Imperial College Healthcare NHS
NHS Trust

TRUST BOARD MEETING AGENDA

Wednesday 28th November 2012
10.45am – 1.00pm

Staff Dining Room, QEQM,
St Mary's Hospital,
Paddington

MEETING IN PUBLIC 10.45am – 1.00pm

1.	**General Business**			
		Paper	**Presenter**	**Time**
1.1	Chairman's Opening Remarks	Verbal	Chairman	5 minutes
1.2	Apologies	Verbal	Chairman	1 minute
1.3	Minutes of the Previous Meeting	1	Chairman	2 minutes
1.4	Matters Arising and Action Log	2	Chairman	2 minutes
1.5	Chief Executive Report	3	Chief Executive	10 minutes

2.	**Quality and Safety**			
2.1	Report from the Director of Nursing • Nursing and Midwifery Strategy • Clinical Risk Management of Cost Improvement Schemes • Clinical Governance Review	 4 5 Oral	Director of Nursing	15 minutes
2.2	Report from the Medical Director • Infection Prevention and Control Report • Cancer Survey Implementation Plan • Quarter 2 Patient Safety and Service Quality Report	 6 7 8	Medical Director Chief Operating Officer Chief Operating Officer Medical Director	15 minutes

3.	**Performance**			
3.1	Performance Report • Month 7 Report	 9	Chief Operating Officer	10 minutes
3.2	Finance Report • Month 7 Report • Single Operating Model	 10 11	Chief Financial Officer	10 minutes

4.	**Governance**			
4.1	Management of Waiting List Action Plan	12	Chief Operating Officer	15 minutes

5.	**Papers for Ratification**

5.1	Chair's Actions: • Endoscopy Full Business Case • Maternity Risk Management Strategy	13 14	Chief Financial Officer Head of Midwifery	5 minutes
	Papers for Information			
5.2	Service Quality and Patient Safety Annual Report – Executive Summary	15	Medical Director	10 minutes
5.3	Report of the Quality and Safety Committee	16	Medical Director	
5.4	Report of the Governance Committee	17	Sir Thomas Legg, Chair of the Governance Committee	

6. Any Other Business			
		Chairman	2 minutes

7. Date of Next Meetings
Trust Board meeting in Public – Wednesday 30th January 2013, Hammersmith Conference Centre, Hammersmith Hospital, Du Cane Road

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING

Wednesday 26th September 2012
Staff Dining Room, QEQM,
St Mary's Hospital, Paddington

Present:
Sir Richard Sykes, Chairman
Sir Thomas Legg, Non-Executive Director
Dr Martin Knight, Non-Executive Director
Dr Rodney Eastwood, Non-Executive Director
Sir Gerald Acher, Non-Executive Director
The Honourable Angad Paul, Non-Executive Director
Mr. Mark Davies, Chief Executive
Mr. Bill Shields, Chief Financial Officer
Dr David Mitchell, Acting Medical Director
Ms Janice Sigsworth, Director of Nursing
Mr Steve McManus, Chief Operating Officer

In Attendance:
Ms Anne Mottram, Director of Governance & Corporate Affairs
Mr. Sam Armstrong, Head of Corporate Services (Minutes)
Dr Jane Fryer, Medical Director, NHS South East London (item 5.2)
Mr. Terry Hanafin, Terry Hanafin & Associates (item 5.2)
Mr Brendan Farmer, Director of Strategy (item 4.1)
Mr. Justin Vale, Clinical Programme Director, CPG2 (item 2.1.2)

1. GENERAL BUSINESS

1.1 Chairman's Opening remarks

The Chairman opened the meeting at 10.45 a.m. and welcomed all present. He noted a number of changes to key personnel.

Professor David Taube has left his position as Medical Director at the Trust and has commenced as the Academic Health Science Centre (AHSC) Director from the 1st September. The Chairman recorded his gratitude for David's commitment and passion for improving care and outcomes throughout his time at the Trust and wished him all success in the new role. Dr David Mitchell is acting Medical Director. Interviews for the substantive post will be held on the 3rd October.

The Hon Angad Paul has been a non Executive Director (NED) at the Trust since 2009 and will be stepping down from his position and the Chairman recorded thanks for the support and work during his time as a NED.

Jeremy Isaac's tenure as a NED has been renewed for a further 3 years.

Professor Tony Newman Taylor has been confirmed as starting as a NED by the Appointments' Commission in October. Tony was previously Principal Faculty of Medicine Imperial College, and a NED at the Brompton. He will take a specific interest in Quality and Safety matters.

The Chairman reported an amendment to the running order of the agenda so that item 5.2, Elective Access Waiting Times, would be taken earlier in the meeting to enable the authors of both independent reviews to be available to present their findings and to be available for any questions raised by members of the public.

1.2 Apologies
Apologies were received from Mr. Jeremy Isaccs, NED, Professor Dermot Kelleher, Imperial College.

1. 3 Minutes of Previous Meeting
The minutes of the meeting held on 18th July 2012 were approved.

1.4 Actions
The action sheet was noted.

1.5 Chief Executive's Report
Mr. Mark Davies presented the report. The Trust was successful in retaining NHS Litigation Authority (NHSLA) Level 3, the highest level of risk management standards, at the August assessment. A small number of Trust's have retained this level and in addition to the associated improvements in risk and governance processes, the Trust will also receive a substantial discount on insurance premiums paid to the NHSLA. The Trust passed 48 out of a total of 50 standards. Mr. Mark Davies congratulated Ms Anne Mottram as the lead and all those who had worked on the project.

With the appointment of Professor David Taube the AHSC continues to make progress.
The Academic Health Science Partnership (AHSP) is developing relationships with partners and a business case will be submitted to the Department of Health (DH) as part of the accreditation process to be formally designated an AHSP.

The Trust Board noted the Chief Executive's report.

