co-serv reporting C. Section Audit Orthopaedic SSI		SC	AS	Surveillance and data systems in place overarching policy in draft format	
v)	Dissemination of information	▪ Transfer and discharge policy ▪ Outbreak policy ▪ Information Governance Policy	▪ October 2013 ▪ January 2013 ▪ September 2011	SC	ADN MAsh	Achieved	
w)	Isolation facilities	▪ Isolation Policy ▪ Isolation Facilities Audit	▪ February 2013 ▪ May 2014	SW	BCM		
x)	Uniform and dress code	▪ Uniform / Work Wear Policy	▪ October 2013	SC	DGMs	Achieved	
y)	Immunisation of service users	GUM protocol required Other areas of vaccine use to be identified Advice in Antibiotic Formulary on vaccinations following splenectomy		SC	CE	Policies requested from areas where service users are vaccinated	

Criterion 10 - Providers have a system in place to manage the occupational health needs of staff in relation to infection

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
10a	Registered providers should ensure that policies and procedures are in place in relation to the prevention and control of infection such that: All staff can access occupational health services or access appropriate occupational health advice	▪ Leaflet for all staff ▪ Attendance Management policy	May 2011	SC	CE	Achieved	
10b	Occupational health policies on the prevention and management of communicable infections in care workers are in place.	▪ Policies in place for Health screening ▪ Liaison with Infection Control Team/PHE	September 2012	SC	CE	Achieved.	
10c	Decisions on immunisation should be made on the basis of a local risk assessment as described in Immunisation Against Infectious Diseases ('The Green Book'). Employers should make vaccines available free of charge to employees if a risk assessment indicates that it is needed (COSHH regulations 2002).	▪ Policy on Occupational Health Standards for Health clearance and Immunisation of healthcare workers	September 2012	SC	CE	Achieved	
10d	There is a record of relevant immunisations	▪ Occupational Health records and policies. ▪ Confidential database		SC	CE	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
10e	The principles and practice of prevention and control of infection are included in induction and training programmes for new staff. The principles include ensuring that policies are up to date, feedback from audit results, examples of good practice and action needed to correct poor practice.	▪ Copies of training presentations ▪ Information on audit included in training sessions		SC SC	WJ WJ ICNs	Achieved	
10f	There is appropriate ongoing education for existing staff (including support staff, agency/locum staff and staff employed by contractors) which should incorporate the principles and practice of prevention and control of infection	▪ Mandatory training and trust e-learning programme for permanent staff ▪ Contractor advice available ▪ Local induction checklist ▪ Temporary staffing policy		SC	WJ WJ		
10g	There is a record of training and updates for all staff	▪ Training statistics discussed monthly at Infection Control Sub-Committee		SC	WJ	Less than 85% attendance recorded at Training sessions	
10h	The responsibilities of each member of staff for the prevention and control of infection are reflected in their job description and in any personal development plan or appraisal	• PDR paperwork and confirmation from HR in relation to Job descriptions • Training Needs Analysis reviewed in line with the Core Skills Framework		SC	WJ	Achieved	
10.2a	Occupational Health Services for staff should	▪ Copy of pre-employment questionnaire		SC	CE	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	include:- Risk-based screening for communicable diseases and assessment of immunity to infection after a conditional offer of employment and ongoing health surveillance					Review in progress for measles immunity	
10.2b	Offer of relevant immunisations	▪ Policy on Occupational Health Standards for Health clearance and Immunisation of healthcare workers	▪ September 2012	SC	CE	Achieved	
10.2c	Having arrangements in place for regularly reviewing the immunisation status of care workers and providing vaccinations to staff as necessary in line with Immunisation Against Infectious Diseases ('The Green Book') and other Department of Health guidance.	▪ Copy of letters for chickenpox and measles review ▪ Cohort Database (confidential information)		SC	CE	Achieved	
10.3a	Occupational Health Services in respect of BBVs should include:- Having arrangements for identifying and managing healthcare staff infected with hepatitis B or C or HIV and advising about fitness for work in line with Department of Health guidance;	Policy on Occupational Health Standards for Health clearance and Immunisation of healthcare workers	September 2012	SC	CE	Achieved	
10.3b	liaising with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses when advice is needed on	Policy on Occupational Health Standards for Health clearance and Immunisation of healthcare workers	September 2012	SC	CE	Achieved	

Criteria	Definition	Evidence	Evidence Verified + Date	Exec. Lead	Op. Lead	Current Status	RAG
	procedures that may be carried out by BBV-infected care workers, and when patient tracing, notification and offer of BBV testing may be needed	Document referenced within the Policy					
10.3c	a risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids;	▪ Policy in place		SC	CE		
10.3d	management of occupational exposure to infection, which may include provision for emergency and out-of-hours treatment, possibly in conjunction with accident and emergency services and on-call infection prevention and control specialists. This should include a specific risk assessment following an exposure prone procedure	▪ Policy in place ▪ Education provided on Infection Control mandatory training programme		SC	CE		

Key:

Initials	Name
AP	Alison Parker, Head of Supplies
BCM	Business Continuity Manager
CE	Caroline Eardley Interim Workplace Health & Wellbeing Manager
DGMs	Divisional General Managers (Kate Warbrick, Richard Brown, Dawn Woods)
ADNs	Associate Directors of Nursing (Rachael Browning, Melanie Hudson, Sue Franklin)
HW	Helen Wynn (Head of Health and Safety)
GC	George Cresswell, Associate Director of Estates
GH	Guy Hanson Synergy Contracts Manager
ICSC	Infection Control Sub-Committee
ICNs	Infection Control Nurses Lesley McKay, Andrew Sargent, Karen Smith
ICT	Infection Control Team
JMcG	Julie McGreal Facilities Manager
KD	Karen Dawber Director of Nursing, Governance and Workforce planning
KW	Kate Warbrick, Divisional General Manager, Scheduled Care
LMcK	Lesley McKay Infection Control ADIPC
Man	Marcia Antony, Facilities manager
MAsh	Mark Ashton
MP	Mel Pickup, Chief Executive
PHE	Public Health England
SC	Simon Constable Medical Director/DIPC
SW	Simon Wright, Chief Operating Officer
TN	Thamara Nawimana, Consultant Microbiologist Infection Control Doctor
WJ	Wendy Johnson Head of Organisational Development
ZQ	Zaman Qazzafi, Consultant Microbiologist

BOARD OF DIRECTORS

WHH/B/2015/ **073**

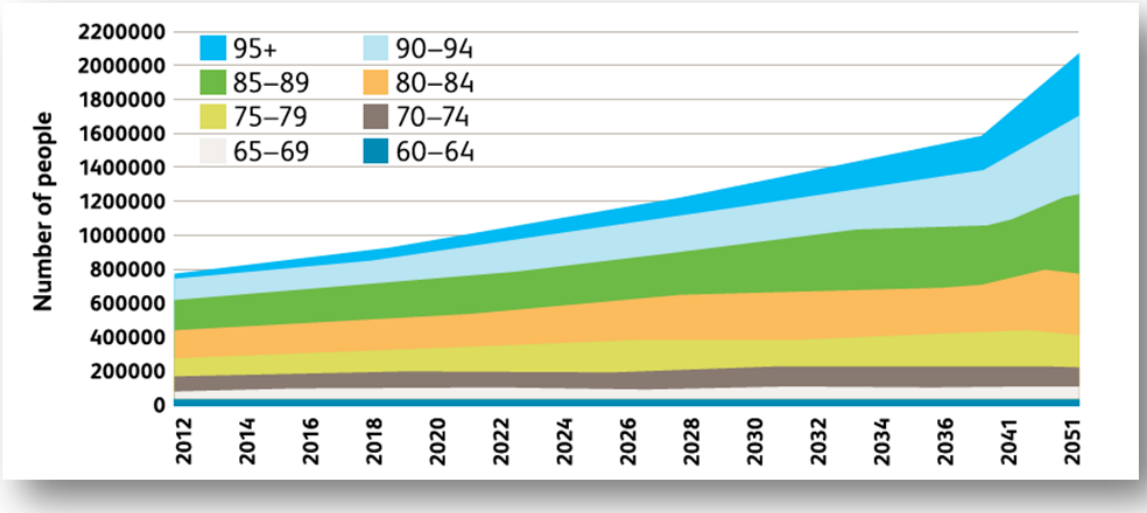
SUBJECT:	To brief the Trust Board on progress of the Dementia Strategy and national and local Dementia CQUINs	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Alison Lynch, Deputy Director of Nursing	
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance	
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO3: To give our patients the best possible experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review SO4/4.3 Failure to manage key contracts appropriately resulting in contract penalties or reduction in service standards; and failure of operational processes to deliver service to agreed contract targets, outputs or standard	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This paper provides the Board with an update on the 10 Key areas identified within the Dementia Strategy and national and local Dementia CQUINs	
RECOMMENDATION:	***The Board is asked to:*** Note the updates on the ten work-streams related to the Dementia Strategy, the work of the Dementia Steering Group (Forget Me Not) and National and Local CQUINs.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

1. Introduction

The Trust approved the Dementia Strategy in October 2013, and have received regular updates in relation to the work of the dementia teams within the organisation. A lot has happened to benefit our patients with dementia, and as an organisation we could not be prouder of our developments. We know that there is the required drive within our hospitals to provide the best possible care for patients with dementia. This paper provides an update to the Trust Board on current achievements and progress made by Trust Dementia Steering Group (Forget Me Not) against the ten key areas of the strategy. It also updates on progress made in relation to the local and national dementia CQUINs in implementing work against the agreed timelines.

2. Background

According to the projections below, there will be over 850,000 (855,700) people with dementia in the UK by 2015; over 1 million (1,007,485) by 2021; and 2 million (2,092,945) by 2051.



The Government identified Dementia as a National priority and within the Department of Health's "National Dementia Strategy" (2009). Following on from this National Strategy a new commissioning framework for Dementia was launched in July 2011. Since this time the Trust has worked on various work-streams toward ensuring that those patients with Dementia receive the best possible care.

The "Prime Ministers Challenge on Dementia", launched in March 2012, its focus being to "drive improvements in health and social care, to create Dementia friendly communities and to undertake better research". Increasing diagnosis rates has been highlighted as a National objective.

3. Trust Dementia Strategy

At Warrington and Halton Hospitals our staff are dedicated to providing the best possible care for patients with Dementia, our Dementia Strategy sets out the framework by which we will achieve this with ten key areas identified which are underpinned by action plans monitored by the Dementia Steering Group.

3.1 Ten Key Areas of the Dementia Strategy

3.1.1 Dementia Champions

Champions are in place at board level and the dementia ward champion role is in place in clinical areas, with specific roles and responsibilities for improving the care of dementia patients within Warrington and Halton Hospitals

We have developed dementia champions to include trained non-clinical and clinical staff in place at

ward and department levels who have all received additional training. We also have active senior medical and senior nursing leads for dementia within the Trust. We are pleased to report that a dementia champion is in place in almost every clinical area and we therefore report that this key area of the strategy has been achieved

The ward/department based champions come together regularly to gain up to date knowledge and skills in relation to patients with dementia in our hospital. They then cascade and disseminate that information in their own clinical area. An example of the work of the dementia champions is to ensure that the ward and department dementia information boards are up to date, and include relevant information for the support of carers during not only their admission, but when care is transferred to the community.

In Accident and Emergency our dementia champion is working closely with the Patient Safety and Quality Champion and Specialist Nurse for Older People and they have produced a series of "special considerations" for dementia care in the department. The special considerations included initial contact (with particular reference to training and education for the reception staff). For clinical staff the special considerations provide essential information for reasonable adjustments, including a higher triage priority required for patients with dementia. A department specific DAWES (Department and Ward Assessment Scheme) has been developed and includes a section of standards expected from all staff in A&E caring for patients with dementia and their families and carers.

3.1.2 Dementia Information

There will be accessible information about the dementia champions which is available to carers, patients and staff. There will be Dementia Awareness packs on the wards, and information relating to dementia will be available on our intranet and Trust website.

