Buckinghamshire Hospitals NHS
NHS Trust

HEALTHCARE COMMISSION INVESTIGATION INTO OUTBREAKS OF CLOSTRIDIUM DIFFICILE AT STOKE MANDEVILLE HOSPITAL, BUCKINGHAMSHIRE NHS TRUST, July 2006.

ACTION PLAN V27
APRIL 2007

HCC ACTION PLAN v.27

Recommendation 1 a
The Trust needs to ensure acceptable standards of cleanliness throughout its hospitals

Lead Director – John Summers, Director of Estates, Facilities and PFI

Key areas to address
Key areas to address are found in pages 32-37. Comments in the HCC investigation include:

- Poor signposting (P.32)
- Shower seats not easy to clean (p 33)
- Inconsistency with styles of isolation notices and displays
- Infection control audit scores of less than 70%
- Some domestic staff unable to understand English
- Standard of cleanliness dependant on conscientiousness of cleaning staff and some areas overlooked
- Cleaning delayed due to equipment and staff not readily available out of hours
- Soap dispensers and alcohol gel dispensers empty, bathroom bins missing and toilet roll holders not available
- No standard training for housekeeper role
- Dirty wards, toilets, commodes and beds
- Soiled clothing bagged for relatives to wash

Planned outcome: Trust to achieve an average score of 80% against the National Cleaning Standards monitoring tool for wards and 90% for theatres. (Daily monitoring tool used throughout the hospital).

High level Board indicator: As above, plus

1. Achieve 81% in the 2006/07 inpatient survey for the question "How clean was the hospital room or ward you were in?" and 84% in the 2007/8 survey.
2. Achieve 75% in the 2006/07 inpatient survey for the question "How clean were the toilets and bathrooms?" and 81% in the 2007/08 survey.
3. Achieve a score of 3 or better for signage, sanitary fittings, bathroom cleanliness, toilet environment in the annual PEAT report (June 07).
4. Achieve a "yes" score for hand decontamination in the infection control section of the annual PEAT report (June 07).

	Actions required	Measures of success	Lead	Completion Date	Current position
1a	1. Complete audit of signage at SMH and replace/renew signs as necessary (page 32)	Achieve a score of 3 or better for signage in the access section of the annual PEAT audit	**Jon Barker Sxho**	**31/10** Review Mar 2007	Audit undertaken. Signs replaced/installed as required. New action: Signage strategy underdevelopment for the SMH site. PEAT visit (07) reviewed signage. Very few areas left to pick up. Signage good.
1a	2. Ensure showers and seats are clean (page 33) (Rec 1b6 in previous version of plan merged with this recommendation Jan 07)	Replacement programme for shower seats in retained estate at SMH. Achieve a score of 1 against national cleaning standard 15. Achieve a score of 3 or better for	**Michelle Thiel Shxo Jane Savino Mdrst BF**	**31/10**	SMH – audit of shower seats in retained estate undertaken. Replacing with shower stools. Wyc has stools rather than fixed seats – inspected routinely, replacements to be identified if necessary when auditing and monitoring. NSIC – new seats

	Actions required	Measures of success	Lead	Completion Date	Current position
		sanitary fittings in the toilet and bathroom cleanliness section of the annual PEAT audit.			installed.
1a	3. Fit notice holders and ensure that infection control and hand washing notices are placed at all wash hand basins (page 36)	Consistent notices across all sites	**BF/RG AM/CG**	**31/10** Updated Jan 07	New acrylic holders installed at SMH. New notices approved by COI and installed in Trust. New guidance from DH – Dec 07 – Estates updated the notices to reflect new guidance and replaced existing ones with laminated screw on signs (Jan/Feb 07).
1a	4. Consider corporate screen savers with infection control/hand wash instructions (p 36)	To be included in IT implementation post CRS project	**JS**	**2007/ 08**	To be followed up with IT now that CRS is ongoing. Consider other messages that can be incorporated.
1a	5. Trust audits of cleaning and infection control to be integrated into Sodhexo quality management system (p.36)	Trust audits to be agenda item at Sodhexo/Medirest meetings. Minutes of Operational meetings at SMH and Soft FM meeting at Wyc. Minutes of the above to be considered at Facilities Team Meeting.	**Geoff Dix Sxho Jane Savino Mdrst**	**15/9** **Now ongoing**	SMH agreed and agenda item in Operational meeting. Wyc – in place. Agenda item for quality monitoring on hard/soft fm meeting and Trust Facilities Team meeting. "Maximiser" system reintroduced,. All Trust audits are reviewed by Director of Estates. Key issues are picked up at Head Nurses' meeting.
1a	6. Budget of £50K for each site from Estates capital programme to be used to resolve works issues arising from the audits (p.36)		**JS**	**14/8** *updated Jan 07*	Progress agreed 25/8/06 £100,000 (Also – bid for £300K submitted Jan 07 for DH MRSA funds was successful)
1a	7. Ward and departmental managers to confirm that acceptable cleaning standards have been achieved through the routine monitoring and integration of domestics into the ward/departmental team.(p.37)	Ward/department managers to sign monitoring reports. Notes of FM operational meeting and Wyc Soft FM meetings. Photograph boards to include domestic.	**Michelle Thiel Sxho Jane Savino Mdrst Head Nurses**	**31/10** ***ongoing monitoring***	Wyc/Am in place (100%). Agreed at Head Nurses meeting 18/9. Wyc/Am monitoring being signed by ward managers. Sodhexo issue sign off forms for SMH nurses. Cleaning schedules are available in every ward and department. Not all wards have photos up (Jan 07). Ongoing through Head Nurses meeting. Trust IC training opened up to PFI provider staff from Jan 07.
1a	8. Integrate weekend and night cleaners where appropriate and improve supervision – at all times, but in particular weekend and nights. Ensure domestic staff have a basic understanding of English.(p.37)	Training records Rota for supervisors and domestics Reduction of complaints or helpdesk calls for out of hours provision	**Geoff Dix Sxho Jane Savino Mdrst**	**31/10** ***now 30/11 Under monthly review (see action column)*** ***30/4***	English courses offered by Trust Education Centre and through the contractors (Aylesbury College). All interviews conducted in English to ensure a basic grasp of the language. WH/AH weekend staff phased out. Supervision 7 days per week and supported by multi-skilled generic supervisor (porters/domestics). 7 day week rota operation. Sodhexo: New rotas in place by December 06. Task completed. Dir of Estates has established

	Actions required	Measures of success	Lead	Completion Date	Current position
					Monday monitoring meetings and checks on the uptake of English courses.
1a	9. Appoint Domestic Manager at Stoke Mandeville (p 37)	Appointment made	**Sxho**	**15/9**	Domestic Manager appointed.
1a	10. Ensure rapid response team is appropriately staffed to be able to respond to the need to carry out terminal cleans(p 37)	Help desk reports	**Geoff Dix Sxho Jane Savino Mdrst**	**30/9**	SMH complete, and liaising with bed management team to prioritise. Service provided 8am to 9pm. WH/AH –complete. Liaising with bed management for priorities. Help desk records response times. Achieved
1a	11. Meet responsibility for filling soap and alcohol gel dispensers including a daily check of all areas to ensure properly stocked (with alcohol gel, soap, towels, toilet rolls and bins), clean and tidy (p 37)	Achieve scores of "yes" for hand decontamination in the infection control section of the annual PEAT audit. Soap dispensers, etc replenished and identified during spot checks and infection control audits.	**Michelle Thiel Sxho Jane Savino Mdrst BF FC**	**4/07**	Consider adding alcohol to soft FM top up list (Currently a nursing responsibility). Filling soap and towel dispensers already a soft FM responsibility. Consider permanent location outside wards, together with leaflets – PB/BF/Inf control. WH/AH to provide materials management service and include alcohol gel. System in place.
1a	12. All toilets to have toilet roll dispensers. No toilet rolls to be stored in toilets. All toilet roll dispensers to be easily reached from toilet seat. All bathrooms and toilets to contain a bin. All paper towel dispensers to be topped up daily. (p 37)	Achieve a score of 3 or better for toilet environment in the environment section of the annual PEAT audit.	**AM BF Michelle Thiel Jane Savino Sxho Mdrest RG**	**31/10** ***NSIC to take longer to complete*** ***Extended to 31/1/0 Extended to 28/2/07***	Ward 20 and 22 complete. WH/AH – not applicable as use toilet tissues not toilet rolls, and all in proper dispenser. Ongoing discussions with NSIC re their special needs. Checking what other spinal units do; however agreed at HCC Implementation Group meeting 30/10 that NSIC need to be an exception on grounds of dignity and respect. JG raised this with HCC rep 1/12. HCC rep in agreement and will raise with the investigation team leader. 11/12 Concern about purpose built toilet roll holders at end of grabrail in assisted toilets in PFI wards at SMH which are not covered. Supplier has no alternatives to offer. Estates consulted ward sisters and installed closed dispensers in all toilets except Burns and NSIC (see discussion above). Regular meetings held to review delivery of cleaning specification.
1a	13. Daily check of cleaning and equipment in all areas to include removal of equipment from wards and corridors (Captains rounds) plus a	Facilities and Estates team meeting notes. Help desk reports	**BF AM Michelle Thiel Sxho Jane**	**31/8**	BF/LF/TS do rounds at SMH. WM/PSdo rounds at WH/AH. Weekly report to team meeting of issues. Achieved