5.2 Elective Access Waiting Times
The Chairman introduced Dr Jane Fryer, Medical Director of South East London and Chair of the Clinical Review Group.

Dr Jane Fryer stated she had been asked to chair the multi-professional group which included membership of internal and external clinicians and managers. The review had focused on developing an understanding of what had happened to patients and sought to answer if there had been any harm to patients as a result of waiting times.

The review focused on four areas: admitted pathways, non-admitted pathways, diagnostics and cancer pathways.

A very large number of patient records were reviewed and from these, any where the outcome for the patient was unclear were investigated further. Dr Jane Fryer explained the processes used to identify patient outcomes, how this had been triangulated with other information and how GPs had been involved in the process.

It was noted that the reviewers had identified that no patients had suffered harm that could be attributed to waiting times. However, some patients had waited much longer than was acceptable and inconvenience and distress may have occurred.

Dr Jane Fryer stated that the review had identified areas of current practice that still require strengthening to provide assurance to the Board that risks of recurrence had been addressed.
Mr. Terry Hanafin, Terry Hanafin & Associates, presented his report on External Governance

Review of the Breakdown in Reliability of Performance Data for Waiting Times. He began by outlining his experience at the most senior level in healthcare, culminating in the last four years acting as an independent consultant. He introduced the report by providing background and context to the decision made by the Trust to declare a performance reporting break from January-June 2012 and subsequently to commission an independent review. The terms of reference, methodology, background, evidence, findings and recommendations of the report were noted.

The review found that there were a number of contributory causes: a lack of standardised process rigorously applied, poor computer systems, inadequate internal reports to help in managing waiting lists, weaknesses in knowledge, expertise and engagement, and weaknesses in management. He concluded that there had been a collective serious management failure, and he had not identified malpractice at an individual level.

It was noted that since the Trust had invited the Intensive Support Team (ITS) to review the issue in mid 2011, numerous key staff changes had occurred.

Mr. Terry Hanafin ended by presenting the recommendations from the review and noted forthcoming challenges such as the CERNER implementation. Mr. Steve McManus added that the Trust was making early progress on structural changes and recommendations from both reviews.

The Chairman thanked the authors of the reviews and stated that he wished to give a formal apology to patients and members of the public for any distress and inconvenience caused. He added that the Trust takes these matters very seriously and is committed to making improvements. He then sought questions from members of the public.

In answer to a question from a member of the public, Dr Jane Fryer stated that her clinical review found that large numbers of patients had been treated appropriately; a small number needed further contact to determine what had happened, around 10 needed to be re-referred and less than 10 could not be contacted, despite multiple efforts.

In response to a question Mr. Terry Hanafin added that the terms of reference for his review did not include reviewing the impact on patients, as this had been carried out by the clinical review group. The member of the public stated his preference would have been for a single review. To a follow up question, Mr. Mark Davies responded by stating the recommendations of the report would be consolidated into a single action plan which he and executive team would ensure was delivered and presented to the Board for scrutiny of progress.

It was noted by the CEO that the papers of the reviews, having been discussed by the Board, were available on the Trust public website, in addition to the paper copies made available at the meeting.

The external reviewers commended and thanked the Trust for the open and helpful manner it dealt with them, including access to staff and papers.

The Trust Board noted the reviews.

Action: Consolidated action plan from the external reviews to return to the public Board in November.

2.1 Report from the Director of Nursing

2.1.1 Review of the Findings of the Francis Report

Ms Janice Sigsworth presented the report. It was noted that the Francis report is now expected to deliver its finding in January 2013. It has been helpful to review the background to the issues

which triggered the enquiries, and these have been discussed at the Management Board and the Quality and Safety Committee.

The Trust Board noted the report.

2.1.2 National Cancer Survey Results
Ms Janice Sigsworth presented the survey results and stated that the poor performance was unacceptable. A patient experience action plan has been developed and will be further strengthened. Ms Janice Sigsworth will be chairing a weekly cancer patient experience implementation group. In answer to a question from Dr Rodney Eastwood, Ms Janice Sigsworth stated that a number of actions had been put in place locally and that possibly more robust ones were needed. Mr. Justin Vale added his commitment to improving the patient experience and stated he would like to reassure the Board that clinical outcomes for cancer services at the Trust were above average in all areas and excellent in some. Improvements will be developed in conjunction with the strategic review of cancer services. The Boiardo discussed the need for further review of cancer services.

Action: The implementation plan to be revised and reported to the November Trust Board meeting.

The Trust Board noted the survey results.

2.1.3 Safeguarding Children Annual Report
Ms Janice Sigsworth presented the report. It was noted that it demonstrates compliance with the requirements and the Board was asked to approve the action plan.

The Trust Board approved the report.

Report from the Medical Director
2.2.1 Infection Prevention and Control Report
Professor Alison Holmes presented the report. It was noted that there had been 2 cases of Trust attributable MRSA year-to-date against an annual ceiling of 9 cases. There were 6 cases of Trust attributable C.difficile, which is under the trajectory for the period. Work continues on targeting antibacterial prescribing and improving the taking of blood cultures.

Cardiac surgery post-surgical outcomes are an area of focus and unconfirmed results indicate an improvement from quarter 1 reports. There is a large-scale programme focusing on antibiotic stewardship. Further integration will occur between infection control and microbiology teams to improve clinical and diagnostic services. It was confirmed that the Trust was working with partners to manage diarrhoea and vomiting ahead of the winter months. In answer to a question from Dr Rodney Eastwood, Professor Alison Holmes stated that infection control data is externally audited annually.

The Trust Board noted the report.