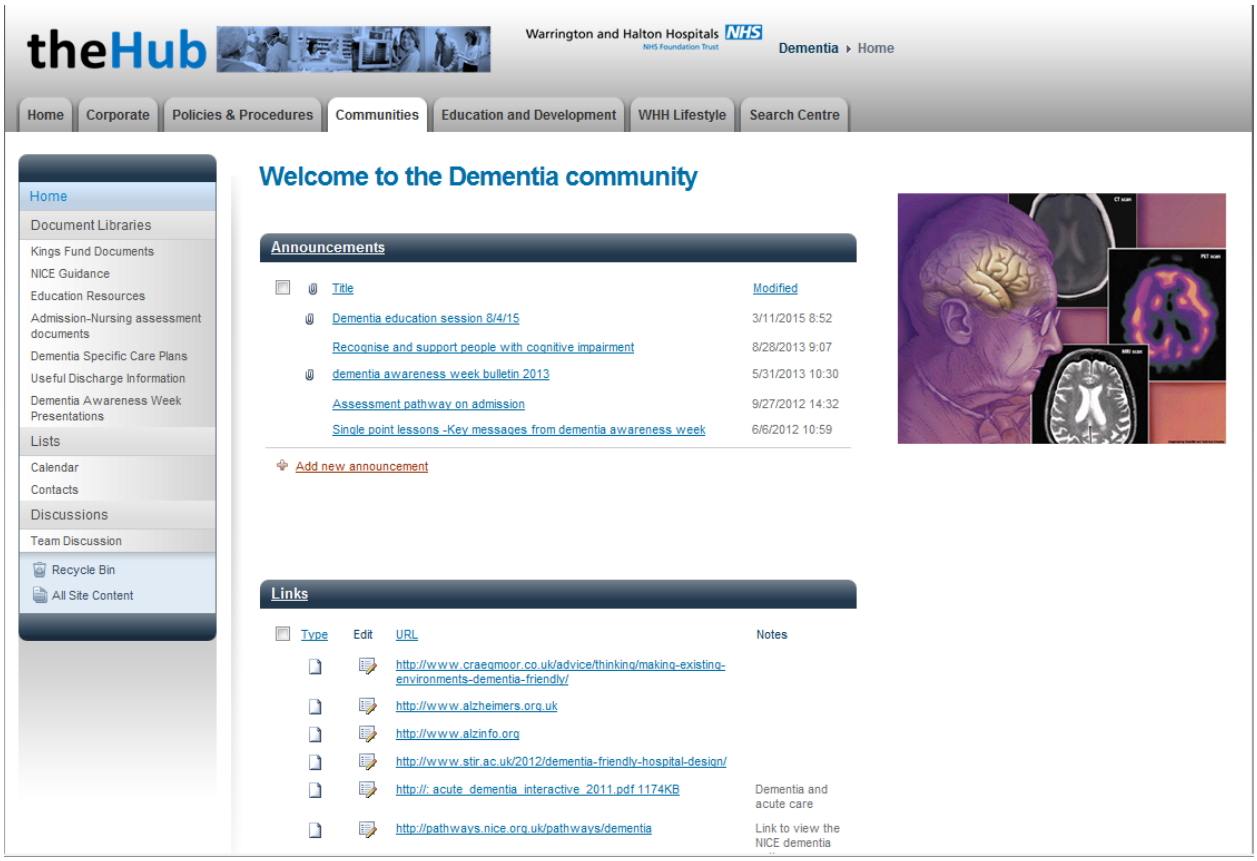
Our Specialist Nurse for Older People has developed series of six Single Point Lessons. Single Point Lessons are a tried and trusted method of communicating essential information to the front-line staff via a cascade system.

Single Point Lessons have been developed based on NICE Guidance and Quality Standards, available expertise and our own local policies and procedures. For example, they describe the way we expect care to be delivered in specific conditions in simple one lesson steps. The lessons are delivered to every ward manager at their embedded daily staffing meetings. The ward manager then goes directly back to their department and delivers the lesson at shift change safety briefings so that staff have received the essential information they require. This is, of course an augmentation to the dementia training that is offer in the trust.

Every ward has a dementia information board, which is updated by the Dementia Champion. Information is provided on local dementia services, and details what the patient and their family with dementia can expect from our services. The dementia web community holds information for staff, and this area and that of the Trust website will be an area of focus in 2015/16.

Additionally our clinical librarian has developed a regular electronic dementia awareness bulletin that can be accessed by all grades of staff with links to latest dementia research and knowledge.

A ‘dementia community’ has been put together within the local hospital intranet which contains the appropriate clinical assessment tools and management plans to support staff in the delivery of care. Links are also given to interactive education websites and voluntary agencies. The community will be redeveloped and launched to coincide with the Dementia Conference planned for October 2015.



3.1.3 Dementia Training

A dementia training framework will be developed to provide awareness and training for all staff within the Trust. Awareness sessions will be included in the mandatory training for all clinical staff. Training will be available as taught, interactive, resource files and e-learning. Training will include the use of non-medication methods of addressing behavioural problems.

A group of key staff are undertaking further dementia champion training sponsored by the Alzheimer’s Society which will enable a train the trainer programme to be rolled out across the Trust. This training commences on 29th April 2015.

On 8th April 2015 the Trust held a Dementia Education Conference at Warrington Education Centre with regionally recognised experts presenting several case studies, particularly geared toward the appropriate management of challenging behaviour. 60 clinical staff attending this conference, initial feedback is excellent with staff commenting on the usefulness of the sessions in providing practical support to them in caring for patients with dementia. Some of the sessions included therapy in the Forget Me Not Unit by our Specialist Occupational Therapist and our Specialist Physiotherapist, and a patient story from the family’s perspective.

The education conference will be repeated alongside the planned Dementia Conference in October 2015.

Staff access and undertake training on e-learning through the NHS e-learning portal. Staff also undertake a level 2 national qualification in the principles of dementia care. This award is achieved through completion of workbooks approved by the Northern Council for Further Education (NCFE). The table below demonstrates the number of staff who have completed or who are working towards NCFE level 2.

Number	Work Area
5	Car Parking and Security
35	Nursing
7	Allied Health/Scientists
5	Administration

The table below demonstrate the number of staff who are working toward NCFE level 2 learning

Number	Work Area
1	Allied Health
1	Nursing
1	Administration/Other

The number of staff trained by staff group is as follow:-

	Medical	Registered Nurses	ST and T	Clinical Support	Information Support	TOTAL
1st April 2014 to 31st March 2015	55	309	147	276	40	827

The particular skills held by the Cognitive Assessment Team are proving invaluable to the staff and families in understanding the specific requirements or needs of dementia patients in a hospital environment. The skills of this team also contribute greatly to smooth patient journey in the interface between community and acute care.

3.1.4 Personalised Care Planning

Following individual patient assessment, the care plan will reflects the needs of the patient relating to:

- *Privacy and dignity*
- *Nutrition and hydration*
- *Pain assessment and control*
- *Communication*
- *Continence*
- *Carer and family involvement*

Our new nursing care booklet includes individual patient assessment relating to the above, however we recognised that a more bespoke care planning method is required. Therefore our Specialist

Nurse for Older People has produced a suite of care plans for patients with Dementia, delirium or cognitive impairment which were launched in November 2014. We will monitor the use of these plans through the DAWES Dementia section.

3.1.5 Patient Experience

Patients and carers feedback will be sought to ascertain levels of satisfaction with care. We will audit the experience of patients, their family or carers to test whether they feel supported by our staff. We will develop plans to address areas for improvement.

We regularly survey to seek the opinion of carers of the care provided to patients with dementia. We have also developed some unique ways ascertaining levels of patient satisfaction that is separate to the Trust's current approach.

The following are the results of an audit of our new approach, the Forget Me Not Wheel, to getting the views of patients and their carers together based on their experience on the Forget Me Not unit.

Did the care approach on FMN unit benefit you/your relative? (Audit between 1st December 2014 and 1st March 2015)

ID No	COMMENTS
Daughter in Law	The staff were wonderful with her, the care approach was just right, they got to know Mrs X's ways. Good clear information given to us even over the telephone!
Daughter	The staff approach is good. They don't make the aggressive episodes worse if you know what I mean. They are learning from us what works – either withdraw altogether or go into another room for a short time.
Son	The ward is very good, they are getting to know my mums little ways. I think she will get what she needs on the FMN ward
Daughter in Law	The care was vastly different on the Forget me Not ward. They are geared up for that type of patient compared to previous admission when the ward just couldn't cope with her so much so that I think they discharged her early because of this. (son) thinks the nurses on B12 were angels. They really looked after her needs, not just physically but her mental well-being. The difference from previous wards was massive. She died yesterday by the way. (condolences offered)
Husband	Yes they looked after her very well, she is still having hallucinations but we are going to see someone at the memory clinic I believe.
Not specified	Overall the care was very good – nothing went wrong. They really looked after Mrs X – it's difficult – they looked after me too!
Daughter	Absolutely excellent, mum didn't want to leave! There was no equipment for her to interfere with, she liked to sit in the chairs and people watch, it was like being in someone's lounge. The staff always introduced themselves to Mum and had time for a conversation with her. It was such a difference from the other ward she was on and helped to keep her calm.
Son	'we thought she was a goner, she wouldn't eat or drink but they got her better on here'
Patient	**'**oh yes, they are very good to me here'
Son	'I am really pleased with how B12 have managed mum, she is so much better overall and so is her behaviour'
Family member	'Her behaviour is managed much better, she was paranoid and having hallucinations – we discussed everything with Psychiatric liaison'
	'they look after her very well, sometimes she doesn't cooperate and they

husband	understand that'
Daughter	'My little Mum entered B12 a frightened aggressive patient. With the skills of your wonderful staff she became a lot calmer and more like my very precious Mum – I cannot thank you enough for all your help and loving care from everybody'

RECEPTION	GARDEN	TOILETS/ENSU	LOUNGE/DININ	PATIENT	QUIET ROOM

Wife	To Sr Stringer - 'the staff have been wonderful, I've had a lot of support and also from the other families on the ward – we are going to keep in touch'
Husband	'I've been very pleased the way they have looked after (my wife)'

3.1.6 Enhancing the Healing Environment

Every single one of our Board members is aware of the excellent progress that has been made since May 2014 to our Forget Me Not Unit. Here are examples of some of socialising and activities on the ward.

Feedback from our dementia carer survey that relates to the environment of the Forget Me Not unit was also received, and a sample of these are included below.

		ITE	G AREA	BAY/SIDE ROOM	
Busy, friendly area where there is always a nurse to have a conversation with		toilets are always clean		Mum loves cubicle 1 and it is nice to have some privacy	Spoke to daughter in the quiet room
Busy, friendly, nice area away from bed	Pleasant in nice weather	functional	Pleasant area	Quiet peaceful	N/A
Excellent friendly	Not been outside as its winter	Very clean, tidy	Plenty going on useful for communicating		Restful on your mind
Lively	Really nice beautiful	Clean adequate	Very nice, calm and bright	lonely	N/A
Bright active	N/A	clean	N/A	Pleasant and calm	N/A
cozy	It looks nice for the summer	handy	Nicely laid out		peaceful
Pleasant Comfortable Clean Relaxed busy	N/A	N/A	N/A	Clean Friendly Welcoming Informative relaxed	

3.1.7 Early identification of Patients with Dementia

All patients over the age of 75 who are admitted to Warrington and Halton Hospitals who present with confusion/ memory loss will be screened by our nursing staff as part of a holistic assessment. All patients who require it will receive an assessment by the specialist nurse team, who will refer the patient to appropriate other services. We will forge partnerships working with community teams to improve the assessment of patients with dementia.

We have achieved consistently our target of screening over 90% of patients eligible by our nursing staff. We are now working toward identification of patients over the age of 70. We regularly achieve almost 100% of patients being screened, and are developing our methods to ensure we can capture patients over the age of 70.

3.1.8 Reduction of movement of Patients with Dementia

Patients will not be moved between wards if at all possible. Moves at mealtimes and medication times will also be avoided. Discussion regarding movement of patients with dementia will focus on the effect on the wellbeing of the patient. Carers and families should also be involved in any decision to move a patient with dementia. Our discharge planning will be holistic and carers and families will be involved in decisions affecting patients with dementia from the time of admission to the hospital.

We have developed a plan to monitor the movement of patients with dementia, and put in place actions to restrict moves that are not in the patient's best interest. The findings of the audits will

now form part of the new Patient Experience Sub-Committee key performance indicators.

3.1.9 Identification System

An agreed system will be in place across the Hospital so that staff are aware of the person's dementia (visual identifier behind the bed or in the notes). This will result in easy identification of patients with dementia on the ward so that appropriate responses can be provided to their needs.
We have launched the use of the Forget Me Flower symbol behind the patient's bed. The symbol reminds staff that the patient either has a diagnosis of dementia or has cognitive impairment and that they should ensure that their approaches to the patient are appropriate. This is accompanied by information to staff, carers and families about what this means for the patient.

Specifically for AED we have developed "forget me not logo" stickers that are attached to the patient documentation to provide a trigger that ensures that that the clinician is tailors their management plan accordingly. These have been welcomed by all staff in the department.

3.1.10 Forget Me Not Campaign

Detailed information has been provided in the first biannual report and in sections within this report in relation to this aspect of the dementia strategy.

Our campaign is spreading far more widely than we could have hoped, and we are regular hosts to visitors from other trusts and organisations who are in the early stages of developing their units and strategies and wish to learn from us – it is great to know that *We Are What Good Looks Like* for other organisations.

4. Trust Dementia Steering Group (Forget Me Not) and National and Local Dementia CQUIN

The Trust Dementia Steering Group (Forget Me Not) has responsibility for delivery of the Trust's Dementia Strategy and the objectives of the Dementia 2013/2015 Strategy work plan, against agreed timelines. The Dementia Steering Group (Forget-Me-Not Group) meets monthly (at least 9 times per year) to provide a strategic direction to developing Dementia services within the Trust. The group has representatives from across professions including Estates, together with representatives from carers, and Alzheimer's UK local representatives..