	Actions required	Measures of success	Lead	Completion Date	Current position
	twice daily check of public toilets. (p 37)		**Savino Mdrst**		
1a	14. Revised cleaning specs to include increased cleaning and use of Chlorclean seasonally and after infection (p 78)	Service variations completed. Contract performance monitoring	**JS CC Geoff Dix Sxho Jane Savino Mdrst**	**31/1/07** Extended to 1/5/07	Draft specifications received from Litmus. Cost estimated at £1.3m pa subject to negotiation following review by Litmus. Meeting Litmus 6/11. Specification being finalised. Testing ongoing at Wycombe and won't be fully in place there until 1/4/07. New national cleaning standards built into the cleaning specification. Revised cleaning specifications issued.
1a	15. Facilities managers to confirm that acceptable levels of cleaning achieved in public areas.	Facilities managers to sign monitoring reports Notes of SMH FM operational meetings and Wyc Soft FM meetings. Help desk reports	**BF WM**	**31/10**	Copies of monitoring returns requested. Medirest summaries provided, detail en route. Reviewed at site operational meetings. Wyc/Am complete. SMH PB providing schedules of monitoring of public areas, BF/LF attending.
1a	16. Soft FM provider to attend head nurse meeting	Minutes of Head Nurse meetings	**FC Geoff Dix Sxho Jane Savino Mdrst**	**30/9**	Achieved
1a	17. Help desk procedures to be published and service agreements with each ward and department agreed	Help desk procedures	**G.Dix Sxho Jane Savino Mdrst**	**30/9**	Achieved and published. BF/AM attended GM meeting 2/11/06 to clarify service to GMs.
1a	18. Audit to be carried out by Trust against National Cleaning Standards	Notes of SMH FM Operational meetings and Wyc Soft FM meeting	**TS PS**	**31/8**	Ongoing review at quality groups and FM operational meetings. Achieved
1a	19. Audit to be carried out by PFI Partner and results shared with Trust and service providers	Notes of SMH FM operational meetings and Wyc Soft FM meeting Positive feedback from patient surveys	**EprsBP UHC NK**	**31/12 Extended to 31/5**	WH/AH – monthly report. Introduction of patient survey. Terms of reference for SMH audit agreed. Audit at SMH was completed in March; action plan awaited by Dir of Estates.
1a	20. Equipment removals to be organised through the helpdesk (rather than leaving in corridors)	Help desk reports Improved environment Equipment removed quickly	**Head Nurses Dept Heads**	**31/8**	Ongoing Achieved
1a	21. Review to be completed each week to ensure changes are sustained	Minutes of Facilities Team meetings	**AM BF JS**	**wkly**	Weekly meetings. Raise unresolved concerns with TEC and HIG. Achieved

Recommendation 1b
The Trust needs to resolve permanently the problem of uncollected clinical waste and dirty linen

Lead Director: John Summers, Director of Estates, Facilities and PFI

Areas to address (pages 32-40)

- Utility rooms blocked by linen and waste bags (p32)
- Delays in collection of clinical waste (p33)
- irregular emptying of waste bins
- hazardous waste left in wards
- inadequate storage on wards
- wash basins difficult to access with poor water flow
- too few toilets for number of patients
- problems with bedpan washer disinfectors with intermittent daily and weekly checks
- NSIC wards had had little upgrading since commissioning and bathrooms in a state of disrepair
- Privacy and dignity re toilet facilities
- Examples of poor environment and furnishings (p40)

Planned Outcomes
a) Sluice rooms accessible
b) Waste and dirty laundry stored securely prior to collection
c) Annual capital programme of refurbishment with prioritisation guided by condition surveys, monitoring and infection control audit reports.

High level Board indicators:
Achieve a score of 3 or better for waste handling in the environment section of the annual PEAT audit (report June 07)
Achieve a score of 3 or better for cleanliness in the food service section of the annual PEAT audit (report June 07)
(Joint) report with Director of Nursing on mixed sex accommodation – November 06 Trust Board.

	Actions required	Measure of success	Lead	By when	Current Position
1b	1. Agree service agreements with all wards, departments and public areas, including waste collection frequencies.	Service agreements on all wards and departments. (*SMH – for hard and soft FM services. WH/AH – for hard, soft and retained estates).* Handbooks in all cleaners' cupboards	**BF JM PB Sxho Jane Savino Mdrst Anne Maguire**	**31/10**	Black bag waste complete. Review of clinical waste collection commenced. All sites agreed and laundry and waste collections are monitored regularly. 3 collections per day at SMH.
1b	2. Ensure an adequate supply of waste bins in public areas together with signage encouraging staff, patients and visitors to use the bins	Achieve score of 3 or better for waste handling in stairs, corridors and other public areas in the environment section of the annual PEAT audit. Reduction of complaints re waste bins.	**BF AM Chris Bunce Ray Clarke**	**31/10 Ongoing** **Extended to 31/3/07**	New bins installed. "Keep hospital tidy" notices produced. New external waste bins installed in SMH Dec 06 – signs on bins. All signs in place. All external bins replaced. Good PEAT score (06/07). Broken bins being replaced as they are found/reported.

	Actions required	Measure of success	Lead	By when	Current Position
1b	3. Provide adequate storage on all wards at SMH including storage for patients' personal belongings as appropriate	Patient lockers on appropriate wards	**PK**	**30/9**	SMH Complete WH/AH not applicable Achieved
1b	4. Ensure layout of hand basins in ward kitchens is accessible for all staff and water flow is adequate for purposes	Achieve score of 3 or better for cleanliness in food service section of the annual PEAT audit	**AM** **PB** **Sxho** **TW**	**31/1/07**	WH/AH complete SMH- audited all wards. Action complete. – checked at PEAT inspection Feb 07.
1b	5. Convert ward 22 to permanent ward and ward 20 to escalation ward at SMH, including redecoration, replacement of shower, number and locations of WCs, waste hold, and access. (This work includes creating new access to admin offices from J corridor).	Ward conversion completed	**BF CC** **Jon Barker** **Sxho**	**30/11 (Wd22)** **Jan 07 (Wd20 and J corridor)**	Estates added an additional side room with ensuite toilet to Ward 22 which now has 29 beds. Wd 22 – macerator replaced by washer disinfector. Wards complete (11 Dec) New access to J corridor completed Jan 07.
1b	6. Carry out weekly engineering checks of washer disinfectors, record checks for all machines in the appropriate book, and conform daily check recorded. Identify all washer disinfectors that do not comply with HTM 2030 and agree immediate replacement using the spare machines from SMH.	Weekly checks in place.	**Sxho** **TW** **AM**	**31/10** ***full completion 31/1/07***	Brought forward the ongoing replacement programme for remaining washers at SMH/WH/AH. Jan 07. SMH now 100% complete. WH – annual and quarterly checks being done. Trust trying to recruit Competent Person at WH to do weekly check. No appointment made as of 12/3. Taylor Woodrow has put interim system in place until Trust appointment can be made.
1b	7. NSIC refurbishment programme to include removal of carpet, improvement to storage, bathrooms and toilets	Capital programme – refurbishment completed	**KC DG** **TM** **Sxho**	**Mar 08**	Scheme costed.1st bathroom underway Oct 06). Further work planned. (Part of the bid for £300K MRSA funds). Programme started Mar 07. Awaiting deliveries. Work ongoing.
1b	8. Improve the separation of male and female toilets	No complaints	**JS** **Sxho** **TW** **AM**	**31/10** *end May 07*	Bays in SMH New Wing have shared toilets, and only problematic if bays mixed. Survey in retained estates of single sex and shared included signage – Jon Barker 30/9. WH/AH – signs complete. JS reported to Trust Board Nov 06. JG and FC took local HCC lead round wards where compliance will be difficult (ie Wds 20/22 SMH, NSIC and Phase 1 WH) 01/12/06 and shared Estates report with her. HCC lead understands situation. Trust to confirm with HCC and StHA that maximum possible has been done within capital resources. Board received formal report March 07 and requested further information about capital cost of changes to Wycombe tower block. SHA monitoring visit awaited.

	Actions required	Measure of success	Lead	By when	Current Position
1b	9. . Carry out all repairs identified from the monitoring/audit reports (p 34)	SMH FM Operational meeting minutes	**Sxho TW AM**	**30/9**	Monitored through team meetings (JS). Achieved.
1b	10. Create waste holds and cleaners' cupboards in wards on the retained estate (Wds 20, 22, Verney, Ophth, McCarthy, Spinal, theatres, X Ray and Path at SMH and all phases at WH and AH) (P40)	Capital programme- waste holds and cleaners' cupboards in place and utilised appropriately	**JS Sxho TW AM**	**31/12/06** *Revised 31/3/07*	SMH- Wd 20/22 waste hold completed. Ophthalmic ward and OPD and Spinal surveyed. WH – new cupboard for 2a/b. SMH – Waiting door for waste hold on 20/22 and prices for Ophthalmology. BF met with Infection Control to review layout of NSIC sluices. Making good progress. Need to reorganise sluices in NSIC – this will impact on other clinical areas. Reviewing changes required as result of new national guidance on waste and sluices received Dec 06.NSIC changes started Mar 07.
1b	11. Develop refurbishment programme for older wards and departments at SMH, including Spinal and escalation wards.	Capital programme – work complete	**BF Jon Barker Michelle Thiel Sxho**	**04/08**	SMH/Wyc/AH condition surveys. Refurbishment ongoing.
1b	12. Improve collection of dirty linen to ensure dirty linen is collected in accordance with the times it is produced on the wards.	Service agreements on all wards and departments (SMH – for hard and soft FM services. WH/AH for hard, soft and retained estates) Achieve a score of 3 or better for linen in the environmental section of the PEAT score.	**BF/Sodexho AM/Medirest**	**31/12/06** extended to 31/3/07	Linen collection frequencies audited to ensure they are at the optimum time and frequency. GMs and Head Nurses reminded that wards should call help desk (24 hours) if they produce additional dirty linen that needs more frequent collection. Times have been adjusted to help wards. (New national guidance may impact on this recommendation). Mar 07 – PEAT found areas where linen was not being collected on occasions. Encouraged staff to report problems through the key messages document going out about HCC action plan and SfBH in Mar and ongoing.
1b	13. Improve arrangements for sending soiled clothes home with relatives to launder	Reduction in complaints	**FC**	**01/12/06**	Two leaflets updated by the COI team. One relates specifically to CDiff and the other is about the handling of soiled clothing. Both leaflets have been sent out to all wards by the Acting Director of Nursing.

Recommendation 2a
The Trust needs to assess and continually improve practice in respect of controlling infection and ensure that it is an integral part of the daily routine of all clinical staff

Lead Director: Graz Luzzi, Acting Medical Director (was previously A Kirk)

Key areas to address

- Senior managers did not opt to attend the infection control committee (p36)
- The accountability arrangements for COI and Infection Control teams were complex (p40)
- Criteria for admission to wards were developed but overridden (p57)
- The risk of an outbreak was not on the risk register until the peak of the 2nd outbreak (p57)
- Other management imperative took greater priority than COI (p67)
- There was no effective response from senior management (p44)
- Insufficient focus on training in infection control (p89)
- Training in Infection control was not mandatory and there was poor attendance (p57)

Planned outcomes
1. Achievement of Saving Lives/Winning Ways objectives
2. Clear lines of accountability for control of infection
3. Regular reports to Board
4. Regular assessment of risk and adjustments to Risk Register as changes happen
5. High uptake of mandatory infection control training
6. Monitoring reports of transfers and failures to isolate reported to Governance Committee

High level Board indicator:
Report to Board every two months to contain information about transfers and failures to isolate, uptake of mandatory training, and current position on MRSA and CDiff and any other infections.