2.2.2 Patient Safety, Service Quality and Serious Incident Report, Quarter 1
Dr David Mitchell presented the quarter 1 report. It was noted that falls causing harm have decreased and falls overall in the Trust are below the national average. Labour and delivery has entered the top three themes for incidents, incidents related to clinical assessment had decreased. Inadequate response to changing patient status remains an area of focus, and an action plan is in place. There has been a notable reduction in serious Incidents (SIs) from 26 to 15. There was one ‘never event’, previously reported to the Board, and this case remains the only one to have occurred from April to date, which is a significant reduction on previous years. Dr David Mitchell drew attention to further areas within the report including complaints and clinical safety alerts.

The Trust Board noted the report

2.2.3 Clinical Outcomes Report
Dr David Mitchell presented the clinical outcomes report for quarter 1. It was noted that there has been little change since the last report to the Board. The report is re-based as mortality is falling nationally by 7–8 % per annum. The Board's attention was drawn to the perinatal alert in the report; this has been investigated and it appears it is the result of a coding practice. A report will be presented to the November Board meeting.

The Trust Board noted the report

Action: A report on Perinatal clinical alert to be presented to the November Trust Board

3.1 Performance Report
Mr. Steve McManus presented the month 5 performance report. It was noted that the Trust maintained its achievements in 4-hour A&E waits; Clinical Programme Group 1 (CPG) is producing an A&E performance protection plan to ensure continued good performances into winter months. Type 1 activity and activity by site will be reviewed and in future reported to the Trust Board.

The Trust fell short of the 95% standard for admitted patients waiting less than 18 week waits, achieving 88.32%, an action plan is being developed to improve performance. The Trust achieved the national waiting time target for patients on non-admitted and incomplete pathways.

The Trust has improved on cancer performance standards from the previous month achieving 5 out of 8 standards, including maintaining performance in the 2-week wait for urgent cancer referrals as well as for 2-week wait symptomatic breast cancer referrals. The Board will receive trajectories for all cancer standards. In answer to a question form the Chairman, Mr. Steve McManus stated that some targets may not be met into quarter 4, however more will be reported on this in due course.

The Board noted the performance report

Action: Mr Steve McManus to present trajectories for all cancer standards in the November performance report to the Board

3.2 Finance Report
3.2.1 Month 5 Report
Mr. Bill Shields presented the month 5 finance report. It was noted that the Trust has an in-month surplus of £856k, a favourable variance of £276k against plan. The year-to-date position is a surplus of £2.1m against a planned surplus of £1m. The improvement is related to Project Diamond funding and reduced risk associated with CERNER implementation and therefore the allocated funds. As a consequence of the improved position, the Trust has had discussions with NHS London regarding revising the forecast outturn to £3.4m. The cost Improvement Programme (CIP) is ahead of plan with a favourable variance of £0.5, however delivery of the plan will may become more difficult in quarters 3 and 4. Performance issues resulting in additional costs or fines could also add risk and winter pressures are being closely observed. The Board noted CPGs performance and discussed the importance of rapid improvements to the position of turnaround. Dr Martin Knight noted the good performances of the central team and how this needs to be integrated further down in the CPGs. Mr Mark Davies noted the current review of organisational structures would be presented to the Board.

The Trust Board noted the report.

3.2.2 Annual Audit Letter
Mr. Bill Shields presented the annual audit letter on the annual accounts, which the Audit and Risk Committee, with delegated authority from the Board, approved in June. It was noted that the opinion was generally positive, however there was an 'except for' qualification due to clinical data quality.

4.1 AHSC Response to Shaping a Healthier Future
Mr. Brendan Farmer introduced the Trust's response to Shaping a Healthier Future. It was noted that the consultation will conclude on the 8th October. The Trust will be submitting an AHSC response. Mr. Mark Davies added that as an AHSC it is important to also focus on teaching and research excellence and therefore a joint response between the Trust and College will be submitted. The College will be debating the options at its management Board on Friday 28th September.

Mr. Mark Davies stated he has met with around 400 members of staff in a series of forums at the Trust and has listened to the views of the public, patients, the commissioners and politicians. He stated that the Trust agrees and supports the process and the clinical model. It agrees with the hypothesis behind the process, which strives to see patients treated closer to home and to centralise clinical expertise wherever possible. Mr Mark Davies further stated that The Trust therefore supports option A, subject to views of the College. A joint response will be submitted following the College's internal discussions. The importance of the NHS funded re-provision of facilities at the School of Medicine from Charing Cross Hospital was noted.

The Chairman invited questions from members of the public. There were no questions.

The Trust Board agreed to support option A, subject to College approval.

5.1 Board Assurance Framework Quarter 1 Report
Ms Anne Mottram presented the report. It was noted that the Trust has five high level objectives and that the assurance framework seeks to manage the risks to achieving these and that this is supported by a programme of work by internal audit. Actions will be updated with the publication of the two external reviews. Each CPG has developed their own assurance framework and it was suggested that the Audit and Risk Committee may want to review these.

The Trust Board noted the Assurance Framework.

6.1 Audit and Risk Committee Terms of Reference
Sir Gerald Acher stated that NEDs of the Audit and Risk Committee will attend 'back to floor Fridays' and aim to observe some theatre procedures.

The Trust Board ratified the Terms of Reference.

6.2 Governance Committee Terms of Reference

The Trust Board ratified the Terms of Reference.

6.3 Quality and Safety Committee Terms of Reference
It was noted that the new Chair of the Quality and Safety Committee will further review the terms of reference in the future.

The Trust Board ratified the Terms of Reference.

6.4 Annual Accounts

The Trust Board ratified the Annual Accounts.

6.5 Annual Report

The Trust Board approved the Annual Report.
6.6. Risk Management Strategy

The Trust Board ratified the Risk Management Strategy.

6.7. Serious Incident Investigation Policy

The Trust Board ratified the Serious Incident Investigation Policy

6.8 Report of the Quality and Safety Committee

The Trust Board noted the report.

6.9 Report of the Governance Committee

The Trust Board noted the report.