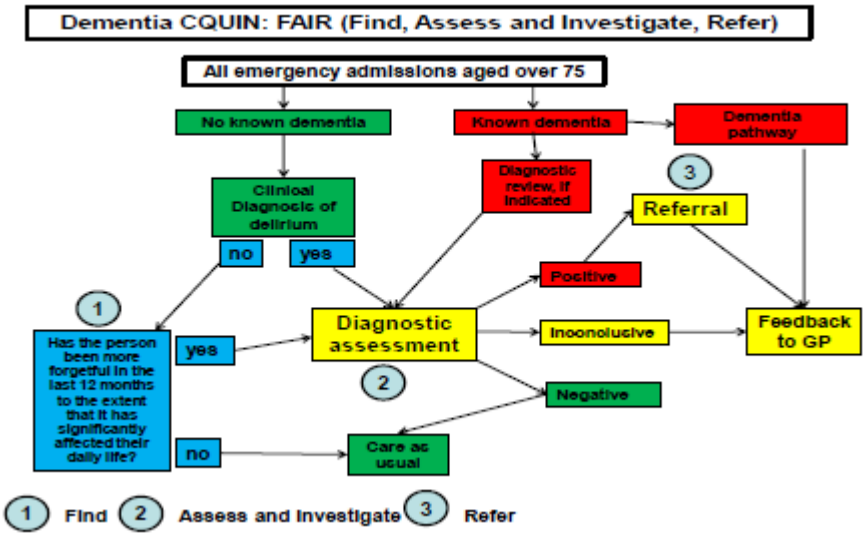
A National Dementia Commissioning for Quality and Innovation (CQUIN) payment framework for was Dementia launched in April 2012. Its aim is to incentivise the identification of patients with Dementia and other causes of cognitive impairment alongside their other medical conditions, to promote appropriate investigations and to prompt appropriate referral at discharge. The CQUIN objectives form part of Trust Strategic Objectives. The Trust agreed a local CQUIN with Warrington Clinical Commissioning Group.

Overview of achievements and progress in both National and Local CQUIN requirements from 1st April 2014 to 31st March 2015:

4.1 National Dementia CQUIN (Financial Impact – £521,621)

Part 1 Find, Assess and Refer (Achieve >=90%)

We are required to and know that it is the right thing to do – find patients who might have dementia, to assess them in accordance with our assessment criteria and refer those patients onto pathways and services, such as memory clinics. We assess the proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services in the community. We need to achieve over 90% in each section.



The value of this part of the CQUIN to the Trust is £312,973. We are achieving this to date as demonstrated in the table below. The Trust has worked hard at implementing the CQUIN and is pleased to report that we have once more achieved full compliance with this element of the dementia CQUIN for 2014/2015.

Dementia	A	M	J	J	A	S	O	N	D	J	F	M
Part 1 FIND 2013/2014	90.43	93.14	91.3	92.87	95.12	95.12	95.2	95.13	96.1	97.76	97.36	94.57
Part 1 FIND 2014/2015	94.55	95.69	95.43	94.26	96.59	92.45	92.7	96.61	96.29	96.93	94.81	N/A
Part 2 INVESTIGATE 2013/2014	96.77	100	100	100	100	93.3	100	96.43	96.88	100	100	100
Part 2 INVESTIGATE 2014/2015	100	100	100	100	100	91.89	100	100	97.22	96.77	100	N/A
Part 3 REFER 2013/2014	100	100	100	100	100	100	100	100	100	100	100	100
Part 3 REFER 2014/2015	100	100	100	100	100	100	100	100	100	100	100	N/A

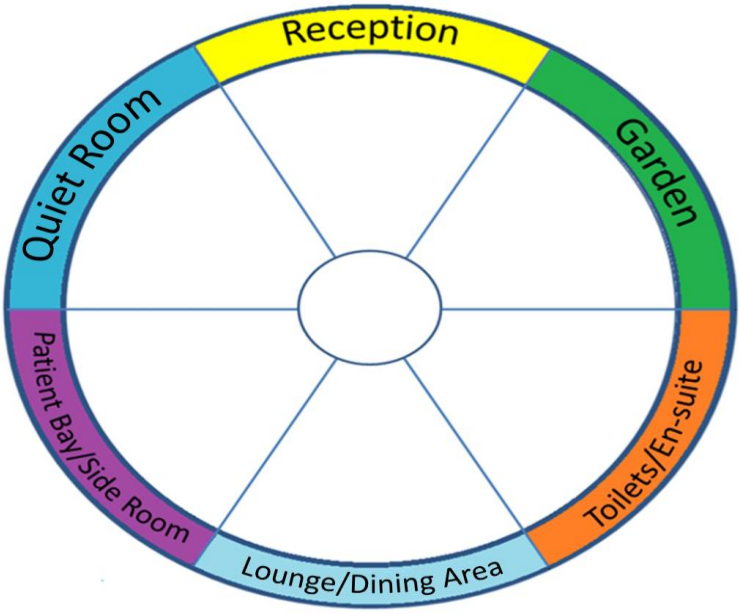
Part 2 Clinical leadership

We are required to ensure we have both a named lead clinician for dementia and that this role is clearly documented in the individual's job plan and appropriate training for staff. The value of this

part of the CQUIN to the Trust is £52,162. Dr Graham Barton is the Consultant-Geriatric Medicine and identified Dementia Lead for the Trust. Information on training can be found at 3.1.3.

Part 3 Supporting carers of people with dementia - monthly audit of carers.

The value of this part of the CQUIN is £156,486. The Trust sends out an audit proforma to carers requesting feedback on all aspects of the service and importantly how carers viewed care of their relatives. The results are compiled into monthly qualitative and quantitative reports which are reviewed by staff in order to change and improve practice across the service. We have also developed a tool called the "forget me not circle/wheel" to encourage further feedback from patients. Please see 3.1.5 for a detailed analysis of responses.



4.2 Local CQUIN – - Improvement in the care and experience of patients with dementia. (Year 1 of 2 year CQUIN)

We have worked toward setting an effective foundation for appropriate management of patients allowing significant improvements in the quality of care and substantial savings in terms of shorter lengths of stay. This effective foundation is further supported by our successful King's Fund bid under the 'Improving Environment of Care for People with dementia'. As part of our local CQUIN we have agreed to improve the care and experience of patients with dementia further throughout the next 2 years. This local CQUIN has a financial value of £198,216.

Since the opening of the FMNU we have monitored the following:

- Length of stay
- Number of completed Dementia Assessments – including This is Me and initial assessment documentation
- Falls
- Pressure Ulcers
- Number of reported incidents of violent and aggressive behaviour on the FMNU.
- Level of the need for !:1 nursing on the FMNU

- Re-admissions with 7 days of patients on the FMNU
- Re-admisisons within 30 days of patients with clinically coded dementia
- Number of patients from the FMNU in permanent admissions to care homes
- Carer feedback.
- Staff sickness in FMNU
- Number of complaints

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness (RN)	0.22	0.14	0.14	0.36	0.06	1	0.5	0.7	4.29	1.2	0	2.4
Sickness (CSW)	0.5	1	1.5	2.03	1.36	0.96	0.88	0.5	4.9	1.7	0.61	0.3
Specialling 1:1 (RN)	4.31	1.87	0	0	0	0	0	0	0	0	0	0
Specialling 1:1 (CSW)	3.88	0.22	5.02	4.45	9.5	2.65	2.07	1.64	9.5	1.87	4.44	4.29
Slips/Trips/ Falls	6	12	5	4	7	12	12	8	8	8	9	10
Incidents of violence/aggression	2	5	16	5	9	4	9	6	9	3	2	5
Readmission within 7 days - FMN Unit	0	0	0	0	0	0	0	0	0	1	1	0
Readmission within 30 days - patients with suspected dementia	29	32	30	36	35	26	33	23	28	27	11	
Average LOS on FMN Unit	Not available	N/A	N/A	N/A	N/A	27.9	15.96	15.58	15.94	15.88	16.25	30.67
Pressure ulcers developed whilst a patient on FMN Unit	1 (grade 2)	0	0	0	0	0	0	0	1	0	0	0
Relative complaints from FMN Unit	0	2	1	0	0	0	1	0	0	0	0	0
Permanent admissions to care homes from FMN Unit	Not available	N/A	N/A	N/A	N/A	7	5	3	10	7	8	11
Completed "This is Me" documents on FMN Unit	Not available	N/A	N/A	N/A	N/A	21	19	21	21	21	15	21
Completed "This is Me" documents across rest of the Trust	Not available						N/A	N/A	N/A	N/A	N/A	N/A
Patients where FMN Unit admission criteria not met	N/A	3	0	0	0	0	2	0	0	3	1	0

These indicators are currently being reviewed in consultation with the commissioners in order to develop a programme of work for year 2 of this CQUIN.

5. Update on other areas of work

5.1 Fundraising

We aim to continue to raise funds for dementia care at the Trust and our Associate Director of Communications is working closely with the newly appointed fundraising coordinator to launch our 'Dig Deep for Dementia' campaign. We want to raise funds to develop areas such as the Forget Me Not Garden and an interactive sound system and technology on the Forget Me Not Unit

5.2 Dementia Education Conference April 2015

We hosted our first ever dementia education conference this month. Over 50 Trust staff were joined by expert regional speakers, patients and carers to learn and share best practice and to hear the impact that high quality, compassionate staff interaction has on patients and families.

5.3 Dementia media and promotion

Since opening the ward we have built a strong media and promotional campaign to maximise publicity of the unit and share the best practice across the service.
Articles and promotion have appeared in:

- Warrington Guardian – pre launch, opening and several detailed follow up articles
- Runcorn World
- Runcorn Weekly News
- Liverpool Post
- Warrington Worldwide
- BBC Radio Merseyside
- BBC North West Tonight
- Nursing Times
- Nursing Standard
- Alzheimer's Magazine
- Health Estates Journal
- Journal of Dementia Care
- Alzheimer's Research UK
- Foundation Trust Network
- Knit and Crochet Magazines (we have received fiddle muffs from as far afield as Canada)

Contact has also been made with national broadcast media planning desks (BBC TV and Radio and ITN/Sky. Whilst the ward is not something they would typically feature as a standalone national item we have encouraged them to add us as a contact for a broadcast venue for future media pieces on dementia.

5.4 Dementia Awareness Week plan

The Forget Me Not Steering group is planning a series of events to be based in the garden, the main entrance and trust conference room which will coincide with the official opening of the unit by a celebrity who has a particular interest in dementia.

5.5 Stakeholder events

The trust has also used its events programme to publicise the ward:

- We were very proud to be chosen to host a stand at the Foundation Trust Network Conference in November2014 – the trust bid was awarded a showcase slot at this national

FT event and we shared learning from our work to over 700 delegates with 60 positive contacts from trusts across the country.

- At the Halton Carers conference in 2015, a display was manned by our senior team and this enabled us to develop effective networking and enhanced communication with carers

5.6 Areas for continued focus

- The dementia web community holds information for staff, and this area and that of the Trust website is to be an area of focus in 2015/2016
- Training figures to be improved
- Further development of the Cognitive Assessment Team since the Trust investment

Recommendations

This paper is for the Board to receive updates on the ten work-streams related to the Dementia Strategy, the work of the Dementia Steering Group (Forget Me Not) and National and Local CQUINs

BOARD OF DIRECTORS

WHH/B/2015/ **074**

SUBJECT:	**Complaints: Patient Experience Quarter 4 Report**
DATE OF MEETING:	29th April 2015
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Michele Lord, Patient Experience Matron
EXECUTIVE DIRECTOR:	Karen Dawber, Director of Nursing and Governance
LINK TO STRATEGIC OBJECTIVES:	SO1: Ensure all our patients are safe in our care SO3: To give our patients the best possible experience SO4: To provide sustainable local healthcare services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO3/3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED:	None
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an overview of complaints and other feedback received by the Trust in Quarter 4, • The Trust received a total of 153 formal complaints between 1 January and 31 March 2015, which is an increase of 45 on the previous quarter. • One case has been closed by the PHSO in quarter 4. Three cases have been partly upheld by the PHSO and the Trust is complying with recommendations. Four cases are currently being investigated by the PHSO. • 590 people contacted PALS in Quarter 4, this is an increase of 103 contacts on previous quarter. • There is an overview of feedback left on *NHS Choices* • 10 formal compliment letters were sent to the Chief Executive. • Graphs demonstrate the total complaints by subject and divisional top 5 complaint themes. • 100% of complaints were closed within agreed timescales. • Examples of learning from complaints (Quarter 3) from divisions is provided

RECOMMENDATION:	***The Board is asked to:*** The Board is asked to note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions recommended.	
PREVIOUSLY CONSIDERED BY:	**Committee** **NA**	Choose an item. Or type here if not on list:
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

EXECUTIVE SUMMARY

This is the fourth quarterly report providing an overview of complaints received by the Trust from 1 January to 31 March 2014. The report is written in accordance with the NHS Complaints Regulations (2009) and complements the patient experience annual report presented in May 2014.

Background

In accordance with the *NHS Complaints Regulations* (2009), this report sets out a detailed analysis of the nature and number of formal complaints. The report also offers feedback from other sources, compliments, NHS Choices and PALS to provide a more rounded picture of the nature of feedback and to emphasise good and bad, with an emphasis on how clinicians and managers are supported by this intelligence in planning service improvement and to celebrate that which is positive and applauded.

Whilst the processes in place to support handling of formal complaints are more robust than in previous years, there remains scope and the will to make improvements and to enhance the performance of the Trust in this area.

1. COMPLAINTS OVERVIEW

During Quarter 4 there were 152,195 attendances to our services. This makes the number of complaints received in quarter (165) just 0.10% of the total attendances.