	Actions required	Measure of success	Lead	By when	Current Position
2a	1. Monthly meeting reviewing Saving Lives programme to develop, review and oversee integration of infection control into directorate governance practice and to monitor other aspects of Saving Lives action plan (This meeting has changed its name to Infection Control Leads Meeting and is bi-monthly).	Directorates conducting HII audits Practice changing	**AK FC Mod Matrons**	**ongoing**	Mod Matrons attend monthly CDiff meetings. Directorate Inf Control leads attend the Saving Lives meeting. CEO chairs Saving Lives meeting. (Now called Infection Control Leads Meeting). CDiff meetings have been incorporated into the new Trust-wide Infection Control Committee. Wards are completing HII 1, 2, & 5 (action plans will go to ICT). Nursing and Midwifery Board will review outcomes. Meetings going well. Terms of Ref for new IC Committee completed. IC Leads Meeting reviews HII audits. Quarterly Directorate Performance meetingsreview directorate action plans arising from HII audits.

	Actions required	Measure of success	Lead	By when	Current Position
2a	2. Develop guidance to CDs/directorate governance leads on directorate governance requirements to ensure IC on directorate governance agenda	IC on each directorate clinical gov team agenda.	AK DR CB	Completed	Letter from AK/AB 14/8 sent to CDs & directorate clinical governance leads. Inf Control Leads identified in all directorates. Roles of Dir Inf Control leads discussed with them at Saving Lives meeting (Sept 06). Control of Infection standing item on template for directorate clinical governance reports
2a	3. Develop annual programme for Directorate Infection Control Leads	Annual programmes specific for each directorate. Identification of directorates with specific HAI problems requiring additional support. Subsequent annual review of plans	DWCG KCa JOD	30 Nov 06 extended to 31/3/07	All Dir IC Leads asked to formulate an annual programme within their directorate. This comprises the High Impact Intervention audits, hand hygiene competencies, and any other relevant infection control work. Minutes of IC Leads meeting record actions in each directorate. Individual directorates now have IC programmes which are monitored through the directorate quarterly review meetings. CG drew these together into a Trust programme. All in place Mar 07.
2a	4. Develop plan for integration of roles and responsibilities of all involved in infection control (eg Directorate Infection Control Leads, modern matrons, ward leads, ICTs)	Implementation of published plan	KCa	31 Oct 06	A draft of the roles and responsibilities of the directorate IC Leads, the modern matrons and the infection control team was brought to the September Saving Lives meeting. Final version circulated to directorate infection control leads and modern matrons.
2a	5. Enhance involvement of front line ward and clinical staff through ward, HII (High Impact interventions) and link practitioners' audits and ensuring audit information disseminated and acted upon.	Conclusion of audits and then changes and actions as a result of the HII audits.	ICTs CB	Initial audits being completed 31 Oct 06 then ongoing	As described in 3 above, a programme of HII audits is in place for each directorate. The majority of these audits are being performed by front line ward staff, including link practitioners (link nurses). Trust wide audits of HII 1, 2b and 5 analysed by Clinical Audit. HII 3(surgical) audited and reported in Feb 07. No 4 not audited. No 6 is the Outbreak tool and is in use. Results of the audits fed back to the Infection Control Leads meeting and to individual directorates through such mechanisms as clinical governance meetings. HI Interventions 1, 2 and 5 in use.
2a	6. Increase awareness of ward teams including ward nurses and link practitioners of governance structures and lines of communication		FC	9 Oct 06	Draft structure was circulated to Head Nurses (after Board acceptance of changes). Action plan is now accessible on intranet.
2a	7. Ensure infection control is part of departmental induction	Directorates departmental induction programmes	FC Head Nurses	31 Oct 06	FC has confirmed there is a template for IC training in the local induction checklists.
2a	8. Infection control issues highlighted in	Modern Matron audits	FC	Starting	Is part of the standards in the corporate nursing folder.

	Actions required	Measure of success	Lead	By when	Current Position
	care plans			**Sep 06**	
2a	9. Review work plan for bringing IC Manual up to date and ensure correct distribution of manual	Delivery of IC Manual workplan within the timescales set.	**CG**	**Started & ongoing**	The IC Department established a prioritised plan to update the infection control manual with Trust wide policies, and the first sections were issued by the end of October. (All wards and departments have a manual copy). Bulk supply printed and distributed end Oct. Additional resources allocated to the team to complete the whole manual by end of March 07.
2a	10. Ensure monthly surveillance figures reported to Directorate Infection Control Leads and through them to directorate clinical governance teams	Readily available timely and accurate data	**JW JO KCa**	**Sep 06 for hard copy data. Intranet availability Mar 07**	Monthly Trust wide data on alert organisms now provided to the Directorate Infection Control leads who have been asked to disseminate them within their directorate, especially at Clin. Gov meetings. CDiff and MRSA non bacteraemia are updated weekly and the MRSA bacteraemia updated as they happen. Monthly reports to Board, Governance and CRRP. Protocols drawn up to ensure data is collected and collated consistently across both sites. Trust-wide monthly figures now on intranet and reported at regular meetings of Mod Matrons and IC nurses.
2a	11. Develop plans for reporting MRSA bacteraemias (red incident or SUI – to be determined), investigating and modifying practice within directorates	MRSA bacteraemia reported as agreed. Investigation and feed back of actions reported as part of incident reporting process	**DW**	**16 Oct 06**	Letter went to all clinical staff about Trust acquired/assoc bacteraemias from Medical Director/DIPIC to communicate process and ensure that relevant review of the case occurs and any changes to practice can be instigated. Letter emailed to all consultants 10/10/06. MRSA Bact. (April – Oct) Reported to Board 30/11 and ongoing.
2a	12. Develop further action plan for reducing MRSA infection and bacteraemia following DH visit 10/11 Oct.	Action plan developed from Department of Health guidance following visit 10 / 11th Oct	**AK ICMF**	**Oct 06 Revised 15/12**	Department of Health team visit on 10 / 11th Oct 06 at Trust request. Positive verbal feedback. Report received 7/11. Following consultation, action plan completed 7 Dec and submitted to DH. Links with HCC action plan clearly identified. Review visit 8 Feb 07identified 3 key messages and the Infection Control Leads Meeting is ensuring that these are addressed by directorates.
2a	13. Public presentation of the annual Control of Infection Report	Report discussed at public meeting	**AK**	**29/9**	2005/06 Report completed submitted to 29/9/06 Board
2a	14. Consultation paper on Infection Control Team structure and accountability	New team structure implemented	**AK**	**Dec 06**	Consultation paper issued to ICTs, went to JMSC 15/9. Consultation with each individual started 25/9. DIPC appointed 23/11/06. Decision to trial a co-lead IC Senior Nurse structure for up to 6 months.

Recommendation 2b
The responsibility for controlling infection should be in the job descriptions of all relevant managers, including ward managers, rather than being seen primarily as the role of the infection control team

Lead Director: Sandra Hatton, Director of Human Resources

Key area to address
The responsibility for infection control should be in the job descriptions of all relevant managers, including ward managers

Planned Outcome
To ensure that all members of staff are fully aware of their personal responsibilities in respect of control and prevention of infection.

High level Board indicator: Confirmation from the HR Director that all staff have had this statement and that all new job descriptions (from 1/10) have this statement included.

	Actions required	Measure of success	Lead	By when	Current position
2b	1. Write to all staff with a statement about their personal responsibilities in respect of infection control and prevention of infection and that it is part of their job description and day to day working.	Attach to payslips at end of Sept Job description templates altered.	**SH**	**30/9**	Completed Responsibility for infection control is included within all job descriptions. Existing employees informed by letter (Sep 06) and new employees have it included in their job description.

Recommendations 3a and 3b

- **The Trust should make training in the control and prevention of infection mandatory for clinical staff**
- **The Trust should ensure that there are adequate resources to provide mandatory control of infection training**

Lead Director: Sandra Hatton, Director of Human Resources

Key areas to address:

- Define what mandatory training in control and prevention of infection looks like for all our staff groups, including those working on the frontline and in support roles. This expands on work already undertaken to ensure there is complete clarity about what is to be provided and to whom.
- Agree an annual programme of training and development in control and prevention of infection control and ensure that attendance is monitored and reviewed.
- Review the Induction programme for all new staff to ensure that the training in control and prevention of infection is appropriate and sufficiently detailed.
- Identify the resources required to deliver the mandatory training requirements including people and learning packages.
- Ensure that all relevant training and workforce strategies are updated to reflect the new mandatory training requirements and the training brochure.

Planned Outcomes

1. An annual control and prevention of infection annual training and development programme
2. Agreement in place as to how this training programme will be delivered and resources earmarked to ensure delivery
3. Updated strategy documents
4. Monitoring and review of mandatory training happens regularly and the Board receives feedback

High level Board indicators:

Annual uptake of hand hygiene and control of infection training of at least 70% of all clinical staff a year from publication of action plan, and 80% of all clinical staff by 31/3/08.

Quarterly reports to HR and Governance Committees on workforce to include data on mandatory infection control and hand hygiene training and evidence of follow up action for non attendees.