6.10 Report of the Finance Committee
It was noted that the Finance Committee has met. It was a useful session and the Committee will focus on financial risks. It was noted that a new non-Trust member had been co-opted as a member of the Finance Committee.

The Trust Board noted the report.

6.11 Report of the Audit and Risk Committee and Annual Report
It was noted that risks associated with CERNER implementation, maternity staffing levels, CIP achievement and never events. Dr Martin Knight requested a report on CERNER implementation be presented to the Board.

Action: Interim report on CERNER implementation to be presented to the Trust Board.

The Trust Board noted the meeting report and annual report.

6.12 Estates Annual Report

The Trust Board noted the report.

Questions from the public.
In answer to a question from a member of the public Sir Gerald Acher stated that reputation was a risk category in the Trust's risk management process and the Audit and Risk Committee recently reviewed extreme risks, many of which are reputational risks.

The meeting concluded at 12.45 p.m.

TRUST BOARD MEETING: 28th November 2012 **PAPER NUMBER: 12/11/28 – 2**

ACTION SHEET FROM TRUST BOARD PUBLIC MEETING – 26 SEPTEMBER 2012

Agenda Item	Action	Responsible	Completion Date
Item 5.2	Consolidated action plan from the external governance and clinical reviews to return to the public Board in November	Mr. Steve McManus	November Board (item 5.2)
Item 2.1.2	Cancer survey implementation plan to be revised and reported to the November Trust Board meeting	Mr. Steve McManus	November Board (item 2.2.2)
Item 2.2.3	A report on Perinatal clinical alert to be presented to the Trust Board	Dr David Mitchell	Revised January Board
Item 3.2.1	Mr Steve McManus to present trajectories for all cancer standards in the November performance report to the Board	Mr. Steve McManus	January Board
Item 6.11	Report on CERNER implementation to be presented to the Trust Board	Mr. Kevin Jarrold	January Board

ACTION SHEET FROM TRUST BOARD MEETING – 18th JULY 2012

Agenda Item	Action	Responsible	Completion Date
Item 2.2.1	Post-surgical infection to be presented to the Trust Board.	Professor Alison Holmes	November Board (item 2.2.1)

ACTION SHEET FROM TRUST BOARD MEETING – 30 MAY 2012

Agenda Item	Action	Responsible	Completion Date
Item 1.5	AHSC review update to be presented to the Trust Board.	Mr. Mark Davies	November Board (item 1.5 – CEO Report)
Item 1.5	Measures to ensure payment from non-resident patients to be reviewed.	Mr. Bill Shields	November Board (item 3.2 Finance Report)

Item 3.2.1	Report on private patients to be presented to a future Trust Board.	Mr. Bill Shields	January Board

Imperial College Healthcare NHS
NHS Trust

Chief Executive's Report

28th November 2012

1 TRUST NEWS

1.1 CLINICAL

1.1.1 NHSLA Risk Management Standards for Acute Trusts Assessment

Imperial College Healthcare NHS Trust was formally assessed for Level 3 compliance by the NHS Litigation Authority (NHSLA) in August. The NHSLA Chief Executive has written to congratulate Imperial College Healthcare NHS Trust on retaining Level 3 compliance with the NHSLA risk management standards for Acute Trusts. Please refer to appendix A for the letter of confirmation.

The Trust will now receive 30% off insurance premiums by passing this assessment which equates to almost 12m over the next 3 years.

Lead Director – Anne Mottram, Director of Corporate Affairs and Governance

1.1.2 NHSLA CNST Risk Management Standards for Maternity Services

Following the Level 3 assessment of the Trust's general acute services by NHS Litigation Authority (NHSLA), our maternity units at Queen Charlotte's & Chelsea Hospital and St Mary's Hospital achieved Level 3 in the CNST risk management standards for maternity services in November, administered by the NHSLA. Please refer to appendix B for the letter of confirmation.

This achievement is particularly outstanding because Imperial College Healthcare is the largest maternity care provider on two sites in London to have achieved CNST level 3

Lead Director – Keith Edmonds, Clinical Programme Director for Women and Children's

1.1.3 NIDCAP Federation International Meeting

The UK NIDCAP Training Centre at St. Mary's hosted the Newborn Individualized Developmental Care and Assessment Program (NIDCAP) Federation International meeting in St. Albans at the end of September. The NIDCAP Federation International (NFI) are an organisation that promotes NIDCAP in hospitals and encourages its use nationally and internationally to support the growth and development of premature infants and to improve the quality of their care and the support for their families. Inga Warren, Director of NIDCAP Training Centre at St. Mary's, and her team ran a successful training session and this has been acknowledged by the President of the NIDCAP Federation who personally wrote to congratulate the team (please refer to appendix C). The event attracts 110 professionals representing five continents, nineteen countries and nine different professional disciplines.

Lead Director – David Mitchell, Medical Director

1.1.4 Friends and Family Test (FFT) Implementation

On 25 May 2012 the Prime Minister announced the introduction of the Friends and Family Test (FFT) with the aim of improving patient care and highlighting best performing hospitals in England. The introduction of the test based on patient feedback was based on recommendations from the Nursing & Care Quality Forum.

From 1 April 2013 Standard NHS Contracts will include a requirement for FFT to be included by providers of all NHS funded acute inpatient services and A&E departments. It is possible that FFT will be included as a National CQUIN. This is currently being considered by DH. There is a North West London sector deadline of implementation from 1 December 2012, but it is likely that these timescales will not be met because further DH guidance is due in December on the implementation, as well as the technical guidance on reporting which is due in Mid November. The team are working on an implementation plan that assumes 1 December 2012 deadline.