Table 1: Trust activity, 1 January – 31 March 2015

Activity	Type									
Month	DayCase	Inpatient	Non-Elective	New	Follow Up	A&E	MIU	Ward Attender	Outside Clinic Attendance	Grand Total
Jan	3,015	408	3,343	10,285	25,620	6,751	1,082	1,189	78	51,771
Feb	2,611	379	2,788	9,375	23,293	6,358	1,111	948	54	46,917
Mar	3,030	514	3,082	10,967	25,892	7,358	1,475	1,117	72	53,507
Grand total	8,656	1,301	9,213	30,627	74,805	20,467	3,668	3,254	204	152,195

Figure 1: Complaints received per 1000 patient attendances for Quarter 4

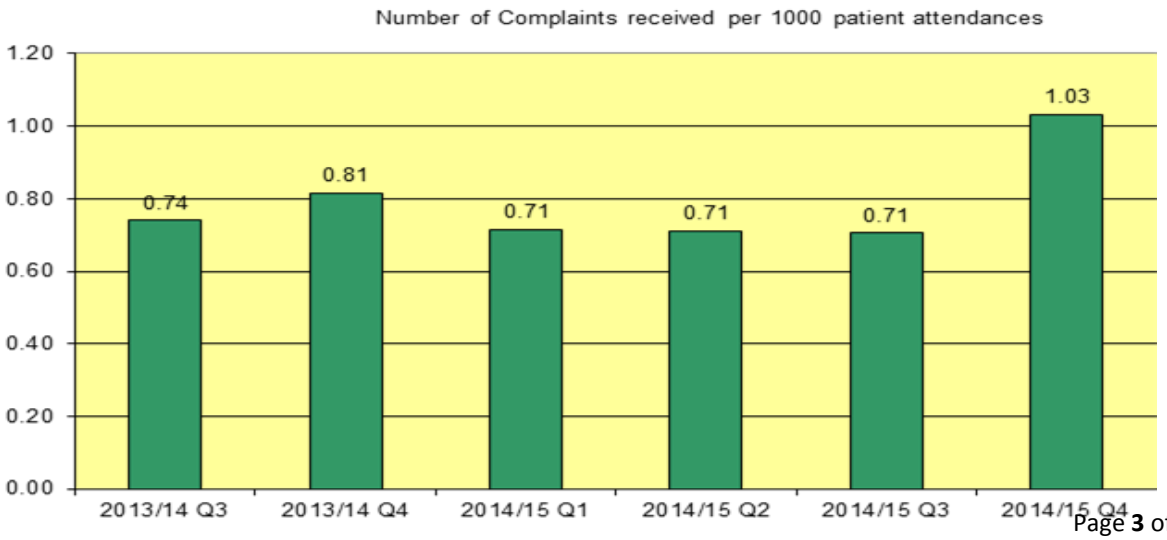


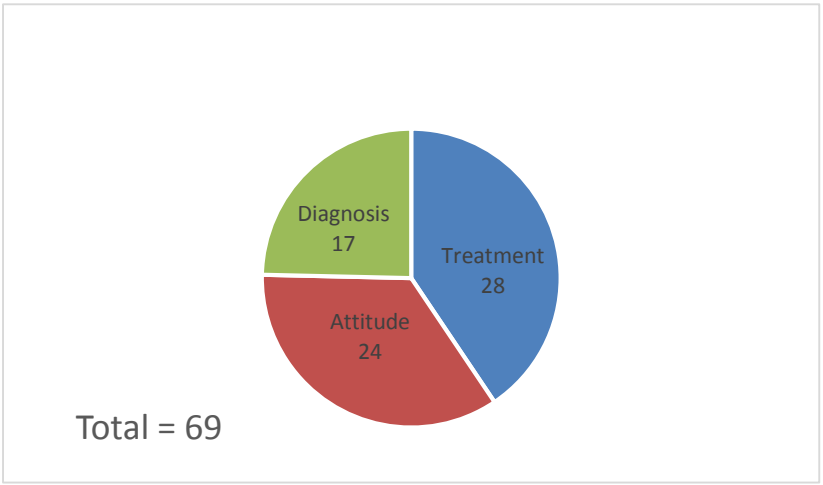
Table 2: Formal complaints received in Quarter 4

Quarter	Formal complaints received
Quarter 4, Jan – March 2015	153
Quarter 3, October – December 2014	108
Quarter 2, July – September 2014	110
Quarter 1, April – June 2014	107

The number of formal complaints received in Quarter 4 was 153. A further 13 were withdrawn and designated as concerns. This is an increase on Quarter 3 of 45. The very high demand for beds and increased incidence of infectious illness in the in-patient population has put increased the pressures on all aspects of the service and has led to more complaints being received, particularly in February and March 2015.

The highest rise in numbers of complaints can be seen in the number of low risk complaints, which have more than doubled from Quarter 3. Moderate risk complaints have risen, with 9 more complaints made than in Quarter 3. High risk graded complaints is at the lowest number for the year in Quarter 4, see Table 3.

Figure 2: Top three themes for complaints made in Quarter 4



A more detailed breakdown of the subjects, by all and by division can be found in figures 3 – 8.

Table 3: Top three subjects by month for Quarter 4

Month	Treatment	Attitude	Diagnosis
January 2015	6 medical	5 medical	3 delay in diagnosis 2 failure in diagnosis
Total	**6**	**5**	**5**
February 2015	9 medical 2 nursing 1 other	1 administrative 1 medical 8 nurse	1 delay in diagnosis 1 failure in diagnosis 3 incorrect diagnosis 1 missed fracture
Total	**12**	**10**	**6**
March 2015	8 medical 2 nursing	2 administrative 4 medical 2 nurse 1 midwife	3 failure to diagnose 3 incorrect diagnosis
Total	**10**	**9**	**6**

Complaints about attitude represent the second highest number of concerns, after treatment. This echoes national trends. The Health & Social Care Information Centre report for 2013 – 2014 (derived from the annual KO41a submission by all Trusts) says that of a total of 114,788 written complaints reported, 13,269 were about staff attitude, an increase of 966 (8%) on the previous year. This rise prompted the Board to request an assurance report that was reviewed in March 2015. This issue will be re-visited and updated as part of the annual report.

Withdrawn complaints should be re-assigned as concerns, but an error in data inputting by the patient experience team has meant that though the outcome of withdrawn has been assigned the type has not been changed to concern. Due to the way the monthly KPI information is generated, withdrawn complaints have been subtracted from the numbers for that report, but they have not been picked up in quarterly totals. This has been recognised and the team have been briefed on this issue. Going forward, in order to ensure the figures are correct and ongoing changes are timely, the type will be changed to concern as soon as the complaint is withdrawn. Quarterly figures will retrospectively check for any case withdrawn in a month after it was opened, to ensure the monthly figure can be updated. The figures have been updated in the quality dashboard.

Table 4: Risk rating of complaints, by quarter

	2014/15 Q 1	2014/15 Q2	2014/15 Q3	2014/15 Q4	Change from last Quarter
Complaints Received	**107**	**110**	**108**	**153**	↑
Low	48	41	39	80	↑
Moderate	40	58	54	63	↑
High	19	11	15	10	↓

All formal complaints were received in the English language with no requests made by a complainant (or enquirers) for the use of the Trust Interpreter Service. There were no formal complaints from or about the care of patients with a disability, where a disability was declared.

Parliamentary Health Service Ombudsman (PHSO)

During Quarter 4, there were nine cases outstanding with the PHSO. One complaint was closed and was partly upheld. The recommendations made by the PHSO have been followed including a letter of apology from the Chief Executive to the complainant for failings in care and treatment. Three more PHSO draft reports have been received, all partly upheld. Two of these have been accepted by the Trust and we await the final report and recommendations. A long disputed PHSO report has been resolved after the PHSO revisited the issues with a second independent advisor. The recommendations will be carried out as agreed. The PHSO are currently considering four complaints and we await further information.

Patient Advice and Liaison Service (PALS)

590 people contacted PALS in Quarter 4, compared to 407 in the previous quarter. There are three main reasons for this increase of 183. The high activity across the Trust for the winter period has prompted more queries and concerns raised. In addition, the decision to charge for disabled parking and associated issues and changes in the way that specialist spinal services are being commissioned regionally by NHS England has led to patients awaiting spinal surgery raising concerns about the new arrangements and further delays to their surgery. Nine PALS cases became formal complaints during Quarter 4.

The PALS Coordinator continues to be assisted by a temporary member of staff and additional support is provided by the Patient Experience Officers. In order to develop a feedback mechanism for user satisfaction with the service, a random sample of 36 PALS sheets were passed to a PALS volunteer. The volunteer attempted to contact the service users by telephone. She spoke to 12 of the sample. The results of this will be shared in the annual board report to be tabled at the May meeting. This method of seeking feedback will be introduced during the next quarter and results summarised and shared appropriately.

The PALS Datix module has been adapted to include the same subjects as the complaints module. This will enable a broad range of reports to be generated, going forward. There remains some

upgrades needed for the PALS module and the team are attempting to deal with a backlog of PALS sheets needing to be recorded on Datix.

Table 5: Examples of PALS contacts from Quarter 4

Q1	Contacts	Q2	Contacts	Q3	Contacts	Q4	Contacts
April	137	July	154	October	175	January	173
May	181	August	140	November	126	February	188
June	137	September	175	December	106	March	229
Total	455	Total	469	Total	407	Total	590

Table 6: Examples of the type of issues that have been raised with PALS

PALS Enquiry	Outcome
The PALS officer assisted a patient who was tearful and struggling to walk in the corridor close to the main entrance. The patient had received several tests during a period of 4 ½ hours and was awaiting further tests. She was aware that her parking ticket was due to expire within 30 minutes, therefore she would receive a fine if she did not renew the ticket.	The PALS officer made arrangements with the Cash Office Manager to enter the patient's car registration number into the Portal machine, as this process would ensure the patient would not receive a fine. The patient felt immediately relieved and was able to return to the out-patient department to await her further tests.
Upon removal of ET tube at the end of the operation a patient's upper tooth had been cracked. The anaesthetist was extremely worried and referred the patient on to the PALS team.	The PALS officer visited the patient on the ward and as the division had agreed to reimburse the dental costs a ward dental domiciliary visit was arranged by the PALS officer.
The family member of a patient attended the Patient Information Hub as they did not know where their relative had been admitted to in the hospital.	A PALS volunteer contacted the switchboard for assistance in finding out what area of the hospital to which the patient had been admitted. The patient was still in the A&E department. Due to the relative's distress, the volunteer escorted him to the department and upon being informed the patient was in resuscitation asked a Sister to notify the relative immediately.
An in-patient's relative, living abroad, contacted the PALS Officer to ask if she can visit the patient as he is in his 90's and does not have any relatives who are able to visit him. The family are due to travel to the UK to visit the patient in 2 months' time.	Arrangements were made for the PALS Officer and volunteers to rotate a daily visit to the ward to spend time with the patient. Also, as requested by the patient, a volunteer purchased a daily newspaper for the patient. The PALS Officer has passed on all messages from the patient to his family by e-mail.
Homeless patient admitted to hospital had no money, clothes or toiletries.	PALS Officer visited the *League of Friends* shop and they provided 3 x shirts and 2 x jeans that fit the patient. We also made up a toiletries bag for him as he did not have deodorant, toothbrush, soap and shampoo. The PALS Officer contacted the patient's social worker to ask if they could visit that day, as he was in need of cash and aid.

1.1 NHS Choices

Patients and visitors can post comments about their experience in our hospitals on the *NHS Choices* website. *NHS Choices* calculate a star rating for each site, based on the feedback, with 5 stars being the highest. Comments posted on this site are monitored by the communications team and responses are passed to the appropriate service for action if needed.

Table 7: Number of patient comments left on *NHS Choices* for Quarter 4, by site

Star rating	Warrington	Halton	CMTC
★★★★★	12	12	4
★★★★	4	0	0
★★★	1	0	0
★★	1	0	0
★	6	1	0
Total for Q4	24	13	4

Table 8: Number of patient comments left on *NHS Choices* for Quarter 3, by ward/department

Ward/Department	Warrington	Halton	CMTC
Accident & Emergency	12	-	-
Anaesthesia	-	1	-
Catering	-	1	-
Children's & adolescent services	1	-	-
CMTC	-	-	4
Diabetic medicine	1	-	-
Gastrointestinal & liver services	2	1	-
General surgery	1	3	-
Gynaecology	3	-	-
Maternity	3	-	-
Minor injuries (Halton)	-	3	-
Ophthalmology	-	1	-
Orthopaedics	1	-	-
Pain management	-	1	-
Halton (unspecified)	-	1	-
Warrington (unspecified)	1	-	-

T

Table 9: Examples of comments received to the *NHS Choices* website

Warrington

World beating healthcare!

We are currently spending a few days on the Labour Ward in Warrington after developing serious complications with the birth of our first child. What can I say except that everybody (midwives, registrars, sister, domestic staff, anaesthetists, surgeon's - simply everyone - sorry if I left you out) have provided us with world beating healthcare, respect, compassion and extreme kindness. I will defend the NHS until the day I die. Very many thanks for the excellent quality of service. If I could rate higher than 5 stars all round, then I would. Very highly recommended. You'll be in excellent hands. Signed: A new daddy.

Gynaecology

Having attended the Gynaecology department at this hospital many years ago I had no hesitation at choosing Warrington Hospital again for my recent referral. How things have changed though.

I attended yesterday and was initially seen by a trainee doctor who was very nice and took notes of my 'back ground' and presenting problem. I was then seen by the consultant who informed me that they had been told of my 'back ground' by the trainee doctor and went on to inform me of my treatment plan, there was no discussion of my 'back ground' , symptoms, scan results etc. I was handed some leaflets and told I would get a letter by post to attend for a hysteroscopy. The consultation with the consultant took approximately 5 minutes.

I know doctors / clinics are busy but surely patient care is why they go into the job, they may see these problems everyday but to me my health problems are new and I'm still none the wiser as to what has caused them.