	Actions required	Measures of success	Lead	By when	Current Position
3a 3b	1. Establish ad-hoc implementation group	Group established	SH	8/8	Achieved
3a 3b	2. Define what mandatory training in control and prevention of infection looks like for all staff groups, expanding on work already in hand to ensure there is complete clarity about what is to be provided and to whom.	Clarity on which groups of staff require which training.	SH/SB AK/CG /RG	17/10	IC mandatory training matrix developed in consultation with senior nurses, CDs, etc, and agreed by group. Agreed by TEC 3/10
3a 3b	3. Agree an interim programme of mandatory training for 2006/07	Clear expectations of training required for the next 5 months	SH SB	30/11	The interim programme has been communicated widely within the organisation. High level of bookings now going through.
3a 3b	4. Identify the resources required to deliver the mandatory training requirements including	Sufficient trainers/e-training packages to	SH AK	17/10 Revised 31/12	Group identified the resources required to train clinical staff up to 31/3. TEC agreed 3/10 to outsourcing package to enhance

	Actions required	Measures of success	Lead	By when	Current Position
	people and e-learning packages	deliver the volume of training demanded.		**Extended 31/3/07**	internal training for the remainder of 2006/07. Group worked on what was required long-term to build this into the overall annual mandatory training programme. Resources reviewed with DIPC plus possible use of e learning. DIPC confirmed resources in place for ongoing training 07/08.
3a 3b	5. Agree a set of mandatory training and minimum standards framework for all staff that enables the delivery of an annual programme of training and development in control and prevention of infection control and ensure that attendance is monitored and reviewed regularly	Published programme of training. Quarterly training reports identifying where uptake is poor so that managers can follow up.	**SH SB AK CG RG**	**17/10 Revised 6/11 Revised 17/1**	Agreed need to establish 2 – 3 training sessions per week. Advice sought from Leicester about use of the e learning package. External provider appointed to supplement training sessions (12 week contract). Bulletin circulated to managers w/c 30/10 with training dates. High level of booking Jan-Mar 07. Annual IC programme is built into changes to **all** mandatory training. Letter to all staff from HR Director about mandatory training. Six monthly census undertaken (Dec/Jan) to check against data collected. Task completed and kept under regular review at HIG meetings.
3a 3b	6. Review the Induction Programme for all new staff to ensure that the training in control and prevention of infection is appropriate and sufficiently detailed. Implement changes.	Confirmation from IC nurses that COI training is sufficient	**SB DH CG RG**	**31/10 31/1/07** extended to 30/3/07	COI nurses reviewing with Training Manager how to build a practical hand hygiene session into the induction programme by 31/1/07. The change to the Induction programme took effect from April 07.
3a 3b	7. Ensure that all relevant training and workforce strategies and the Training Brochure are updated to reflect the new mandatory training requirements.	IC Training matrix to be published in quarterly training bulletin.(next one due Jan 07)	**SH SB**	**31/10** *extended to 31/1/07*	Review undertaken. IC training matrix published. New Framework and Annual Training Plan is being developed with the mandatory training leads. New Education Training & Development Strategy and revised HR Strategy ratified byBoard in March 07. Frequently Asked Questions sheet to be produced for all staff about mandatory training. HIG agreed that task was complete.

Recommendation 4

Recommendation 4a
In the clinical management of patients with CDiff greater attention must be given to ensuring that patients do not become dehydrated.

Lead Director: Graz Luzzi, Acting Medical Director (was previously A Kirk)

Key areas to address

- For several patients the record of fluid balance was poor
- There was evidence of inadequate fluid replacement where treatment was not as active as it could have been (more apparent with older patients)

Planned Outcomes
1. Ensure management of dehydration in patients with diarrhoea is part of clinical teaching for medical staff
2. Evidence of adherence to the guideline
3. Evidence that all patients with diarrhoea are on a dehydration management programme

Recommendation 4b
In the clinical management of patients with CDiff, good records must be kept of their intake and loss of fluid
Lead Director: Fiona Coogan, Acting Director of Nursing

Key areas to address
Patients with diarrhoea must have accurate assessment of fluid input and output to monitor hydration

Planned Outcomes
a) Ensure timely and responsive management of patients with diarrhoea
b) Ensure patients do not become dehydrated
c) Develop a core care plan (checklist) for patients with diarrhoea including clinical management and nursing care

High level Board indicator: Audit outcomes and complaints monitoring

	Actions required	Measures of success	Lead	By when	Current position
4a	1. Guideline confirmed, updated and on intranet	Compliance with guideline	**JO MW DW**	**completed 30/10 Reviewed Feb 07 New guideline due April 07**	Guideline 242.2 (Management of persistent diarrhoea related to CDIff) and Guideline 225.1 (Management of CDiff induced diarrhoea and colitis) both on intranet. These will be combined and updated in April 07 to include forthcoming guidance from the DH on the management of CDiff.
4a	2. Clinical training sessions on C Diff and infection control for junior docs – to discuss with relevant education leads	Training programmes for junior doctors (Medicine)	**AK**	**Sep06**	Training sessions in infection control and related topics included in the junior doctor training programmes. Reconfirmed Feb 07.

4b	1. Establish small working group	Group in place	**FC**		Done. Led by Marilyn Park.
4b	2. Audit of hydration of patients with diarrhoea designed. Piloted on 18/08/06. Initial audit to be completed within 60 days. Repeat within 3-6 months.	Audit completed, providing data for comparison with future re-audits and checking for consistency of approach across all sites	**LH CB**	**Sep 06**	Initial audit completed.
4b	3. Draft Checklist for People with Diarrhoea. Head nurse and IC consultation. Finalise draft checklist, launch and implement it. Monitor and audit effectiveness of checklist.	Final checklist launched. Evidence of compliance with the checklist.	**FC CB N&MB**	**30 Apr 07**	Checklist circulated to all wards. Head Nurses monitoring usage and auditing over 6 month period. This audit to include audit of guideline 242. Audit completed end of Mar. Report due end of April.

Recommendation 5 (also refer to Recommendation 8b and 6b, 8b, 8c and 13)
Within 60 days of publishing this report the criteria for transfer between wards should be reviewed to ensure that clinical advice is taken fully into account and that acutely ill patients are not placed on inappropriate wards without adequate medical and nursing support

Lead Director: Karen Bastin, Operations Director

Key areas to address:
- Bed moves (internal and external transfers)
- Escalation processes
- Ward closures
- Allocation of beds
- Accountability and roles of bed managers, ward coordinators, on call managers and NNPs, etc
- Whole process to be integrated with infection control processes.

Planned outcomes
1. A comprehensive corporate bed management policy agreed by TEC which is fully integrated with the infection control policy. Policy to include: transfer criteria, how to reduce bed moves, escalation criteria, isolation processes
2. Clarification of key roles and their responsibilities (eg bed management)
3. Launch of new policy and sessions for key staff to ensure processes are embedded.
4. Weekly emergency beds meetings of operational TEC members

High Level Board indicators:
1. Progress report on implementation to Board November 2006
2. Decrease in the number of patient complaints re patient moves.

	Actions required	Measures of success	Lead	By when	Current Position
5	1. Draft documentation circulated		**JSw**	**18/8**	Achieved
5	2. Agenda item on August WSOM and emergency access performance meetings		**KB**	**31/8**	Discussed at WSOM. Comments invited from PCTs Completed
5	3. Final drafts for September TEC and TMB	Approved Corporate Policy	**KB**	**15/9**	Drafts considered in September by Trust Executive and Trust Management Board, which includes all clinical directors. (Following receipt of comments from HCC revised policy reviewed by Board 30/11)
5	4. Approval by TEC	Approved Corporate Policy	**KB**	**26/9**	Approved by TEC 26 Sept. Key elements implemented. (see above)
5	5. Launch with Comms team beginning of Oct	Information shared with all staff through bulletin, web and service newsletters,	**KF JSw**	**16/10**	Due to service complexity publication now 16/10 to ensure comprehensive implementation planning.

	Actions required	Measures of success	Lead	By when	Current Position
		service meetings, etc Will undertake a sample survey of key staff in November to measure success of communication.			Bed Management Policy publication on schedule for 16/10 via the intranet. "Open sessions" for staff held during October / November at Stoke, Wycombe and Amersham Hospitals. Bed Management policy on agenda of Ward Managers / General Managers meetings. Individual meetings held with head nurses. Bed Policy published on intranet 17/10. First audit data presented to HIG 17/10. Information in Staff Bulletin.
5	6. Run awareness sessions in October/November	All key staff clinical and managerial have access to awareness sessions and policy	**KF** **JSw**	**15/11** **revised** **30/12** **Ongoing**	Implementation and training package developed with bed management lead. Training sessions for Directors, GMs and service managers, head nurses, ward managers, A&E. Presentations to directorate/service meetings. Commenced week beginning 16/10 for 4 weeks. To include all sites and access for night staff. HMAC 16/11. w/c 20 Nov – further targeted training provided, including the newly issued Golden Rules. JSw did training session at TEC 28/11. Further in depth training organised for bed managers, NNPs and discharge coordinators. Training ongoing. HR to include awareness of bed management policy on induction checklist (May 07).
5	7. Establish a system for monitoring compliance with the bed management policy *Wording of task changed by HIG on 12/2/07*	Actions to address non compliance identified and implemented swiftly through bed manager's audits – reporting through weekly GMs meeting, and monthly Clinical Risk Review Panel meeting. Progress report to Board November 2006 Summary audits to be developed for CRRP, TEC and HIG.	**KB** **All** **Ops** **Dirs**	**30/11** **ongoing**	First audit reviewed 17/10. Bed audit outcomes being reported weekly to the GM's meetings and TEC. Also monthly to CRRP (from Nov 06) (and ultimately to the Governance Committee from Jan 06). The Lead Director will be responsible for ensuring information is available in a timely fashion. Discussion on bed management at Nov Board meeting. Ongoing refinement of weekly data collection noted at HIG 20/1. Review of transfer protocols and procedures across the Trust. Bed Management audits to be reviewed at weekly Emergency Meeting. March 07 – summary information requested for HIG and other meetings.

Recommendation 6a
The Trust must ensure it is treating all patients with dignity and respect

Lead Director: Fiona Coogan, Acting Director of Nursing

Key area to address

- Lockers for patients admitted as emergency cases
- Reduction in number of patient moves (see recommendation 5)
- Shortage of staff (see recommendation 8a)
- Staff awareness of the need for promoting dignity and respect

Planned outcome
Promote a culture of dignity and respect for all

High Level Board Indicators:
1. Achievement of 90% patients surveyed in the 2007 national inpatient survey (Mar/April 08) responding that they were treated with respect and dignity whilst in hospital.
2. Achievement of 92% patients surveyed in the 2007 national patient survey (Mar/April 08) responding that they were given enough privacy when being examined or treated.
3. Review of complaints to pick up dignity and respect issues to be included in the Essence of Care quarterly report to Governance Committee, starting with the Dec 06 report.