Lead Director – Janice Sigsworth, Director of Nursing

1.1.5 Equality Delivery System

The Equality Delivery System (EDS) is a set of goals and outcomes aimed at providing Trusts with a systematic way of meeting their public sector equality duty under the Equality Act. The tool aims to drive improvement and comprises four goals, two of which are service focused (Better health outcomes for all; Improved patient access and experience) and 18 outcomes. Each year participating Trusts are required to consider their progress in selected outcome areas and present evidence to stakeholder panels who score performance. For 2012/13 the Trust focused on delivery of two service outcomes (1.2- patients' health needs assessment and 2.1 patients, carers and communities access to services). A stakeholder event will be held on 23 January 2013 to undertake the scoring.

Lead Director – Janice Sigsworth, Director of Nursing

1.1.6 JAG Accreditation for Endoscopy

Both Hammersmith Hospital and Charing Cross Hospital were visited by the Joint Advisory Group (JAG) Accreditation team on GI Endoscopy in July and have subsequently been awarded full JAG accreditation for one year. This is another great quality indicator of our commitment to patient safety and the team was congratulated for the high standard of achievement having met all of the required JAG Accreditation standards. A letter to confirmation the accreditation can be found in appendix D.

Lead Director – David Mitchell, Medical Director

1.2 PEOPLE

1.2.1 Organisational Health Index (OHI)

The OHI Survey was conducted in May/June 2011 and the results informed much of the changes with which the Trust has subsequently been engaged. The survey was conducted amongst the Trust's senior and middle managers. It was initially anticipated that the survey would be repeated in 2012 but on reflection it was felt this was too short an interval, especially in the light of the significant organisation and executive changes taking place during 2012.

It has therefore been decided to review the survey with a view to issuing it in the first quarter of 2013 which will enable a report on the findings and following actions to come to the Board in July 2013.

Lead Director – Mike Griffin, Director of People and Organisational Development

1.2.2 Employee Relations

The Trust has served notice to the RCN and Unison of its intention to withdraw from the arrangements inherited from the legacy Hammersmith Hospital Trust whereby the senior representatives of these two unions are given time off for Union duties on a full time basis. The arrangement is anomalous and is not a sustainable model for the future.

The transition to a more conventional arrangement will not be without its difficulties in the short term and will require both unions to actively recruit additional representatives to cover the gap in representative capacity brought about by this change. The Trust is committed to assist the unions in achieving this. Meetings with the Union Regional Officers to discuss the changes have been conducted cordially and professionally.

Lead Director – Mike Griffin, Director of People and Organisational Development

1.2.3 Medical Director Appointed

Professor Nick Cheshire, Clinical Programme Director for Circulation Sciences and Renal Medicine has been appointed as the Trust's Medical Director and will take on the post from 1 December 2012.

As the Trust's Medical Director, Professor Cheshire will play a pivotal role building greater alignment between the Trust and its doctors, and extending the influence of medical staff in the management and development of the Trust. In addition, he will support the development of the Trust's clinical leaders, and act as the board's champion for patient safety to ensure that we consistently meet the high clinical standards required as a partner in the Imperial Academic Health Science Centre

1.2.4 AHSC Director of Operations Appointed

Anne Mottram, Director of Corporate Affairs and Governance, has been appointed as the AHSC Director of Operations. Anne will work with Professor David Taube to drive forward and build our Academic Health Science Centre.

1.2.5 Non-Executive Director Commences in Post

Professor Sir Anthony Newman Taylor joined the Trust in October as a Non-Executive Director. Sir Anthony has just retired as principal of the Faculty of Medicine at Imperial College, London. In addition to his role on the Trust's board, he will also chair the Trust's Quality and Safety Committee

1.2.6 Nursing and Midwifery Joint Academic Posts

The Trust welcomes two new joint academic appointments with Buckinghamshire New University to support nursing and midwifery academic activity: Professor Susan Procter and Dr Debbie Mazhindu.

2 PERFORMANCE

2.1 Month 7 Performance Summary

The Trust continued to sustain excellent performance in all of the Quality Performance Indicators particularly infection prevention and control, venous thromboembolism assessments and stroke care.

The Trust's 18 week performance remained on trajectory in October, with performance for admitted, non-admitted and incomplete pathways improving from the previous month.

The 4 hour maximum waiting time in Accident and Emergency for the 'type 1' target of 95% was just missed by 0.1% in October, with Charing Cross and St Mary's Hospitals falling just below target. All sites achieved over the 95% target for 'all types'.

The Trust achieved 4 of the 8 national standards for cancer waiting times, including maintaining its performance in the 2 week wait for urgent cancer referrals. The Trust has a robust plan in place to enable continued performance improvement for all cancer standards.

Lead Director – Steve McManus, Chief Operating Officer

3 FINANCE

3.1 Month 7 Financial Summary

The Trust had a surplus in month of £2,163k; a favourable variance of £499k. The year to date position at month 7 is a surplus of £5,120k against a planned surplus of £1,798k. The improvement predominantly relates to the continued inclusion of funding for Project Diamond and non-recurring income for overage on the sale of Acton Hospital.

CIP delivery is now ahead of plan by £1,442k year to date. Despite this good performance the second half of the year is more difficult and has a higher percentage of CIPs to be delivered. At the CIP Board future performance was reviewed and therefore some CPGs may need to move into special measures should this not improve.

Lead Director - Bill Shields, Chief Financial Officer

4. RESEARCH AND EDUCATION

4.1 Award for excellence in teaching and medical education

The Trust's excellence in teaching and medical education has been recognised by the prestigious Elisabeth Paice Award for Educational Excellence. Named after the London Deanery's former dean director, the awards mark the educational endeavour of London trusts, dental and GP practices and other local education providers.

The award was for best faculty development programme, Training Tomorrow's Trainers Today (T4), a joint initiative with Central and North West London NHS Foundation Trust and delivered across 10 acute Trusts in North West London.