Well done

My partner went in for an endoscopy and his appointment was on time and not time consuming at all. They respected his decisions to not be sedated and went through with the procedure. He was then released and hour and a half after his allocated appointment time. Well done Warrington NHS team, you certainly know something about time keeping that others don't, I'm impressed.

Halton

Minor injuries review

I attended this department on the 9th March and could not fault the care and attention I was given. Special mention to the senior nurse that attended to me. Cannot praise this department high enough. Well done.

Top marks to all staff

I have had to stay in Halton hospital several times up to ten days. And I honestly say hand on heart they can't do enough to put you at ease and see to your every need swiftly and with a smile. Not only the nurses and doctors everyone from people coming round with papers or radio request's and the

front desk. And the food on the wards is very nice, ' tasty ' fresh and hot. I have just had a spell in ward B4 the nurses and doctors are amazing. And often stopped for a little chat even though they were very busy.' They made the time, even through the night. Thank you very much Ward B4. I hope they get to read my comments.

CMTC

Excellent care from ward and theatre staff

I was recently a day case patient for sacroiliac joint injections, was on the day case ward and had my treatment in the X-ray treatment room. All of the staff involved in my treatment were very friendly, helpful and caring. This includes the staff carrying out the procedure, theatre staff and ward staff. Prior to the procedure, the staff on the ward regularly checked on all of the patients in my bay and took time to ensure that everyone felt at their ease. During the procedure, the theatre staff looked after me really well and did everything they could to reduce any stress that I was feeling. It is never a pleasant experience going into hospital for a procedure but all of the staff did a great job of ensuring that this was as good as it possibly could have been. Overall, I would describe the service I received from staff at Halton Hospital as exceptional.

Carpal tunnel decompression

Once again the treatment was fantastic! This was my third visit in the last four months or so and each time I was treated with the utmost dignity and respect. There is nothing that is too much trouble for the team, they are wonderful! Please pass on my compliments to all the staff involved in my care. My surgeon did a wonderful job and all the theatre staff were great. I am recommending the CMTC to all my family and friends as the place to go for orthopaedic treatment. Thank you once again for a great experience.

Bilateral patella femoral

(Partial knee replacement both knees), this is an excellent treatment centre, totally caring and professional staff. Clean and friendly, food was excellent as well! The physio team was second to none with the dedication they shown me. I was invited back to the knee clinic 3 times a week for 2 weeks, which I found so useful to my rehabilitation. I would recommend this treatment centre to anybody.

Total right hip replacement

I was admitted to the treatment centre on Feb 12th for surgery on my right hip my left hip was replaced in Oct 2013.The right hip replacement was done on the day I was admitted and I was able to go home on the14th Feb. Both hospital stays were excellent in every way a credit to all concerned well done and many thanks for giving me back my quality of life.

1.2 Compliments

The Trust received 10 formal compliments through letters sent directly to the Chief Executive. The patient experience team were asked to request the divisions to send copies of compliment letters, cards and other tributes from patients and their families. This has started in March 2015 and wards are not compliant in that first month.

Table 10: Compliments by division, January – March 2015

Quarter 4	Letters received	Unscheduled	Scheduled	WCSS	Trust
January 2015	2	-	1	-	1
February 2015	4	2	2	-	-
March 2015	4	3	1	-	-

Table 11: Tributes received, reported for Quarter 4

March 2015	A6	B1	B12
Thank you cards	14	6	5
Chocolates	4	23	10
Biscuits	1	-	6
Flowers	-	1	-
Donations (£)	-	1	-
Bottles of juice	-	-	4

Table 12: Excerpts from compliment letters

My husband and I would like to thank you and all the staff on Wards A3 and A8 for the wonderful care they gave my father. He was admitted to Warrington General on December 26th 2014 following one of his falls, but, passed away on Friday 13th February 2015 at the age of 95. Everyone who came into contact with him was so caring, compassionate and totally professional. His final hours were stress-free and we felt so happy and confident about his care. *Our admiration to you all at Warrington General.*

Dear Dr Razzaq – I'd just like to express my heartfelt thanks to you and your superb team in the Radiology Units in Halton & Warrington. *The speed and professionalism that was shown in the handling of my wife's ultrasound, biopsies, CAT and bone scans have been second to none and you do the NHS proud (a service very dear to our hearts). Most of all, the very personal care and support that my wife has received from yourself and your team have proved a huge benefit to us both in dealing with the traumatic experience of a second breast cancer diagnosis.* *The knowledge that yourself, Denise and Prof. Clarke are on the team gives us great hope for a successful solution to my wife's current illness. In fact, as we walked away from Mr Farooq's clinic at Warrington bearing the news of my wife's positive biopsy results, rather than being overwhelmed by fear, we both felt like a very positive and protective circle had started to close in around us.*

After a roller coaster of emotions regarding my grans deteriorating health. She was moved onto ward A3 and the care and compassion she received was second to none. The nurses, doctors and especially the carers were amazing with her and tended to all her needs and our questions. This is a very busy ward but nothing was too much for them. After being told on another ward she had days to live she left A3 weeks later with a big smile and a wave, these angels need recognition. xxxx

2. FORMAL COMPLAINTS

2.1. Data collection and analysis

Top 5 themes provided quarterly are sent to the divisions to assist local identification of themes and trends. Custom reports provided in this period include an assurance report for the Board on complaints about attitude and a report for the Falls Group as part of their triangulation.