	Actions required	Measures of success	Lead	By when	Current Position
6a	1. Ongoing Essence of Care benchmarking on privacy and dignity standard	In answer to the question "overall, did you feel you were treated with respect and dignity while you were in hospital" obtain a "yes, always response from 90% of patients in the 2007 National Inpatient Survey (75.4% "yes always" response to this question in the Nov 05 inpatient survey). Quarterly review of a sample of complaints, looking specifically for dignity and respect issues. Information to be included in the Essence of Care report to the Governance Committee	**FC**	**29/12** *extended to 31/3/07*	Part of Essence of Care rolling programme completed Dec 06. Input from Complaints Dept held up pending start of Patient Services Manager. In meantime, CEO providing Acting Dir of Nursing with sample complaints. Audit results circulated to nursing teams. Good presentation on privacy and dignity at NMB – to be rolled out at Sister/charge Nurse meeting in April.
	2. Develop and publish chaperone policy	In answer to the questions "Were you given enough privacy when being examined or treated?" obtain a "yes, always" response from 92% of patients in the 2007 National Inpatient Survey (85.5% "yes always" response to this question in the Nov 05 survey).	**LH**	**30/11/ 06**	CRRP approved 26/9. Risk Management Committee (Oct) approved. Approved by Governance Committee 20 Oct 06. Diversity Committee comments included. Policy launched (HMAC and NMB). (Guideline 47.1 19 Dec 06)
	3. Ensure all relevant wards have bedside cabinets for patients to store their belongings	Modern matrons to confirm to Director of Nursing that there are bedside cabinets for all beds in appropriate areas of responsibility	**FC** **MN**	**Sep 06** **Extended To 28/2/07**	Identified that Ward 10 PFI at SMH did not have bedside cabinets for patients. They have storage boxes beside the bed. The patients in this area are only on the ward for a short period of time. Not having bedside cabinets frees up space around the bed which makes it easier to carry out clinical interventions. The decision to take this approach was based on practice in other emergency admission wards around the country. HIG decided 11/12 to reopen this issue and place lockers on MAU SMH and WH until MAU function was reviewed. Completed Mar 07.

Recommendation 6b
The Trust must pay particular attention to providing single-sex accommodation

Lead Director: Fiona Coogan, Acting Director of Nursing

Key areas to address
Insufficient effort made to eliminate mixed sex accommodation

Planned Outcome
To work towards complete single sex accommodation in all ward areas other than emergency admission areas

High Level Board Indicator:

1. Report to November 06 Board on use of mixed sex accommodation.
2. Achieve score of 75% or more in the 2007 national patient survey (reports Feb/Mar 08). (2005 survey – Trust only achieved 62%; results for 2006 currently being audited).

	Actions required	Measures of success	Lead	By when	Current Position
6b	1. Develop guideline for breach of single sex accommodation. Include guideline in corporate bed policy.	Compliance with the policy (*see also rec 5)*	LH KB	**Sep 06**	Management of single sex accommodation has been incorporated into the corporate bed policy *ref Rec 5* Guideline has been circulated to all ward areas for information.
6b	2. Monitor single sex accommodation during matron's round	Reports from Modern matrons to FC and N&MB	Head Nurses	**Oct 06**	This is included on the audit template for the Matron's round and in the weekly bed management audit.
6b	3. Person i/c of ward to be instructed to complete IR1 form when this is not achieved and record in patient notes with plan to correct as soon as possible	IR monthly synopsis	Ward Mana-gers	**Sep 06**	FC has written to ward managers.
6b	4. Report to November Board followed by quarterly compliance reports	Report to Board. Improved situation reported in national inpatient surveys	FC JS	**30/11 ongoing**	Board reviewed this alongside whole bed management policy in Nov 06.

Recommendation 7
Recommendation 7a The Trust must review and where necessary improve the standard of documenting decisions about clinical management

Lead Director: Graz Luzzi, Acting Medical Director (was previously A Kirk)

Key areas to address

- Medical and nursing assessments were recorded in multidisciplinary notes, but nursing assessments and care planning were poor
- Reviews by junior doctors were a record of their findings but there was little evidence of conclusions reached and recommendations (p29)
- When recommendations were made in notes they did not always appear to be implemented.
- Drug charts were missing for 2 patients, and records of fluid balance and blood pressure monitoring were poor.

Planned Outcomes
1. Raised awareness of deficits in note keeping/documentation
2. Greater responsiveness to identified deficits in note keeping
3. Improved handovers
4. Rolling audits of record keeping and ongoing vigilance
5. Outcomes reported to Gov/Board as part of clinical governance report

Recommendation 7b
The Trust must review and where necessary improve the standard of implementing decisions about clinical management
Lead Director: Fiona Coogan, Acting Director of Nursing

Key areas to address
Improve where necessary standards of documentation

Planned Outcomes
"Maintenance of Records and Record Keeping for Nurses and Midwives" Policy to be in use by 4/9/06 and audited across all wards by Oct 07.
Review Essence of Care Benchmark on Records and Record Keeping

High Level Board Indicators:
Outcome of record keeping audits to be reported in Governance report

	Actions required	Measures of success	Lead	By when	Current Position
7a	1. Ensure every junior doctor is given an email address on arrival	Each doctor to have email address	GL	**Oct 07**	All junior docs have an email address on the NHS mail system, but not a Trust address. The Ed Centre Administrators hold all F1 and F2 addresses and are developing electronic distribution lists for other junior grades. Pending introduction of the email list system in Oct 07, the Med Education Tutors have confirmed they can contact all junior docs in training.
7a	2. Junior doctors' involvement in note keeping review – expand pilot project	Regular records of audits	CB GL	**Feb 07**	Clinical Audit implemented this in Feb 07 with the new intake of junior doctors. Acceptance that this will be done by each new intake.

	with next intake of junior doctors				Monitoring framework being developed by Clinical Audit.
7a	3. Develop guidance on note keeping to be included in induction packs for junior doctors and distribute to current juniors as pilot, modify for Feb 07 intake. Ensure feedback on results of these audits.	Guidance included in Feb intake induction pack and ongoing.	**CB GL**	**Oct 06** **Implementation Feb 07**	This guidance has been included in induction packs for the last year. Updated guidance was produced for the Feb intake. Making good progress (TCAEC Committee April 07).
7a	4. Ensure note keeping audits are reported to directorates and acted upon	Outcomes in directorate governance reports	**CB GL**	**Oct 06** **ongoing**	New audit format developed for junior doctors to review notes. Audit implemented with new junior doctor intake in Feb 07. Senior review of casenotes requested from consultants by Med Director 19 12 06. Methodology piloted and discussed at TMB. (Ongoing action aligns with 7a2 above). Reminder to be issued April 07.
7a	5. Ensure that educational supervisors are aware of importance of note keeping and incorporate this into junior doctors' appraisals	Appraisal documentation	**GL/DB SE**	**Oct 06** **ongoing**	GL has written to education supervisors
7a	6. Ensure where note keeping identified as a problem for individual junior doctor this is acted upon – develop the process	Appraisal documentation	**GL Clin tutors**	**Oct 06** **ongoing**	Letter from Med Director and Dir of Med Ed sent to Clinical Directors 16/10
7a	7. Review Hospital at Night and handover issues – develop process	Guidance published	**GL**	**Aug 06**	Handover paper agreed TMB and HMAC. Meeting arranged (Mar 07) to review Hospital at Night and to check that key principles are in place. Confirmed that guidance is still in place. Meetings ongoing.
7a	8. Develop standardised integrated notes across the Trust with uniform charts, etc (Work being led by the Clinical Casenotes Committee which reports to ISC).	Integrated notes with no duplicate forms	**FA ED**	**2007/8**	Integrated elective notes to be trialled in Treatment Centre. Maternity almost complete. Clinical Casenotes Cttee has an ongoing programme for reviewing documentation for day surgery; theatres; emergency admissions/medical; discharge letters. ED to check robustness of programme. Med director has asked Chairman of Clinical Records Committee to make reports to HMAC. Programme to be aligned with the CRS programme. Roll out of CRS to SMH (autumn 07) will enable merger of notes between WH and SMH.

7b	1. Develop audit tool (for nursing records)	Audit tool	**FC LH CB**	**Sep 06**	Completed. The standards for record keeping are in the policy which is included in the corporate nursing folder which will be distributed to each ward.
7b	2. (Merged with 3 from 26/3/07) Start implementation of "Maintenance of Records and Record Keeping for Nurses and Midwives. Do cross ward/site audits (annual per ward). Report findings to N&MB.	All wards have been audited a year from now Compliance with the policy. Annual report from Head Nurses to NM&B of findings and actions	**Ward Sisters FC Head Nurses**	**Oct 07**	Corporate Nursing Folder launched. Each ward will be audited (Using audit tool above) once within next year (Oct 06-Oct 07). This will incorporate MDT notes.

7b	3. (Was 4 prior to 26/3/07). Carry out essence of care review of benchmark on records and record keeping	Governance Committee receives quarterly reports on Essence of Care standards	**LH**	**June 06**	Completed. Audit carried out in June 06, themes identified and action plans completed. Head Nurses' responsibility to ensure all actions followed up. Acting Dir of Nursing to ensure that Board is advised of Essence of Care outcomes.

Recommendation 8a

Lead Director: Fiona Coogan, Director of Nursing
The Trust must work with the strategic health authority and PCT to agree appropriate levels of nursing staff and then ensure that the Trust has sufficient nurses to provide acceptable and safe care, including on escalation (overflow) areas
Key area to address
Nursing establishment – particularly the ability to staff escalation areas

Planned outcomes
To agree a safe nursing establishment for each ward area

High Level Board Indicators:
Nursing workforce reports to HR Committee

	Actions required	Measures of success	Lead	By when	Current Position
8a	1 Provide CEO with report on nursing establishment that is benchmarked against similar Trusts	Completed report	**FC CE JMo**	**Sep06**	Final draft Report received 15/9. Discussed at TEC 26/9. Board received report Nov 06.
8a	2 Agree a workable establishment for each area within the Trust and agreed safe nursing establishments in place	Agreed budgeted establishments for each ward	**FC Board**	**30 Nov 06** extended to 28/2/07	Implications of report have been costed by finance. Escalation area staffing was agreed Aug 06 and permanent staff recruited. Board to determine costed programme Nov 06. Board decided 30/11 to seek further assistance from StHA Chief Nurse. Comments received (11/12) from Chief Nurse. Model being developed. Board received update in March 07 and noted improvements and ongoing work for new Director of Nursing to pursue. Information to be used by incoming Director of Nursing.
8a	3.Ensure adequate staffing is maintained on wards releasing staff for escalation areas	Monitor success via incident forms relating to staffing of escalation ward at SMH	**FC KB**	**ongoing**	2 former escalation areas converted to medical wards (Wd 20 SMH and Wd 6a WH). These wards are staffed with substantive staff. Ward 3X temporarily designated as the escalation ward. Now Ward 7 SMH. Patient Safety Manager has confirmed quarterly reports from the IR system about staff shortages will be presented to TEC and HR director (for HR reports). Steady reduction in staff shortages reports since Sep 06.