5. NWL NEWS

5.1 "Shaping a Healthier Future" Consultation

The AHSC submitted its response to Shaping a Healthier Future in early October (the public consultation closed on 8 October). The NHS NWL cluster is currently collating the feedback from the consultation which will be presented on the 28 November. It is understood that NWL will also outline the timetable for the next phase of the programme that culminates with a decision by the JCPCT at this meeting. As requested by NHS NWL, the Non-Executive Directors have been invited to this stakeholder event.

Lead Director – Mark Davies, Chief Executive Officer

5.2 West Middlesex University Hospital NHS Trust (WMUH)

In September WMUH announced it would seek a merger partner following discussions with NHS London in respect of its long term viability. We have expressed an interest and understand that their Board are looking to reach a decision in early January 2013 on a preferred partner with whom to develop a more detailed case.

Lead Director – Mark Davies, Chief Executive Officer

6. AHSC NEWS

6.1 Academic Health Science Partnership (AHSP) Development

The Partnership submitted its prospectus on 1 October to be designated by the Department of Health & NHS Commissioning Board as an Academic Health Science Network (AHSN) to improve the health and healthcare of the 2 million people living in North West London. The Partnership has been informed that it is through to the interview stage which is due to take place on 3 December. The AHSN designation will be for 5 years from spring 2013. Lord Darzi, as Chair of the Partnership, is leading the search for a suitable high calibre Managing Director, and plans are in place to build a small permanent core team to drive forward its development. The Trust and AHSC continue to play an active role in ensuring the AHSN is successfully established.

Lead Director – Mark Davies, Chief Executive Officer

6.2 Academic Health Science Centre Review

Following the appointment of Professor David Taube as the new AHSC Director in September, plans are in place to build a small dedicated team to push forward the development of the Imperial AHSC. A high-level budget has been agreed by both College and Trust and the refurbished office space for the AHSC Directorate at the Hammersmith Hospital is now being equipped.

Final discussions to formalise the relationship between the College and the Trust through a signed Joint Working Agreement are underway with the intent of signature prior to Christmas. This document will include Intellectual Property and the new Terms of Reference for the AHSC Strategic Partnership Board and the AHSC Joint Executive Group.

Lead Director – Mark Davies, Chief Executive Officer

7. IMPERIAL COLLEGE HEALTHCARE CHARITY NEWS

7.1 Trustee News

The Charity has recruited Professor Hilary Thomas as its new trustee and chair of its research and development grants committee, following the departure of Professor Dame Carol Black. Hilary brings academic, management, specialist and consultancy expertise, having worked in the public, private and voluntary sectors. Formerly medical director at Royal Surrey County NHS Trust and at Care UK as well as Professor of Oncology at Surrey University, she is now a Partner at KPMG, leading on clinical quality, and Trustee of Breakthrough Breast Cancer.

Professor Matthew Swindells is stepping down as Chair of the charity next July. He has been asked to lead the new Population Health Organisation within Cerner, which was formally created a few weeks ago. This is an area of work with a high degree of new development to meet the needs of

health systems in all parts of the globe. Matthew will lead this from the Cerner offices in Kansas City. He will therefore be relocating with his family in July 2013**.**

7.2 Art News

A new exhibition in the main entrance of Charing Cross Hospital is due to be officially launched on 11th December 2012 with Lord Burlington, son of the Duke and Duchess of Derbyshire, in attendance. The exhibition, commissioned by the Charity, will comprise 25 black and white photographic portraits of the “greats of the art world” taken by renowned photographer Jorge Lewinski. The exhibition can be viewed from 26th November.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 4**

Report Title: 'Everyone counts': Trust Nursing and Midwifery strategy 2013-16

To be presented by: Ms Janice Sigsworth, Director of Nursing

Executive Summary

The Trust Nursing and Midwifery strategy 2013-16 'Everyone counts' was launched at the annual Nursing and Midwifery conference on November 15th. Aligned to key strategic priorities and underpinned by national policy, the strategy comprises four key improvement-focused themes: getting the basics right every time, helping staff to do their job, valuing and developing our workforce and everyone's a leader. The themes have been validated by patients, service users and staff during a series of engagement events. The strategy will be delivered by the Senior Nursing and Midwifery leadership team. Delivery of the strategy will be monitored through the Nursing and Midwifery Professional Practice and Quality and Safety Committees, with regular reports to the Management Board.

Key areas for discussion: To note the strategy

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report

a. For Decision ☐
b. For information/noting √

Nursing and Midwifery strategy 2013-16 'Everyone counts'

1. Background

The first Trust Nursing and Midwifery (N&M) Strategy 2009-2012 'Our Vision, Our Promise' was launched in November 2009. Comprised of four objectives (safe and effective care, integrated service education and research, recruiting and retaining talented individuals, and strengthening nursing and midwifery leadership) the strategy directed the delivery of focused work streams to improve patient care, patient experience and staff experience.

Three years on, the strategy has been revised. It sets the direction and directs the on-going delivery of nursing and midwifery care within the Trust, whilst driving quality and productivity and ensuring alignment from ward to board in respect of the nursing and midwifery quality, safety and effectiveness agenda. It aligns nursing and midwifery with our aspirations to become a Foundation Trust and our corporate mission to improve the health of the communities we serve and our international recognition for the quality of patient care, education and research.

The document will be used to promote the work of the Trust to both current and prospective staff, and to patients, carers and families; also, the commitment of nursing and midwifery to the delivery of safe, effective, high quality and compassionate care.

2. Trust Nursing and Midwifery strategy 2013-16 'Everyone counts'

The new Nursing and Midwifery strategy 'Everyone counts' is comprised of four key improvement-focused themes: getting the basics right every time, helping staff to do their job, valuing and developing our workforce and everyone's a leader. It is aligned to Trust strategic priorities and is informed by national policy (including NHS Operating framework 2012/13, NHS Outcomes framework 2012/13, Chief Nursing Officers vision for nurses, midwives and caregivers) and recommendations from national inquiries and high-level reviews where there are implications for nursing and midwifery (e.g. Francis inquiry on failures at Mid Staffordshire Foundation Trust, Pearson commission on dignity in care, Prime Ministers Nursing and Quality Care Forum).