2.2 *Formal complaints, Themes for Quarter 4*

Figure 3: Graph showing all complaints by subject, Quarter 4

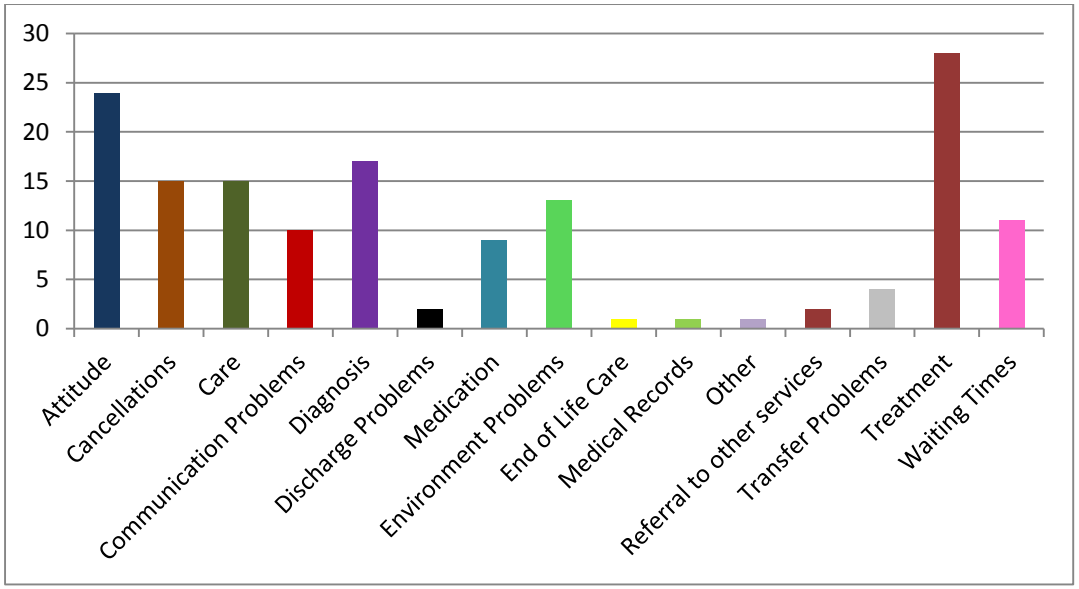


Figure 4: Graph showing top 5 subjects for Unscheduled Care, Quarter 4

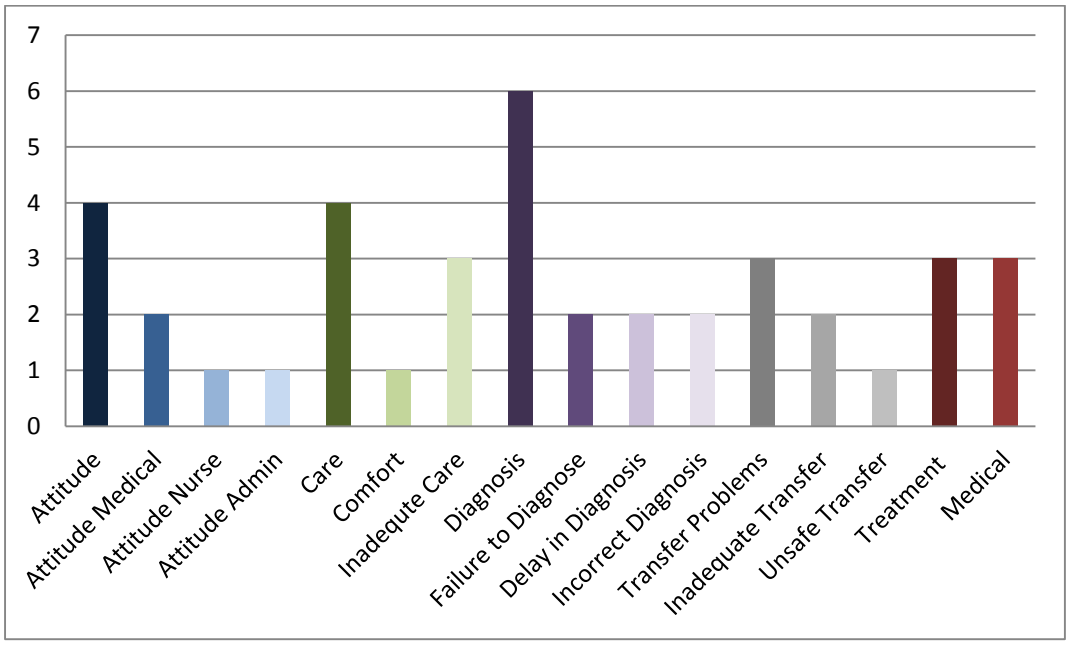


Figure 5: Graph showing top 5 subjects for Accident & Emergency, Quarter 4

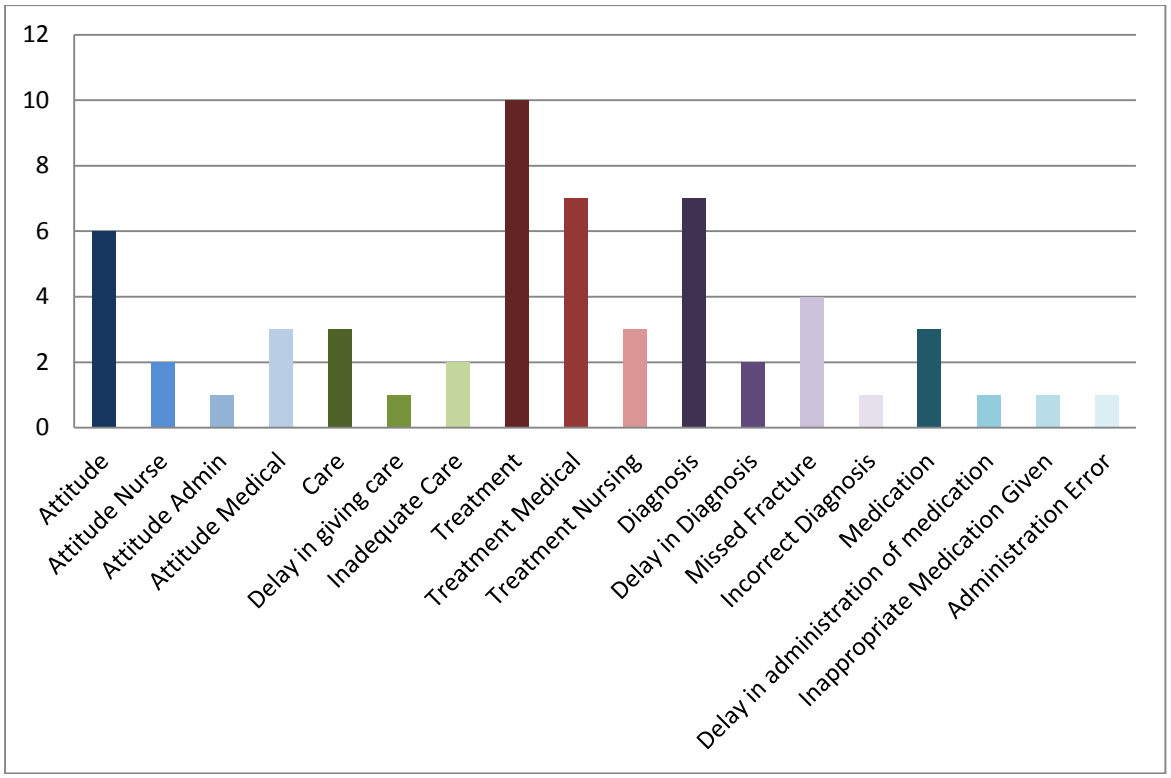


Figure 6: Graph showing top 5 subjects for Scheduled Care, Quarter 4

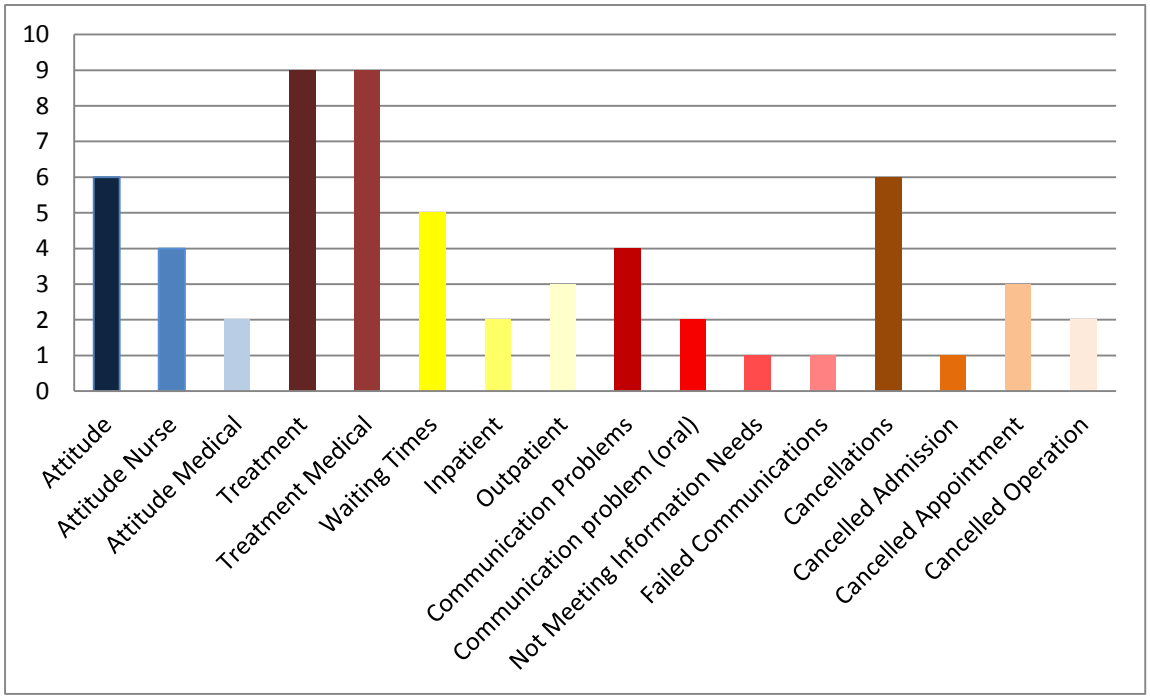


Figure 7: Graph showing top 5 subjects for WCSS, Quarter 4

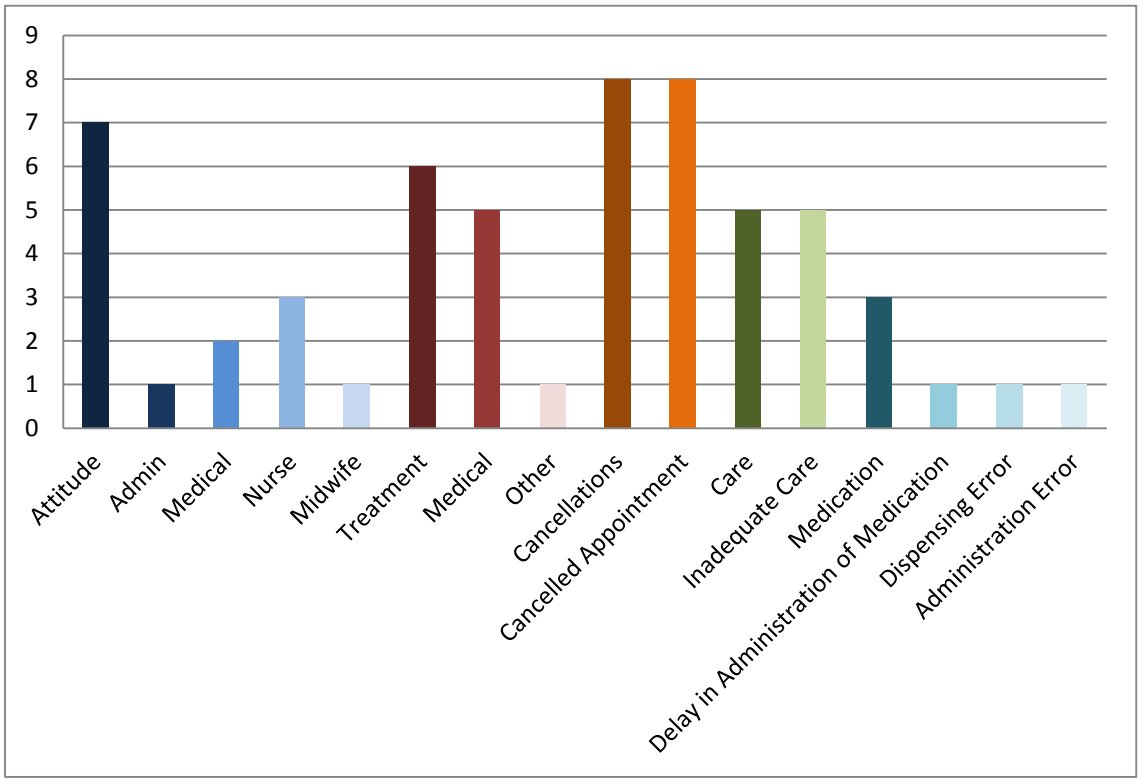
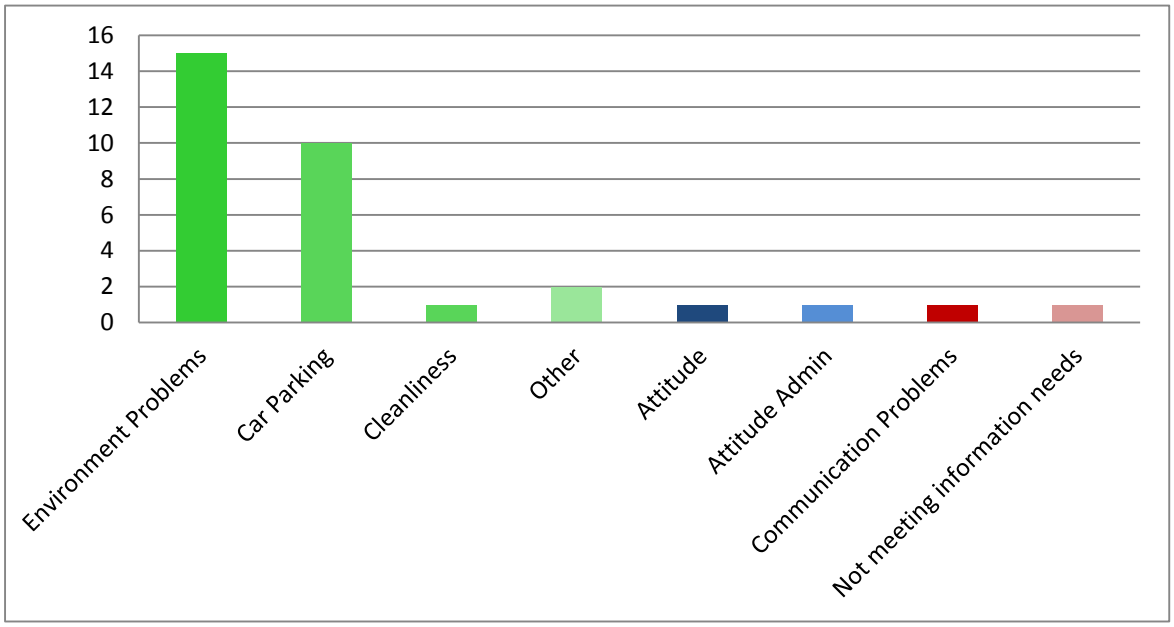


Figure 8: Graph showing top 5 subjects for corporate areas, Quarter 4



2.2 *End of Life Care complaints review*

Recommendations made by Norman Lamb MP, following his review of the Liverpool Care Pathway, this report contains a summary of those complaints made that raise concerns about any aspect of end of life care. Please note that in April 2014 this subject was added to the Datix system, so no complaints with EOL as a component from prior to that date could be reported. In the last report, there were two complaints still under investigation. These have been updated and new complaints added.

Table 12: Complaints made with end of life care concerns, Quarter 4 including update from Quarter 3 report

Summary of concerns regarding EOL care	Risk rating/ Date	Subject	Sub-subjects	Outcome
Daughter has complained about the care of both her mother and father, both inpatients and on different wards. Re. Father: • Father had COPD and was admitted to the Acute Medical Unit with Pneumonia. The doctor informed family that he had Pulmonary Fibrosis and that he had one to two days left to live. The Palliative Nurses attended. As mother was already in hospital family asked the ward manager if they could be placed somewhere together for the last few days and were told it was not possible. Complainant would like a full explanation of how this decision was made. • During the hours the family waited for their father to pass, they didn't have a private room to grieve and were shown a reception room, where people waited for appointments. There were no drinks machines, no privacy and when he did finally pass they were handed a leaflet. Complainant's brother even had to close the curtains and blinds out of respect. Patient was just left there lifeless and the family stood outside the room with their mum in her wheelchair in tears, with nurses and doctors coming and going. Complainant felt they received no privacy, dignity or respect. The complainant said her father was a person, greatly loved by his family and deserved more than to see his wife exhausted and emotionally broken, with heart failure, struggling to be by his side on his death bed. Concerns raised about mother's care involved transfers and nursing care	Moderate	Wait Care Drug Care Transfer EOL Privacy	Outside 4 hour target Inadequate care A2 Delay in administration Inadequate care Inadequate transfer Respect & Dignity Poor respect shown to family	Still awaiting consent to investigate

Summary of concerns regarding EOL care	Risk rating/ Date	Subject	Sub-subjects	Outcome
Granddaughter of lady who died on acute medical ward has made a complaint about her care. Issues: • Complainant's mother contacted the hospital and was told that patient had a comfortable night and informed of the visiting times. Her condition deteriorated around 2pm and your mother was informed immediately, she was there within ten minutes but sadly her mother had already passed away. • Complainant is very upset that her grandmother passed away on her own and felt that she should not have been put onto a ward with restricted visiting times. • Complainant found it very distressing that a black bag with her grandmother's name was left outside the cubicle whilst the family were with her. She assumed this was a body bag. She would like an explanation why this was placed there whilst the grieving family were there.	Low 05/01/15	EOL Privacy and Dignity	Poor communication with family Lack of dignity	Upheld Not Upheld
The complainant is unhappy with the length of time her father has been on the cancer pathway and requests some information regarding the delays.	High 04/03/15	EOL Treatment		Cancer lead asked to contact his daughter to discuss concerns – these were resolved and the complaint was withdrawn
Patient's daughter wants a review to be completed of her mother's care when coming in through AED and on ward A6. She felt that AED was overcrowded and elderly patients should be sent to Halton hospital, out of the way of as she feels Warrington hospital is chaotic.	High 09/03/15	EOL Treatment	Medical Medical	A meeting is being held on 21/04/15 to discuss/answer issues. The complainant lives abroad and is returning home this month.

2.4 Concerns raised in Quarter 4

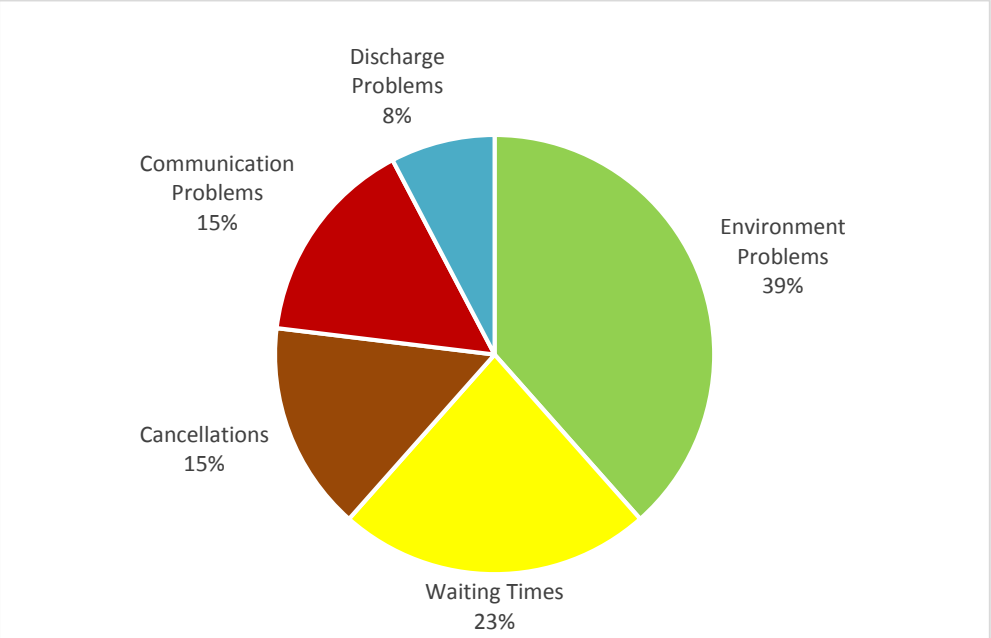
Total concerns logged for Quarter 4 was 21, 13 of which were withdrawn complaints. Withdrawal of a formal complaint might be prompted for several reasons, for example:

- The signed consent has not been received, despite reminders by the team
- The complainant may have a change of heart
- The complainant experience team may realise, while processing a complaint, that they can solve the problem and contact the patient to resolve their issue.
- The complainant does not wish to go through a lengthy formal process and asks if their issue can be resolved more quickly.
- The patient experience team ask a member of the relevant team to ring the complainant and they are able to resolve the issue over the 'phone.