Recommendation 8b (links to Recommendation 5)
Within 60 days of publishing this report, the Trust needs to develop and publish criteria for the opening of escalation areas
Recommendation 8c (links to Recommendation 5)
Adherence to the criteria for opening escalation areas must be audited and reported to the Board

Lead Director: Karen Bastin, Operations Director

Key area to address

- Clarification of criteria for opening escalation areas
- Audit of compliance with the criteria for opening escalation areas

Planned Outcomes
Comprehensive corporate bed management policy agreed by Trust Board, fully integrated with infection control policy that includes the criteria for opening escalation areas and the process of auditing adherence to the criteria

High Level Board Indicators:

1. Operational/performance reports to the Board show decreased use of escalation beds.
2. Evidence through the noted minutes of the Governance Committee (re reports from the Risk Review Panel) and TEC that bed management issues are identified, discussed and action plans for issues are being addressed.

	Actions required	Measures of success	Lead	By when	Current Position
	Recommendation 8b				
8b	1. Within 60 days of publishing this report, the Trust needs to develop and publish criteria for the opening of escalation areas	Consistent approach to escalation in accordance with corporate bed policy. Likely to result in reduced number of times when escalation areas opened. Escalation areas only opened as part of an agreed plan to deal with capacity issues and in accordance with the policy. Evidence through minutes of GMs meeting and TEC that non compliance has been addressed with individuals/services concerned and plans agreed to stop reoccurrence.	**KB**	**4/10**	Criteria for opening escalation wards described within draft bed policy, including alert status and staffing matrix As for bed policy. (Rec 5 above) Bed Management Policy approved by TEC 26/9. New policies implemented and publication of comprehensive bed policy was rolled out from 16 Oct. Compliance monitored at Board Nov 06. Process in place and being monitored. Ward 7 SMH is escalation ward.
8b	2. TEC approval of the corporate bed policy	Positive report on implementation of the bed management policy to Board Nov 06.	**KB**	**26/9**	TEC approved 26/9 following consultation with clinical directors Policy reviewed after 2 months and position reported to Board Nov 06.
	Recommendation 8c				

8c	1. Develop process for auditing compliance with the criteria for opening escalation areas	Robust information available to the Board re the numbers and frequency of escalation beds opened. Bed managers audit forms reviewed at the weekly GMs meeting, issues highlighted to TEC and to the Risk Review Panel. Numbers of individual patient moves for a non clinical reason decreased in line with policy (monitored through the bed managers' logs to GMs and Risk Review Panel).	**KB**	**30/9**	Audit sheet developed for use by bed managers. Completed. Is included in pack of audit documentation used by Bed Managers as part of monitoring the corporate bed management policy (Ref Rec 5). CEO reports progress in "operational" report to Board.
8c	2. Include reports on opening of escalation beds in the monthly Clinical Risk Review Panel meetings and at weekly General Managers meeting. Exec director lead to ensure that TEC are advised (TEC minutes are reported to Board).	Evidence in minutes that this is on relevant agendas.	**KB**	**30/10**	Weekly CEO led emergency access meeting instituted from early September 06 and escalation issues discussed. Bed Management Department audits use of escalation areas and reports to above meeting and CRRP (latter from Nov 06). Data collection commenced 9/10/06 by the bed management team / lead nurse (capacity). First Bed Management Audit figures presented to HIG 17/10

GOVERNANCE RECOMMENDATIONS

Recommendation 9a

Within 60 days of the publication of this report, the Trust must review its arrangements for governance to ensure that the board is aware of clinical risks and that consideration of risk is an integral part of all major decisions.

Recommendation 9b

The views of clinical staff and particularly any concerns about the safety of patients must be heard at the level of the board.

Recommendation 10a

Control of infection needs to be an integral part and focal concern of clinical governance

Recommendation 10b

The role of the Director of Infection Prevention and Control must be reviewed. The post holder must have relevant experience and competency as set out in the DH publication *Winning Ways*

Recommendation 11

The Trust needs to ensure that the safety of patients is not compromised in the pursuit of other strategic objectives. In this judgement, the Board and senior managers need to give sufficient importance to the control of infection and the advice of the Director of Infection Prevention and Control

Recommendation 12a

The Trust must improve the arrangements to manage risk, ensuring that structures and lines of accountability are clear

Recommendation 12 e

The Trust must ensure that the risk register contains the key clinical risks and is used to inform decisions about investment

Recommendation 12 f

The Trust must have a system in place to ensure that lessons from incidents are learnt across the Trust

Lead Director: Anne Eden, Chief Executive (from Jan 07. Was previously led by A Bedford, Interim CEO).

Key areas to address

- Concerns raised consistently at CRRP not discussed at higher committees
- System and strategic issues from complaints/SUIs not addressed
- Little response to consultants' written concerns
- Themes from complaints to go to Board
- Gov Committee not looking at stats on movements/inappropriate placement/failure to isolate, etc
- Gov structure too complicated
- Governance Committee proving little leadership
- Greater integration of COI issues in departmental governance
- DIIC to attend hospital COI committees
- COI annual reports to go to Board
- Discussions in committees to be minuted
- Review what items are held in private
- Risks discounted in favour of govt targets
- Culture not seen as open

Planned Outcomes

a) Simpler governance structure
b) Clarity of committee and managerial accountability
c) Clarity of thresholds for upward referral
d) Board aware in good time of clinical risks
e) Board has specific reports on infection rates
f) Board receives analysis not just numbers
g) Minutes accurately record discussions
h) Risk register includes clinical issues
i) New DIPC appointed & attends COI site meetings
j) Trust has system for disseminating lessons
k) COI actively integrated into departmental governance arrangements
l) Staff have confidence that concerns will be listened to
m) Staff understand the pre-eminence of patient safety *(keep repeating this in literature sent to all staff.)*

High Level Board Indicators:
Assurance Framework/ Risk Register presented to Board quarterly – evidence of greater use of the register by all parts of the Trust.
Scores of 13 + to be discussed at Governance Committee and the highest risks drawn to attention of Board in the quarterly review of the Assurance Framework.

	Actions required	Measures of success	Lead	By when	Current Position
9a	1. Governance Review Group to be focus of review – already in place	Recommendation to Board	AK AB		Gov Review Group met regularly – made recommendations to 29/9 Board and stood down.
9a	2. SHA advice to be acquired	Regular attendance at Action Planning group	AB TU		SHA attend weekly Action Plan meetings, and have provided good practice examples.
9a	3. External advice to be sought	Attendance at Gov. Review Group	AB	ongoing	Portsmouth Head of Governance met Governance Review Group 4/9. Visit to Kings Healthcare Nov 06 also yielded useful examples.
9a	4. Proposals on any revision to structure to Sept Board	Board accepts proposals	AB	29/9	Draft given to CEO 7/9. To execs 12/9, Board 29/9 Agreed governance structure implemented. Foundation for move to integrated governance put in place.
9a	5. Advice on minute taking to be issued	Advice published	AB	30/9	Issued 28/9 by CEO
9a	6. DIPC role to be reviewed	Review completed			Achieved. Consultant microbiologist appointed in this role 23/11/06.
9a	7. Board to have detailed reports on infection rates, starting in Sept	Regular IC report to Board	AK	29/9	Report to FPI Sub committee (now Board Seminar) 31/8. Report to every Board meeting.
9a	8. CDs to be instructed that COI must be integral part of directorate clinical governance	Instruction to CDs	AB AK	8/06	Achieved - Letter sent by CEO and MD 14/8 asking that IC is a standing item on all Directorate CG meeting agendas. Included on the Directorate Clinical Gov reporting template for CRRP.
9a	9. CEO to tell all staff they must feel free to report concerns upwards, and beyond own manager if necessary	CEO newsletter to all users	AB	14/8	Achieved – CEO newsletter to all staff 14/8/06
9a	10. CEO to issue advice on relationship between hitting access standards and patient safety		AB	30/9	Done verbally in TEC, TMB, Consultants meetings, etc. Also reported nationally in HSJ. Staff newsletter 280906.
9a	11. Operational report to be added to each Board agenda, where current risks and progress on earlier risk can be discussed.	Minuted discussion and actions	AB	29/9	Board receives operation report from CEO and report from Governance Committee which meets monthly.
9b	1. The views of clinical staff and particularly any concerns about the safety of patients must be heard at the level of the board.	Board minutes	AB	4/10	All staff have been encouraged to go up line if immediate line managers don't act. CEO newsletter 14/8. Major risks go now to HCC action meeting/TEC/Board. CEO guidance to Chairs of committees advising them to ensure that urgent high

	Actions required	Measures of success	Lead	By when	Current Position
					risk issues discussed in their committees are raised with the appropriate executive director/TEC –issued with information about review of governance structure.
10a	1. Control of infection needs to be an integral part and focal concern of clinical governance	Directorate clinical governance minutes, CRRP minutes, etc	**AB**	**ongoing**	Letter sent jointly by MD/CEO 14/8. Reinforced at each directorate quarterly review.
10b	1. The role of the Director of Infection Prevention and Control must be reviewed. The post holder must have relevant experience and competency as set out in the DH publication *Winning Ways*	Board review of role 12 months after appointment	**AB**	**23/10**	Achieved Consultant Microbiologist appointed DIPC 23/11/06. Board review of how post is working built into Board programme for 2007/08
11	1. The Trust needs to ensure that the safety of patients is not compromised in the pursuit of other strategic objectives. In this judgement, the Board and senior managers need to give sufficient importance to the control of infection and the advice of the Director of Infection Prevention and Control	Policy clearly communicated. Board agenda and discussion highlighting safety.	**AB**	**ongoing**	Clear messages consistently given by CEO in all management/clinical fora that although the trust will hit targets, an individual patient's safety will not be compromised by targets. (Consultants open meetings, CEO newsletters, TEC/TMB)
12a	1. The Trust must improve the arrangements to manage risk, ensuring that structures and lines of accountability are clear	Each directorate to provide details of highest risks to CRRP. Monitoring complaints about lack of clarity Good implementation of bed policy	**AE JG**	**23/10 Revised 31/12 Extended to 24/1 (Jan Board mtg)**	Revised operational management structure introduced 30 Oct. Lines of accountability clarified. Guidance on management of nursing areas re-clarified. Committee chairs authorised to raise issues direct with top management rather than using minutes alone, and CRRP Chairman reports clinical issues (monthly) direct to TEC and Governance. Governance structure reviewed by Board (29/9). Terms of reference for Board committees updated. Comprehensive Governance report to Board 30/11. HIG agreed 29/1 the initial task is complete and improvements will be noted at each regular review of the governance recommendations. Assurance Framework discussed at Board Jan 07. Revised Board Assurance Framework Policy discussed at Governance Cttee 23 Feb 07Board Assurance Policy agreed by Board March 07.