Key stakeholders have been engaged in developing the new strategy. Examples of Nursing and Midwifery strategies from the other trusts, including the Shelford group of Hospitals, were also reviewed. The themes have been validated by over one thousand patients, service users and staff during a series of engagement events including focus groups and surveys with nursing and midwifery staff and an event held as part of National Nurses Day celebration when 800 'passers-by' in three hospital foyers provided their opinion.

3. Delivery

The strategy was launched at the Trust annual Nursing and Midwifery conference on November 15th 2012.The strategy will be delivered by the Senior Nursing and Midwifery leadership team led by the Nurse Director with Heads of Nursing accountable for CPG-specific implementation plans. Delivery of the strategy will be monitored through the Nursing and Midwifery Professional Practice and Quality and Safety Committees, with regular reports to the Management Board.

Imperial College Healthcare NHS
NHS Trust

Everyone counts

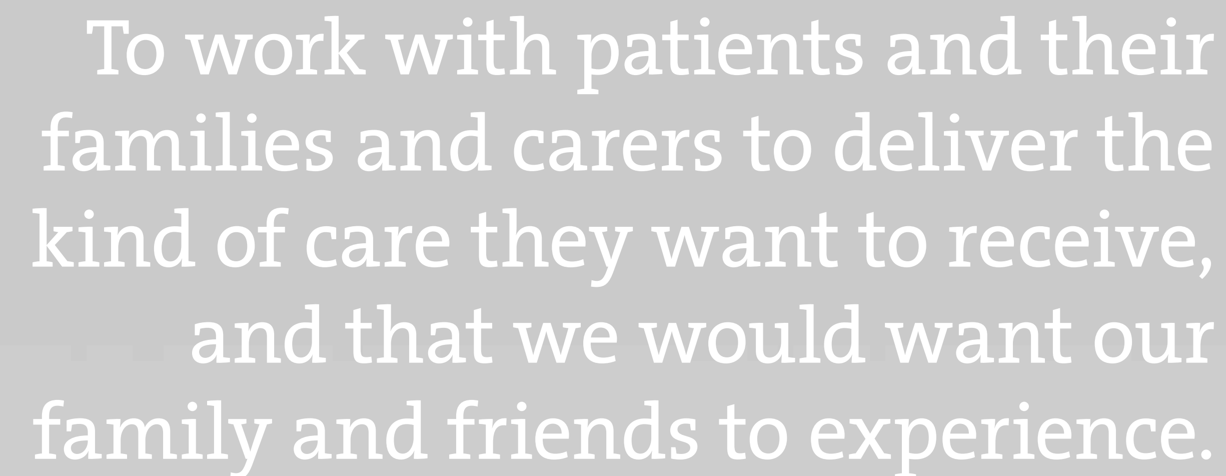
Nursing & midwifery strategy 2013-2016

Theatre

It's three years since we launched our first nursing and midwifery strategy and lots has changed. This strategy builds on the ways in which nurses and midwives at Imperial have worked with commitment and passion to improve the care delivered to patients. As we go forward we have a number of challenges to face. This new strategy focuses our attention on what matters most to patients, their families and staff, and the ways in which we can work together to deliver high quality, safe, effective care with compassion and kindness in a complicated and changing world.

We have had so many successes together over the last three years, and I am very proud of what we have achieved, but as always, there is more to do, so I am seeking your continued support and commitment to making a difference to the patients we care for and the colleagues we work with.

Janice Sigsworth
Director of Nursing



To work with patients and their families and carers to deliver the kind of care they want to receive, and that we would want our family and friends to experience.

We will strive to provide excellent care which is safe, effective and compassionate.

Objective one

Getting the basics right – every time

Treating patients with dignity and respect

- deliver care in a kind, compassionate and respectful way
- be sensitive to people's choices
- develop relationships with our patients that involve better listening and decision-making: "no decision about me without me"
- deliver care which meets the individual needs of all patients, including single-sex accommodation, providing adequate food and drink and ensuring pain is managed effectively, and considers inclusivity and personalisation

Year-on-year improvements in patient care

- consistently provide safe, effective high quality patient care and embed a culture of improvement, focusing on our harm-free care indicators
- deliver initiatives that support all clinical quality external accreditation, for example Care Quality Commission (CQC) essential standards, Safety Thermometer, Commissioning for Quality and Innovation (CQUIN), Quality Accounts, NHS Litigation Authority
- measure what we do and use variations in our data so we can commission improvement projects and research in areas such as timely administration in medicines administration, falls and pressure damage
- utilise shift handover effectively
- integrate hourly rounding into day to day practice
- sustain improvements in patient care as measured by local and national standards
- learn from others, and share and celebrate best practice

Safeguarding children, young people and vulnerable adults

- integrate safeguarding training, supervision and practice to instill a safeguarding culture in our organisation
- measure what we do and the effectiveness of policies, processes and practice
- meet the needs of people with mental health problems and those with issues involving mental capacity

Standardising our clinical documentation

- document what we do in partnership with patients and the multi-disciplinary team
- contribute to the implementation of Trust-wide electronic patient records, by providing evidence-based nursing and midwifery documentation

Listening to patient, family and carer feedback to improve the care we give

- use patient stories and feedback to monitor and improve what we do
- use a range of methods and tools to capture patient feedback, which includes diverse and hard to reach groups
- embed the cycle of feedback, action and audit so that change happens and improvements are delivered
- look at the whole patient journey and use models of feedback to explore patient pathways and overall experience

Embedding a culture of lifelong learning

- make sure our staff have the knowledge and skills to do their jobs and the capability to deliver the highest standards of care through annual appraisal
- give new starters a positive induction and clear expectations
- maintain excellent learning environments
- deliver an internship programme so that we retain newly qualified nurses
- create mentors who support and develop our students
- support our staff to gain degree, masters and doctoral qualifications