Table 13: Concerns for Quarter 4, by division

Division	Number of Concerns
Scheduled	5
Unscheduled	2
AED	3
WCSS	5
Corporate	6
Total	**21**

Figure 9: Concerns by subject, Quarter 4



There has been an increase in issues raised, both formally and informally, about the environment as a result of the recent changes in parking arrangements and charges. Some concerns are regarding the decision to charge for disabled parking and others are challenges to fines and notices received from the new parking company.

2.5 Responding to people in a timely manner

In Quarter 4 we responded to 100% of our complaints within agreed timescales. Provision of high quality, well investigated and thorough responses is equally important to both patients and the Trust. Though we achieve this objective, on occasions we have to re-negotiate the response date with complainants when the division is struggling to complete their response. This can cause anxiety

for complainants and the patient experience team have developed an escalation flow chart to ensure that any unforeseen delays are identified in a timely manner so that complainants are informed of any extension needed as early as possible.

Table 14: Complaints closed in agreed timescales for Quarter 4

	January 2015	February 2015	March 2015
Number of complaints closed in month, resolved within the agreed timescale	19	21	25
Number of complaints closed in month, not resolved within the agreed timescale	0	0	0
Number of complaints closed in the month	19	21	25
% complaints closed in month, resolved within agreed timescale	100%	100%	100%

2.6 Complaints withdrawn

During the period from January – March 2015, a total of 13 complaints were withdrawn. Examples of the reasons for withdrawal were:

- Interface incident was mistaken for a complaint.
- Complainant decided to withdraw.
- Contact with patient led to feedback being given and complaint being withdrawn
- Out of time request.
- Patient denied making complaint when contacted.
- Complainant came in to discuss complaint and decided to withdraw.
- Request for more information by PET not answered by deadline date
- Cancer Lead asked to ring complainant. Once information needs met, complaint withdrawn.

2.7 Returned complaints

During Quarter 4, two people felt they were unhappy with their initial responses and wrote to/contacted us asking for further information, to meet with us, or to provide clarification. The number of returned complaints has lessened over the past year. This is partly because of more diligence and increasing skill and experience of the patient experience team and senior team in ensuring that the response sent to the complainant answers all questions and is comprehensible and compassionate.

There remain six return complaints open at time of reporting. We are not currently meeting the thirty day response target for answering returns. This is mainly because as a whole we tend to prioritise open complaints that have a deadline and are the bulk of the complaints workload. Sometimes, delays are because we are trying to arrange meetings with complainants, but overall we need to improve the turnaround on these.

Table 15: Returned complaints by division for Quarter 4 and outcome

Division	Not upheld	Partly upheld	Upheld
Unscheduled Care	1	1	0
Scheduled Care	0	0	0
WCSS	0	0	0
Corporate	0	0	0
Total	1	1	0

2.8 Complaints linked to serious untoward incidents

During Quarter 4. No complaint has been made that is the subject of a serious untoward incident investigation. A total of 19 complaints were linked to a reported 36 incidents that included falls and other patient safety incidents already reported and acted upon.

2.9 Formal meetings organised

The number of meetings held with complainants in Quarter 4 is disappointing. A total of five meetings have been held. Of these four were for open complaints and one a return. While we cannot force complainants to have meetings, there is a sense that a meeting can be very satisfying for complainants and more successful in allaying concerns. They can be particularly useful with grieving families, helping to appease their anxieties that "things went wrong" or poor decisions were made. There are five meetings to be arranged for complaints made in Quarter 4. One of these was cancelled when the patient had to come into hospital. The logistics of arranging meetings is complex. The patient experience team administrator has to first establish who will need to attend with the division(s), then juggle several diaries to ensure clinician, manager, patient experience team availability and finally ensure the complainants are available.

3. LESSONS LEARNED

The following table provides examples of closed complaints and actions taken by the divisions who are responsible for implementing and monitoring lessons learned. Each division has specific systems in place to feedback learning from complaints, firstly during/after the investigations and then through divisional groups, e.g. Divisional Integrated Governance Groups (DIGG, senior nurse/ward manager meetings.

Table 16: Examples of complaints, action taken and learning from Quarter 3

Description of Complaint	Actions	Learning
Scheduled Care: Complainant was unhappy with the attitude of the consultant towards his wife during his consultation. The consultant told his wife that if she continued to interrupt he would ask her to leave.	Consultant apologised for his manner. He had felt that he could not get a good history from the patient because of his wife's interjections, but he was sorry to upset her with his request for her to let him complete his questions of her husband.	Review of complaint during investigation. Consultant will reflect on complaint during his annual PDR as part of the revalidation process.

Unscheduled Care: Complainant felt that the AED staff were unhelpful in responding to the issue of the patient being expected to wait in a crowded area at risk of infection. Patient at times waited in the car but was told staff would not come out to notify her when it was her turn to be seen as they were too busy. Complainant said that AED staff did not contact the on-call haematology team and have, on one occasion, inappropriately sent patient away with oral antibiotics; only for haematology consultant to arrange admission the following day for IV antibiotics.	Consultant investigated this complaint. He informed the complainant that he had raised this issue with all the staff and instructed triage nurses to inform the medical and nursing co-ordinator immediately when they assess a patient with potential neutropenia so that arrangements can be made: • for them to be suitably housed away from other patients • so that blood count can be checked as soon as possible in their attendance. Consultant informed complainant that this system does seem to be working better for this type of patient. The alert card the patient carries has been updated to include information that she is neutropenic. Apologies were made for the brusque attitude of AED staff in taking the history.	New way of working when patients with neutropenia are triaged. Inappropriate and unprofessional communication fed back to all staff with expectations for professional and respectful communication.
WCSS: The mother of a child attending AED was unhappy with the attitude of a health care assistant from the children's department. She was upset that she was questioned as to why she had not brought her son in the night before and if social services were involved with the family.	Matron investigated the complaint and apologised for the poor experience. She had discussed the concerns with the HCA who saw them. Matron explained that the questions asked were mandatory as part of safeguarding rules. She did apologise if the way in which these questions were asked was in any way offensive. The HCA passed on her apologies.	The matron described the following actions: • HCA asked to reflect on the way she approaches her questions and to listen to the child and parent first. • HCA to complete the Trust 'care and compassion' booklet (a reflective workbook carried out under the supervision of a clinical manager). • HCA to feedback her assessments to the qualified staff. • Matron will keep HCA under review to ensure that there are no repeats of this episode.

4. ACTIONS

As identified in the annual complaints report in May 2014, the following identifies any progress on actions/improvements:

- Developing this skills and knowledge of the Patient Experience Team.
  Development in line with the competency framework continues. Recent issues with aggressive patients has led to a request for "breakaway" training for the team. The trainer will liaise with the PALS Coordinator to ensure the training meets the needs of the team. PALS volunteers will also be offered the training.
  Regular team meetings have been instituted to discuss issues and developments. The next meeting will be dedicated to reviewing system use and processes.

- Developing a responsive, combined service – making it easy.
  Increased pressures/activity have made it difficult to institute regular training for divisional staff. Informal and *ad hoc* training has been provided on request. A formal presentation was made to medical staff in Orthodontics in March 2015, which was positively evaluated. A presentation at the ward managers meeting and more intense training for divisional investigators is being held in WCSS in June 2015.

- Monitoring and performance management in place.
  Policy audit is due. Will be completed and disseminated in May 2015. A new flow chart for escalation of delayed responses has been written and discussed in the patient experience team. This will be sent to divisions for their input.

- Focus on return complaints to understand underlying root causes and better identification of outcome.
  The number of returns has been relatively low. More work to be undertaken to support divisions in responding in a timely manner.

- Improved complaints monitoring through updating complaint category information collected – making data meaningful.
  PALS module is updated to mirror the subjects in the complaints module. The team has undertaken a small telephone satisfaction survey. This will be rolled out in the next quarter. Results will be included in the annual report.

- Updating the complaints information for patients and visitors, electronic as well as paper based.
  Posters and new leaflets are in place. An easy read leaflet is also available.

- Completion and assurance for action plans developed as a result of complaints.
  The divisions have identified processes for ensuring that action plans developed as a part of a complaint investigation are recorded on CIRIS. These will be reported locally within divisions, at the appropriate sub-committees and at Board.

5. RECOMMENDATIONS

The Board is asked to note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented above.

BOARD OF DIRECTORS

WHH/B/2015/ **075**

SUBJECT:	**Medical Appraisal and Revalidation Annual Report**	
DATE OF MEETING:	29th April 2015	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Lesley Kinsey,	
EXECUTIVE DIRECTOR:	Dr Simon Constable – Medical Director – Responsible Officer	
LINK TO STRATEGIC OBJECTIVES:	All Choose an item. Choose an item.	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	SO1/1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework SO1/1.2 Risk of harm through failure to comply with Care Quality Commission National core healthcare standards and maintain registration and failure to achieve minimum requirements for NHSLA Standards within maternity services and wider Trust. Choose an item. SO2/2.1 Failure to engage and involve our workforce in the design and delivery of our services. SO2/2.2 Risk that the Trust does not have the right people with the right skills ie workforce is not competent and cannot deliver as commissioned.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED:	None	
EXECUTIVE SUMMARY (KEY ISSUES):	In summary, our process and systems enable, track and monitor the completion rates via a robust Notification System with a comprehensive Policy which identifies Practice, Procedure and Accountability which has enabled a very successful 3rd yearly set of Results that have consistently exceeded the GMC Target of 80%. YEAR 1 – 1st MAY 2012 (GO LIVE DATE) – end of April 13 – **99.4%** YEAR 2 - April 2013 – end of March 2014 - **93%** YEAR 3 - April 2014 – end of March 2015 - **96%**	
RECOMMENDATION:	***The Board is asked to:*** 1. Note the process and progress of Medical Appraisals to support GMC Revalidation 2. Note the overview of the annual position for 2014/15.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Appraisal Revalidation Group Chaired by the Medical Director

	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	Choose an item.

Medical Appraisal and Revalidation
Annual Report 2014 – 2015

EXECUTIVE SUMMARY

This Report provides assurances to the Board that our Medical Appraisal System and Processes for monitoring the completion of Annual Appraisals to support GMC Revalidation for the Medical Workforce are robust. In order to meet the GMC Requirements for Revalidation, every Doctor MUST participate in an Annual Appraisal; ensure FIVE Consecutive Appraisals are completed within their Revalidation Cycle and have acquired a 360 Patient/Colleague Feedback Report. This process then informs the GMC directly via **GMC Connect** which contains the names of every doctor who holds a Registration Number and is licensed to practise in the UK. They identify the Employer - Designated Body - for whom they have a prescribed connection to a RO - Responsible Officer and for whom a Recommendation/Non-Engagement/Deferral for Revalidation is able to be made. All NHS Designated Bodies (Employers) throughout the UK must engage in this system and failure to do can remove the doctor from the GMC Register and remove their right to practise medicine. The GMC have also made clear the minimum requirements for each Appraisal and relevant Supporting Information. Information on the supporting evidence available for each doctor is collated from a variety of sources and discussed at the bi-monthly Revalidation Decision Making Panel. In addition to the information required by the GMC, a recommendation from the doctor's Appraiser and/or Clinical Lead is also sought and they are asked to give details of any issues or concerns they may have regarding the doctor under consideration. Details of any complaints made against the doctor during the revalidation cycle are also made available. A decision is made by the panel once all the information available has been considered.

In summary, our process and systems enable, track and monitor the completion rates via a robust Notification System with a comprehensive Policy to identify the practice and procedure and accountability which has enabled a very successful 3rd yearly set of results that have consistently exceeded the **GMC Target of 80%**

- YEAR 1 – 1st MAY 2012 (GO LIVE DATE) – end of April 13 – **99.4%**
- YEAR 2 - April 2013 – end of March 2014 - **93%**
- YEAR 3 - April 2014 – end of March 2015 - **96%**

CONTEXT

The GMC have strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. Where any doctor fails to meet those standards, the GMC acts to protect patients from harm - if necessary, by removing the doctor from the Register and removing their right to practise medicine. The introduction of Medical Revalidation across the UK in early December 2012 provided a new way of regulating licensed doctors that seeks to provide extra confidence to patients that their doctors are up to date and fit to practise. Only licensed doctors have to revalidate, usually every five years, by having Annual Appraisals based on the GMC's Core Guidance for doctors, *Good Medical Practice*[1]. The majority of licensed Doctors are expected to be revalidated for the first time by the end of March 2016.

[1] **GMC – Good Medical Practice 2013 –**

The GMC have agreed supplementary guidance with the four health departments of the UK to help doctors understand how they can meet GMC requirements in the first cycle of Revalidation, which will last from early December 2012 to the end of March 2018. This is in line with the GMC Guidance that was published for all licensed doctors.

The Guidance, which is for Doctors and Responsible Officers, will ensure Doctors are recommended for Revalidation in a consistent way.