	Actions required	Measures of success	Lead	By when	Current Position
12e	1. The Trust must ensure that the risk register contains the key clinical risks and is used to inform decisions about investment	Every directorate has a live risk register An identified person in each directorate who maintains the directorate risk register. All Trust business cases to identify risks and significant risks to be included on the register. Gov Committee to review register for clinical content.	**AE** **JG**	**23/10** *ongoing* *31/12* *Extend* *To 31.3.07*	Risk registers for each directorate are on the Q drive which is available to CRRP members and Exec directors. System for updating the register reviewed.. Got best practice from other Trusts and StHA on style and use of risk register and risk assessment tool. Board approved revised Corp Objectives (Nov 06). TEC/Board received revised Assurance Framework Jan 07. Governance Committee received an update on progress with the changes to the Risk Register in Jan 07 and received full report on highest risks on the Corporate Register in Feb 07 together with revised Risk Management Strategy and Risk Management Policy. Board received Risk Mgt Strategy, Board Assurance Framework Policy, current Assurance Framework action plan, Corporate Risk Register and paper on top risks at its March meeting. Flow on information on risk and risk management now established between the directorates and the Board.
12f	1. The Trust must have a system in place to ensure that lessons from incidents are learnt across the Trust	Lessons learned/changes made will be published in the annual risk management/clinical governance reports to the Board. SUI sign off reports will identify lessons learned and be reported to the Governance Committee and the Board. Quarterly bulletin of lessons from complaints/incidents, etc to Board. Staff engagement will be assessed by questionnaire	**AE** **JG**	**30/11** **Extend** **To 31/1/07**	SUI process reviewed. Incident reporting process reviewed. Quarterly Clinical Governance Reports improved. Regular Patient Safety Bulletin sent to all directorates with information about lessons from incidents and complaints. Comprehensive report to Governance Committee 20/10 (and ongoing) Comprehensive report to Board 30/11 Red incidents to be added to directorate review agendas. Monthly sharing of learning from red incidents in directorates at CRRP. HIG decided 29/1 that the system had improved and this task should be shaded as complete. Ongoing improvements will be noted at each full review of governance.

Recommendations 12b/12c/12d
12b - The Trust must ensure that there is analysis of the risks raised by clinical incidents which is drawn to the attention of the Board
12c - The Trust must ensure that the Board undergoes (annual) training in the management of risk
12d - The Trust must ensure that the Board plays a stronger role in examining and, if necessary, challenging assessments by Trust managers

Lead Director: Sandra Hatton, Director of Human Resources (as from Jan 07 – previously was led by S Knight, Director of Strategy and Communications)

Key areas to address

- No evidence from minutes that these concerns were discussed at the Gov Committee, FPI, or the Board (p.57) -the risk of an outbreak of a healthcare acquired infection was not included on the risk register as a risk for the Trust as a whole until the peak of the second outbreak (p57)
- At the FPI meeting at end of April 2005 the outbreak was discussed including the public relations aspects but none of the discussion was minuted (p 63)
- The CDiff outbreak was not reported to a public meeting of the Board until 29 July 05. Members of the Board were unable to explain why the second outbreak was not discussed in public at the board before it appeared in the national media, nor why earlier discussions in other meetings had not been minuted. Members of the board had poor recollections of the events and discussions concerning the outbreaks of CDiff (p 63)
- The Trust did not consistently follow the advice of the IC team, even at the height of the 2nd outbreak, and there was no mechanism to reconcile the advice from the IC team and the options preferred by managers (p 67) – At the height of the 2nd outbreak, in Feb 05, the Board members, sitting as the FPI group took the decision to pursue targets, despite the outbreak. External organisations did not feel that those responsible for the management of the Trust took the outbreaks sufficiently seriously. Other management imperatives took greater priority than the control of infections. When the possibility of closing the Trust to new admissions was considered, the advice of the IC team was not sought.
- The NEDs did not appear to be fully informed about the organisation and its challenges, particularly in relation to clinical risk.
- There was a lack of evidence of discussion by the Board of key issues relating to clinical risk, particularly the outbreaks of CDiff
- The Trust's preparation for and approach to our investigation did not appear designed to facilitate full and balanced scrutiny
- Decisions by the Board: (p86); in the context of the first and second outbreaks of CDIff the Trust did not appear to act on the principle that risks should be identified and appropriate changes implemented to protect the interests of patients.
- There was no evidence of any discussion of the outbreaks by the Board in public until after the outbreaks had been reported in the national press. We are unable to determine whether the board genuinely failed to discuss any aspect of such a fundamentally important matter, or whether discussions did in fact take place but that these discussions were not recorded.

Planned Outcomes
1) Risks raised by clinical incidents are regularly drawn to the attention of the board via a revised system of structured reporting and the way in which agendas are constructed.
2 All Board members will have a thorough and up to date understanding of governance and risk management (theory)
3) The Board as a whole, and individual, will have undergone development to provide effective governance and risk management (practice).

High Level Indicators:
Board development programme to include annual risk management update.
Risk register to be reviewed by the Board quarterly (as part of the Assurance Framework)

	Actions required	Measures of success	Lead	By when	Current Position
12b 12c 12d	1. Contact the National Clinical Governance Support Team to identify support and a possible programme for Board Development	Contact made and support availed	**SK**	**10/8**	Completed and team from CGST identified to provide support.
12b 12c 12d	2. Provide a range of supporting reference materials to Board members on effective governance, risk management and related topics	Info circulated and discussed	**SK**	**31/8**	NEDS apporached re training requirements. Research carried out on publications/evidence of good practice to share. Conference call on 25/8 with Nat Clinical Governance Support team.CGST able to offer a range of support to the overall process of implementation and development. Planning meeting held with NCGST. 6/9 Dr Foster "The Intelligent Board" circulated to board members along with CGST Integrated governance document and web references
12b 12c 12d	3. Agree the programme to be offered with CEO and Chairman	Development programme planned, delivered and evaluated Risk Management training delivered annually	**SH**	**20/10** **31/10** extended to 30/6/07	Programme being agreed with the Chairman and CEO. Initial session drafted and meeting with CGST on 6/10 to identify training opportunities and support. Priority to be given to risk management, then general Board development as new team created. Board Risk Management training session on 30/11. Scoping underway. Draft outline programme with new CEO to put in place after Board changes. Proposed programme for middle managers being drafted. Board Development event postponed until all new NEDs in post in June 07.In meantime full risk report presented to March Board.
12b and d	4. Process for analysing and raising risk at Board level revised to ensure effective and timely reporting and challenge	Reports received quarterly and evidence of challenge and discussion at board level of risks raised by incidents with subsequent remedial actions	**SH JG AE**	**25/11** **Extend to 31/1/07**	Interim proposal on governance structure to Board 29/9 See recommendation 9 above. CRRP raises urgent issues directly with TEC. Board holds bi-monthly seminars Board receiving regular risk rerpots. HIG to note improvements at each full review of the governance recommendations.

Recommendation 13
The Trust must have an effective process to assess the risk of failing to isolate patients with diagnosed or suspected transmissible infections and ensure the appropriate isolation of patients who pose a potential or actual high risk of infection to others. This process must involve the infection control team.

Lead Director: Karen Bastin, Director of Operations

Key areas to address
Process for assessing the risk of failure to isolate infectious/potentially infectious patients

Planned outcomes
- An audit process to pick up failures to isolate.
- Inclusion of this process in the corporate bed policy
- Evidence of its use

High Level Board Indicators:
Number of failures to isolate included in the infection control report (standing item) to the Board and in the bed management review (Nov 06).

	Actions required	Measures of success	Lead	By when	Current Position
13	1. Develop process for monitoring failure to isolate patients	Process included in corporate bed policy and evidence of compliance with use of audit form. Include in monthly bed reports to Risk Review Panel and in general manager weekly meetings. Reduction month on month in the number of failure to isolate cases.	**KB**	**30/11**	"Failure to isolate" audit form for bed managers included in the bed policy. Bed policy integrated with infection control policy. Reviewed alongside all bed management issues at November Board. Evidence of working policy also monitored by South Central StHA. Weekly audit data shared with Operational directors and staff.

Recommendation 14
a) The Trust needs to improve its systems to ensure that appropriate action is taken in response to complaints and should ensure that
b) complaints are investigated in an objective manner
c) complaints are analysed, themes identified, links made to claims and incidents, and audit triggered where appropriate
d) where appropriate, action is taken if staff are found to have provided poor care
e) the Board fully considers the recommendations of external reviews and follows their recommendations unless there are compelling reasons not to. When not complying, the principles involved should be considered in a full and public meeting of the Board.
f) action plans are generated in response to serious complaints, and then implemented and monitored.
g) lessons are disseminated across the Trust

Lead Director: Jan Grant, Acting Director of Governance (was previously Alan Bedford, Interim Chief Executive)

Key areas to address

- No analysis of complaints for Board
- Board decisions on IRs to be explicitly recorded
- Collation of views – not an investigations
- Tone of replies defensive, sometimes hostile
- Clarity of accountability for post complaint actions
- High numbers of complaints about nursing care (acute hospital portfolio)
- Lessons not disseminated
- Consideration of when there needs to be formal action against staff

Planned Outcomes
1. Complaints completed to time
2. Response tone appropriate
3. Where necessary, incidents investigated, not just subject to staff responses
4. Accountability and process for action from complaints clarified
5. Formal action against staff considered where warranted
6. Themes and trends identified and reported to the Board

High Level Board Indicators:
Feedback to Board on complaints trends and themes – a standing item.

	Actions required	Measures of success	Lead	By when	Current Position
14a	1. Strengthen complaints team immediately to address backlog.	80% compliance with 25 day rule from Jan 07	**AB FC SK**	**Sep06**	Decision to enhance staffing taken 9/8. 1 p/t staff added in August. Outside help from complaints expert added Sep 06. CEO asked for briefing 5/9 on what was needed to clear backlog. Interim support acquired. Acting Director of Governance considering long term changes.
14a	2. Identify appropriate person to review	Detailed trends to be		**31/10**	Complaints Policy (Nov 06) included a detailed flowchart of responsibilities. The

	Actions required	Measures of success	Lead	By when	Current Position
	every complaint to identify in detail themes and trends, especially in clinical care/communications.	included in all relevant committees.	**JG**	**Extend to 31/7/07**	complaints manager reviews each complaint as it comes in; records its issues and themes on the central complaints database. This information, plus PALS information, is provided to quarterly to Governance Committee and the Board. Each Directorate has a complaints lead. Report on trends in complaints was discussed at October Governance Committee and is included in Board report (Nov 06). Trends reported to Governance Committee Jan 07. CRLS to provide formal reports to Governance Committee in future. Backlog of complaints has reduced significantly. Complaints Review Group Current 2 NEDs remained on Complaints Review Group as Associate NEDs. New Patient Services Manager started 11April 07. She will develop a remedial action plan to report to Governance and Board.
14a	3. Clarification of accountability for dealing with complaints/taking action afterwards in service areas.	A complaints lead in each directorate	**AB**	**1/10**	TEC confirmed 29/8 that there will be a lead in each directorate/dept. Process agreed 1/10/06. in place.
14a	4. AB to write guidance on style of complaint replies	Guidance available	**AB**	**30/9**	AB circulated guidance 27/9/06
14a	5. AB to write guidance on “investigation”	Guidance available	**AB**	**30/9**	AB circulated guidance 27/9/06
14a	6. AB to prepare guidance on taking action with staff as a result of complaints following debate within execs	Guidance available	**AB**	**30/9**	AB circulated guidance 27/9/06.This is confirmation of existing complaints policy
14a	7. Reporting to Board	Quarterly reports to Board	**AB**	**30/11**	Quarterly reports on themes starting with November 06 Board and CEO takes major complaint issues direct to Chair/Board as appropriate.
14a	8. Support and complete process review by 3i: CEO and Governance Director to support this ongoing review. New processes to be in place by end 2006	External audit of complaints process to be undertaken mid 2007.	**AE** **JG**	**31/12** (Audit) July 07	CEO met review team 9/8 to agree new process. • Complaints report completed and was discussed at Governance Committee on 20 Oct. 06. • Handling of complaints and new system discussed with Service Managers, and guidance and flowcharts issued. • New complaints handling process commencde across the organisation from 1 November. Revised Complaints Policy to TEC 28/11 and Risk Management 4/12 and put on intranet as immediate guidance. Approved by Governance Committee Jan 07 and on intranet. Terms of reference for audit of compliance with complaints Policy agreed with Clinical Audit Feb 07. .Audit results and action plan to be presented to July Governance Committee then to Board. Training programme also underway.

Initials on above charts

AB Alan Bedford; AE Anne Eden; AH Amersham Hospital; AK Andrew Kirk; AM Anne Maguire; BF Brian Freeman;BP Brian Pluck; BW Bernard Williams; CB Carol Bingham; CC Chris Catton; CDs Clinical Directors; CE Celina Eves; CG Catherine Greaves;COI Control of Infection; DB David Bailey; DG David Griffiths; DH Derek Harrowell; DIPIC Director of Infection Prevention and Infection Control; DR Dorothea Reid; DW David Waghorn; Eprs Enterprise;FA Felicity Ashworth; FC Fiona Coogan;GL Graz Luzzi; ICTs Infection Control Teams; KB Karen Bastin; KC Ken Cooper; KCa Kathy Cann; KF Karen Finch; JB John Blakesley; JG Jan Grant; JH Jon Hilton; JM John Machray; JMo Janet Monkman; JS John Summers; JSw John Swiatczak; JO Jean O'Driscoll; LDP Lisa DU Preez;Mdrst Medirest; MN Malcolm Newton; MW Mike Welson; NCGST – National Clinical Governance Support Team; NEDs – Non Executive directors; NK Nigel Keen; NM&B Nursing and Midwifery Board; PB Perry Batchelor; PK Patrick Kirkpatrick; PS Paul Smith; RG Rose Gallagher; SB Sarah Barth; SD Sarah Darby; SE Sally Edmonds; SMH Stoke Mandeville Hospital; SH Sandra Hatton; SK Sheryl Knight; StHA – Strategic Health Authority; Sxho Sodhexo; TEC Trust Executive Committee; TM Terry Meek; TS Theresa Smith; TT Tom Travers; TU Tracey Underhill; TW Taylor Woodrow: UHC United Health Care; WH Wycombe Hospital; WM Wendy Martin; WSOM Whole Systems Operational Meeting

Appendix 1

The HCC Implementation Group (HIG) maintains a continuous review of this plan and reports progress and issues to the Board and Governance Committee at each meeting. Time will be allocated to reviewing one of the recommendations in depth according to the timetable below. The reviews will continue on a rolling programme. HIG is a meeting of Exec Directors, DIPC and senior quality managers and is chaired by the CEO.

HIG REVIEW TIMETABLE 2007

No.	**Recommendation**	**Lead Director(s)**	**HIG date**
1	The Trust needs to ensure acceptable standards of cleanliness throughout its hospitals and resolve permanently the problem of uncollected clinical waste and dirty linen	John Summers	8 Jan
2	The Trust needs to assess and continually improve practice in respect of controlling infection and ensure it is an integral part of the daily routine of all clinical staff. The responsibility for this should be in the job descriptions of all relevant managers, including ward managers, rather than being seen primarily as the role of the infection control team.	Andrew Kirk Sandra Hatton	15 Jan
	MRSA ACTION PLAN REVIEW	Andrew Kirk Jan Grant JeanO'Driscoll	22 Jan
3.	The Trust should make training in the control and prevention of infection mandatory for clinical staff and ensure that there are adequate resources to provide that training.	Sandra Hatton	29 Jan
4a.	In the clinical management of patients with C.Difficile greater attention must be given to ensuring that patient do not become dehydrated and that good records are kept of their intake and loss of fluid. (Medical staff)	Graz Luzzi	12 Feb
4b	In the clinical management of patients with C.Difficile greater attention must be given to ensuring that patient do not become dehydrated and that good records are kept of their intake and loss of fluid. (Nursing staff)	Fiona Coogan	26 Feb
5.	Within 60 days of publishing this report the criteria for transfer between wards should be reviewed to ensure that clinical advice is taken fully into account and that acutely ill patients are not placed on inappropriate wards without adequate medical and nursing support.	Karen Bastin	10 Apr
6.	The Trust must ensure it is treating all patients with dignity and respect and pay particular attention to providing single-sex accommodation.	Fiona Coogan	23 Apr
7.	The Trust must review, and where necessary improve, the standard of documenting and implementing decisions about clinical	Graz Luzzi	12

	management.	Fiona Coogan	Mar
8.a	The Trust must work with the strategic health authority and PCT to agree appropriate levels of nursing staff and then ensure that the Trust has sufficient nurses to provide acceptable and safe care, including on escalation (overflow) areas.	Fiona Coogan	23 Apr
8b	Within 60 days of publishing this report, the Trust needs to develop and publish criteria for the opening of escalation areas. Adherence to these criteria must be audited and reported to the Board.	Karen Bastin	10 Apr
9.	Within 60 days of the publication of this report, the Trust must review its arrangements for governance to ensure that the Board is aware of clinical risks and that consideration of risk is an integral part of all major decisions. The views of clinical staff and particularly any concerns about the safety of patients must be heard at the level of the Board.	Anne Eden	23 Apr
10.	Control of infection needs to be an integral part and focal concern of clinical governance and, with this in mind, the role of the Director of Infection Prevention and Control must be reviewed. The post holder must have relevant experience and competency as set out in the Department of Health's publication, Winning Ways.	Anne Eden Jean O'Driscoll	8 May
11	The Trust needs to ensure that the safety of patients is not compromised in the pursuit of other strategic objectives. In this judgement, the Board and senior managers needs to give sufficient importance to the control of infection and the advice of the Director of Infection Prevention and Control.	Anne Eden	8 May
12.	The Trust must improve the arrangements to manage risk, ensuring that: • Structures and lines of accountability are clear • There is analysis of the risks raised by clinical incidents which is drawn to the attention of the Board • The Board undergoes training in the management of risk • The Board plays a stronger role in examining, and, if necessary, challenging assessments by Trust managers. • The risk register contains the key clinical risks and is used to inform decisions about investment. • A system is in place to ensure that lessons from incidents are learnt across the Trust.	Sandra Hatton 12 b/c/d (Board Devt) Jan Grant 12 a/e/f (Risk Mgt)	18 June 4 June
13.	The Trust must have an effective process to assess the risk of failing to isolate patients with diagnosed or suspected transmissible infections and ensure the appropriate isolation of patients who pose a potential or actual high risk of infection to others. This process must involve the infection control team.	Karen Bastin	10 Apr
14.	The Trust needs to improve its systems to ensure that appropriate action is taken in response to complaints. In particular it should ensure that: • Complaints are investigated in an objective manner • Complaints are analysed, themes identified, links made to claims and incidents, and audit triggered where appropriate. • Where appropriate, action is taken if staff are found to have provided poor care • The Board fully considers the recommendations of external reviews and follows their recommendations unless there are compelling reasons not to. When not complying, the principles involved should be considered in a full and public meeting of the Board. • Action plans are generated in response to serious complaints and then implemented and monitored. • Lessons are disseminated across the Trust.	Jan Grant	4 June

BOARD REVIEW TIMETABLE 2007/08

Agenda item	Lead Director	Date
Review of Assurance Framework and risks to corporate objectives	Acting Director of Governance	January 07 (Completed) Mar 07 (Completed) July 07 Nov 07 Mar 08
Review of Risk Register by Governance Committee	Acting Director of Governance	Jan 07 – on Feb 07 agenda (then bi-monthly)
Governance report to Board on highest risks (as part of Assurance Framework review)	Acting Director of Governance	Jan 07 (new assurance framework) - completed Mar 07 completed July 07 Nov 07 Mar 08
Board Report on separation of male and female toilets	Director of Estates, FM and PFI	Mar 07 - completed
Board Report on Infection Control including MRSA Bacteraemias RCA	Director of Infection Prevention & Infection Control	Standing item
Overall progress and key exception report (including MRSA action plan)	Chief Executive	Standing item
Report on trends, themes in complaints and incidents (Governance report)	Acting Director of Governance	Alternate meetings (following review by the Governance Committee)
Board review of the role of DIPC	Chief Executive	Nov 07