In order for a Recommendation to be made, a Doctor **must**, as a minimum:-

- ✓ be ***participating*** in an Annual Appraisal process
- ✓ to ensure ***FIVE consecutive appraisals*** have been completed in preparation for their Revalidation cycle
- ✓ 360 Colleague Feedback
- ✓ 360 Patient Feedback

The GMC have also made clear that the minimum requirements for each Appraisal and relevant supporting information are as follows:-

- Evidence of Continuing Professional Development
- Review of significant events, complaints and compliments which relate to the 12 month period prior to the appraisal that precedes any revalidation recommendation.
- Evidence of regular participation in quality improvement activities that demonstrate the doctor reviews and evaluates the quality of their work which must be considered at each appraisal. The activity should be relevant to the doctor's current scope of practice.
- Evidence of feedback from patients and colleagues (once if the five year cycle) must have been undertaken.
- Focused on the doctor, their practice and the quality of care delivered to patients
- Gathered in a way that promotes objectivity and maintains confidentiality

Below are the identified 10 Steps to GMC Revalidation

1. Register on GMC Online
2. Confirm your responsible officer
3. Get a date from the GMC
4. Find out the local appraisal format
5. Gather supporting information
6. Prepare for appraisal
7. Participate in appraisal
8. Sign-off appraisal
9. Repeat steps 5-8 every year
10. Receive your revalidation confirmation from the GMC

Key Elements of Current (Notable) Practice – Progress Update

- **Monthly ARG Meetings** – Terms of Reference/Minutes/Action Plans/National Updates –Networks/NHS England/maintain up-to-date knowledge – *informs the Strategic People Committee/Education Governance Committee/Medical Education Quality Committee*

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http://www.gmc-uk.org/static/documents/content/GMP_2013.pdf_51447599.pdf

- Incomplete/Overdue Appraisal Tracker /Revalidation Panel Tracker – both shared and discussed to ensure Team are engaged and all necessary actions are taken.

- **5th Bi-Annual Appraiser Forum Meeting -** coordinated to "listen and support the Appraisers" – 12.05.15
  - Individual ***FEEDBACK Reports*** directly from CRMS are given to each Appraiser to drive quality and expertise in the process and evidence their skills as Appraisers.

- We are also running a comprehensive **Evaluation Survey** to enable the Team and the Doctors to reflect on the process as it will be three years (May 2015) since the new Strengthened Medical Appraisal and Revalidation System went LIVE. This Survey seeks to obtain their views on the implementation of the system and a Report detailing Key Findings and Results will be published in the Summer of 2015.

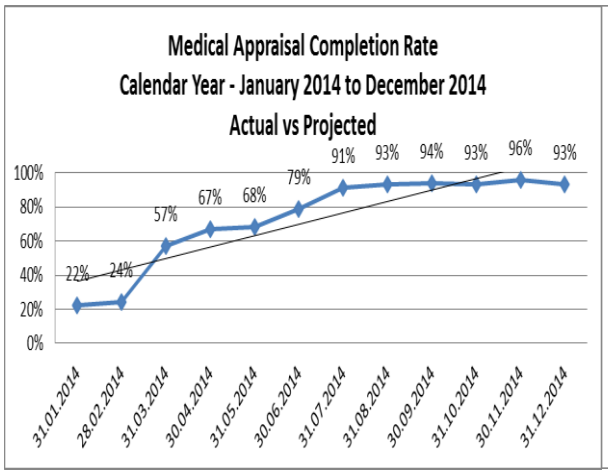
- Deliver Quarterly Figures directly to **NHS England** which are linked and collated to the GMC as follows:-

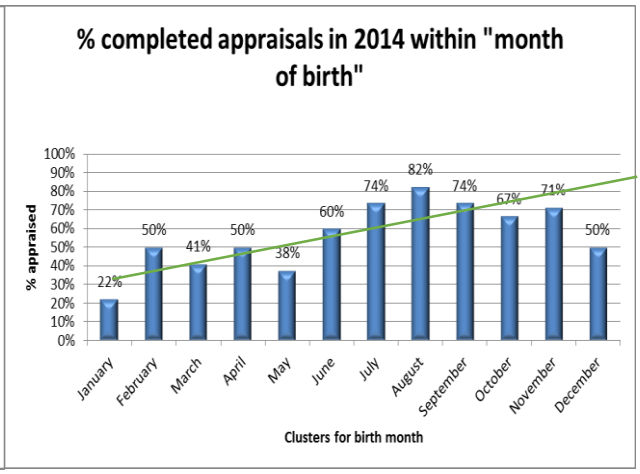
○ The number of doctors with whom the designated body has a prescribed connection
○ The number of doctors due to hold an appraisal meeting in the reporting period
○ The number of those doctors above who held an appraisal meeting in the reporting period
○ The number of those doctors above who did not hold an appraisal meeting in the reporting period
○ The number of doctors above for whom the RO accepts the postponement is reasonable
○ The number of doctors above for whom RO does not accept the postponement is reasonable

- Present all Data Sets directly in the **Bi-Lateral Board Reports**
  - BY DIVISION
  - BY OVERAL TRUST POSITION
  - BY % COMPLETE/INCOMPLETE per month.
  - No. who have been given a "Positive Recommendation to the GMC"

Medical Appraisal and GMC Revalidation		Actual Mar	
Appraisal / Revalidation	Number of doctors with whom the designated body has a **prescribed connection**	212	
	Number of doctors due to hold an appraisal meeting	14	6.60%
	Number of those within #2 above who **held an appraisal meeting**	11	78.57%
	Number of those within #2 above who **did not hold an appraisal meeting**	3	21.43%
	Number of doctors within #4 above for whom **the reason is both understood and accepted by the RO**	0	
	Number of doctors within #4 above for whom **the reason is either not understood or accepted by the RO**	3	
	Number of doctors who have been given a positive recommendation by the RO to the **GMC for Revalidation**	0	

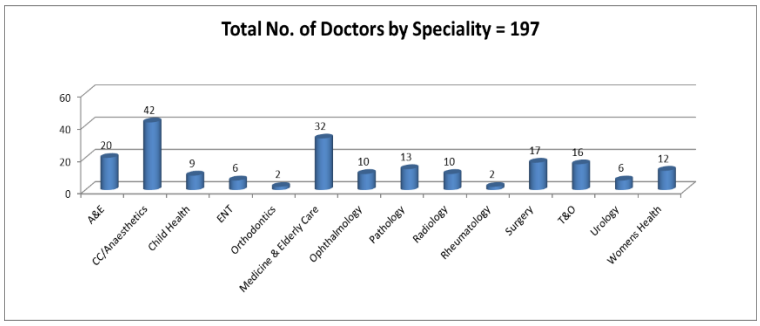
- Tracking Results by **Calendar Year**:-The Trust continues to achieve fantastic results for the completion of Medical Appraisals in 2015. Our 2015 Calendar Year achieved 93%. There is also an extremely high level of engagement in which is evidenced by the "in month" completion rates and the "upward trend".

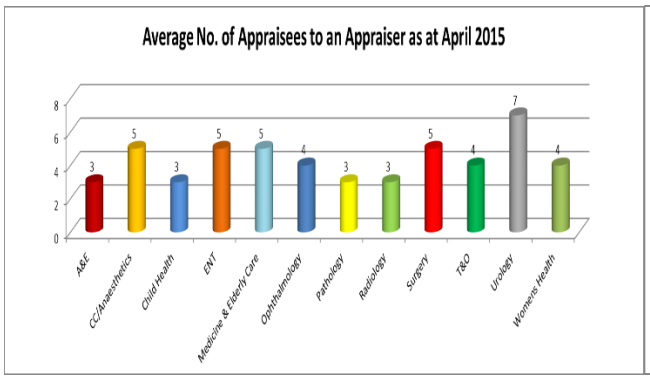


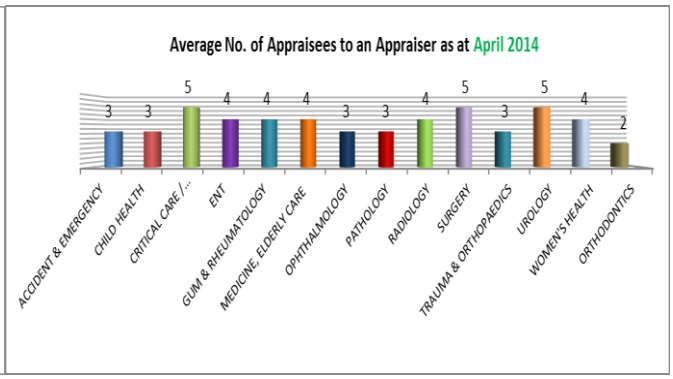


***The GMC Target is 80% based on a 20% margin which allows for those Doctors who may have Sickness, Long-Term absence and/or Maternity Leave*

- **GMC Good Practice... "Allocation Process"** - "New Appraiser Training and Allocation of Appraisees" – Clustering exercise within the Specialties - NEW Medical Appraiser Training Course for 2015 – 21.09.15
  - *"A doctor should normally have no more than three consecutive appraisals with the same appraiser and must then have a period of at least three years before being appraised again by the same appraiser... a doctor should not act as an appraiser to a doctor who as acted as their appraiser within the previous 5 years"*
  - ALL Clinical Leads respond and review their Clusters and identify the changes as required.







- **All Doctors (temp/locum/agency)** with a prescribed connection to the Trust and are employed for **six months or more** are included in the Trust Medical Appraisal and Revalidation process.

- Track the engagement of **360° Feedback** - monitor completion rates and trigger communications (required once within a 5-yearly cycle for revalidation)

360 Degree Status	End of June 2014 - %	End of Sept 2014 - %	End of Dec 2014 - %	End of March 2015 - %
Complete	178 - 80.91%	176 - 81.86%	182 - 82.35%	188 - 78.99%
In progress	7 - 3.18%	11 - 5.11%	9 - 4.07%	17 - 7.14%
Not started	4 - 1.82%	5 - 2.33%	6 - 2.71%	6 - 2.52%
Not yet requested (new starters)	31 - 14.09%	23 - 10.70%	24 - 10.86%	27 - 11.34%
TOTAL NO. OF CANDIDATES	**220**	**215**	**221**	**238**

NEXT STEPS

- Continue to ensure all Locum/Temporary/Short-Term Doctors are provided with EXIT Reports (template is available) in line with the Medical Appraisal Policy and that this Action is recorded for all locum and short-term contracts. This will also ensure their practice is reported for *every contractual movement whilst employed within the health service/health care setting*.

- Strengthen the quality of the **Supporting Information** – Trust Data - Delivery of robust Reports that may be able to be offered through the HED system and Clinical Governance Reports in relation to Complaints/Incidents.

- Ensure Remediation "maintaining high professional standards" Processes are factored and robustly coordinated to ensure a doctor can be appropriately supported (e.g. further training and resources (financial and otherwise) provided and recognised accordingly.

- NHS England - ALL England Appraisal Network (relevant for ALL Designated Bodies) – have produced a set of **"Medical Appraisal Position Statements" – 27 MAPS** which are inviting ALL DB's to benchmark their current processes and practices against these recommendations. This work stream will highlight further our Areas of Good Practice and where we can further improve upon. This workstream will be completed by year end 2015.

Reference number	Topic	Title
L1	Logistics	MAPS: Appraisal vehicles for doctors connected to NHS England
L2	Logistics	MAPS: Career breaks
L3	Logistics	Guidelines for the deferral of a revalidation recommendation (Note: this document is an approved guideline with Gateway number, not a draft MAPS. It is included here for completeness)
L4	Logistics	MAPS: Handling late sign off of appraisal
L5	Logistics	MAPS: Postponement of appraisal
L6	Logistics	MAPS: Scheduling medical appraisals
L7	Logistics	MAPS: Appraisal of doctors who temporarily exit training
L8	Logistics	MAPS: Technology-assisted appraisal
L9	Logistics	MAPS: Interrupting appraisal
L10	Logistics	MAPS: Timing first patient feedback after change in role

L11	Logistics	MAPS: Allocating SPA time within job plan for appraisers in secondary/mental/community health sectors
A1	Appraisers	MAPS: Routine appraiser assurance review
S1	Supporting information	MAPS: Inclusion of key information at appraisal
S2	Supporting information	MAPS: Information about practice and supervision in non-training posts for doctors connected to Local Education and Training Boards
S3	Supporting information	MAPS: Sharing information to support appraisal
S4	Supporting information	MAPS: Demonstration of safeguarding competence by GPs
S5	Supporting information	MAPS: Amplification of CPD credits in primary care
S6	Supporting information	MAPS: Principles for training of doctors with a prescribed connection to NHS England
S7	Supporting information	MAPS: Patient feedback in non-standard situations
S8	Supporting information	MAPS: Quality improvement information for general practitioners
S9	Supporting information	MAPS: Scope of work and appropriate supporting information for a General Practitioner
S10	Supporting information	MAPS: Incorporating locally generated supporting information into medical appraisal
S11	Supporting information	MAPS: Supporting information for medical appraisal: the role of the designated body
S12	Supporting information	MAPS: Assessing supporting information for appraisal in the context of the volume of a doctor's work
S13	Supporting information	MAPS: Principles for assessing a doctor's supporting information
S14	Supporting information	MAPS: Principles of CPD for revalidation
S15	Supporting information	Spreadsheet of SI vs Scope of work

RECOMMENDATIONS

NO FURTHER ACTIONS ARE REQUIRED

CONCLUSION

KPI – Key Performance Indicators	RAG SCORE
1. Medical Appraisal Meeting Figures	GREEN
2. Medical Appraisal Completion Figures	GREEN
3. Appraiser/Appraisee: Ratio/Capacity	GREEN
4. Appraiser Training – RATIO TARGET	GREEN
5. System of Accessing Supporting Information	GREEN
6. Revalidation Rates	GREEN
Total = 6 indicators NO RISKS IDENTIFIED	OVERALL STATUS = GREEN

The Board is asked to note the contents of the Report and to be assured that our systems of monitoring and managing Medical Appraisals to support GMC Revalidation are robust and adhere to GMC Guidance and Practice. The ARG Team will continue to review and improve on practice as required.