Integrating education and research into the care that we give

- regularly review nursing and midwifery policies, guidelines and procedures to make sure they are based on the best current evidence
- underpin and support developments in nursing and midwifery practice with our own research programme aligned to the academic health science centre and network strategies
- support our staff to publish and to present at conferences
- promote careers in research to strengthen our focus on evidence-based care

Measuring the impact of staff education on improvements in patient care

- deliver annual improvement in the number of positive responses to national patient survey questions that ask us about the knowledge of our nurses and midwives
- identify improvements in patient care arising from education and training initiatives

Developing the role of the clinical academic nurse and midwife researcher

- provide support for nurses and midwives on a clinical academic career pathway
- value and celebrate academic achievement alongside clinical excellence
- provide a structured training and support programme for our research nurses and midwives

Valuing and developing our workforce

Getting our staffing right

- recruit talented individuals who share our vision and values
- reduce our reliance on temporary staffing and aim for a local vacancy factor of no more than five per cent
- reduce levels of sickness and absence
- promote a clear work/life balance by providing flexibility in the workforce
- use the Trust safe staffing position statement to regularly review our staffing levels to make sure they are safe and meet changing needs
- listen to what our staff say about what would help them to be productive and efficient

Respect our patients and colleagues
Encourage **innovation** in all that we do
Provide the highest quality **care**
Work together for the **achievement** of outstanding results
Take **pride** in our success

Listening to our staff

- encourage open and transparent communication at all times
- develop the principles of 'open hour', communicating through regular e-news, podcasts and tweets
- demonstrate commitment to our staff by making sure senior nurses and midwives are consistently present in clinical areas
- help and support our staff to be open and to raise concerns when things are not right
- make sure our staff have rewarding and worthwhile roles and that all nurses and midwifes have individual annual appraisals

Using the specialist roles in our workforce to improve practice

- recognise the contribution of specialist nurses and midwives to patient care and patient outcomes
- develop a highly visible nurse and midwife specialist workforce who motivate and inspire
- harness specialists' expertise to pioneer innovations and excellence in practice

Prepare everyone to lead – building and strengthening leadership

- support and develop ward sisters and charge nurses to deliver excellence in clinical practice
- develop our staff through annual appraisal, and using experiential and practice opportunities as well as education opportunities
- support our staff to do the right thing for people we care for, to be bold when they have good ideas and to speak up when things go wrong
- create equality of opportunity to develop the leadership potential of our staff
- free up the time of our leaders, so that they have time to lead

Delivering improvements

- define the leaders' roles and responsibilities for improving patient care and the patient experience
- support key leaders in developing a Trust-wide forum for sharing strategies that have improved patient experience, safety and effectiveness

Enabling our leadership teams to deliver on clear expectations

- develop all staff to lead
- provide an opportunity for staff to develop networks and their leadership roles, externally
- ensure that the appraisal process includes clear objectives by which leadership is measured

Supporting the delivery of care through visible clinical leadership

- raise the profile of the nurse and midwife leaders role in quality rounds, grand rounds, back to floor Friday and Trust-wide leadership events
- support leaders in their development of future leaders
- support the development of a leadership conference to celebrate innovation and achievement

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 5**

Report Title: Trust's Approach to Managing Clinical Risk within CIPs

To be presented by: Ms Janice Sigsworth, Director of Nursing

Executive Summary:

This is a paper for the Trust Board aimed at stimulating discussion and raising awareness of the recent reports from the National Quality Board (NQB), and in doing so assess ICHT's governance system and processes for managing its Cost Improvement Programme (CIP). This is of the highest importance for the Trust and is being considered within the context of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the "Francis Report") which is due to be published in the new year, as well as the changing landscape of the new health system.

ICHT has had a CIP for three years. 2012/13's CIP plan will deliver £52m in-year savings. The NQB has recently set out a range of *"How to"* guides including "*How to*: Quality Impact Assess Provider Cost Improvement Plans" which has been published to support all parts of the health system to minimise the impact of overly ambitious or poorly governed CIPs, and to ensure patient quality and safety is not put at risk.

This paper, approved by the CIP Board and Management Board, acts as an initial self-assessment of ICHT's CIP governance systems and processes against the NQB guidance (which itself is reflective of the guidance issued by Monitor to providers as described in the *Amendments to Applying for NHS Foundation Trust status – Guide for applicants (July 2010)* and *Delivering sustainable cost improvement programmes (January 2012)*).

ICHT's CIP broadly meets the criteria set out in the NQB guidance:

- The CIP Board, with executive team membership, meets monthly, focusing on monitoring delivery and challenging Clinical Programme Group (CPG) teams that are not delivering to plan;
- The CIP Delivery Board, chaired by the Head of Transformation, is a fortnightly forum for leadership teams from all CPGs and corporate directorates to attend and discuss the delivery of CIP and tackle challenges being faced;
- The Head of Transformation meets with the Head of Operations and Head of Finance of each CPG every fortnight to review progress and holds them to account for delivering their CIP;
- There is a clearly defined process for CIP sign-off once the schemes have been fully scoped and worked up and entered into the central CIP database thereby ensuring a clinical risk assessment is completed and considered for each CIP scheme;
- A clinical risk matrix is included within each CPG's Financial Performance Pack which is discussed at a local level in the Trust at each CPG Board, as well as corporately at both the CIP Board and individual monthly CPG Performance Reviews;
- The CIP Board will continue to review, led by the Medical Director with the Director of Nursing with input from the Director of Corporate Affairs and Governance, the processes around CIP risk assessments to ensure they comply with Trust policy and are adequate to support safe delivery of the CIP work programme (as required by the Trust's *Risk Management Strategy including Risk Management Processes 2012-13 (August 2012)*).

The full report is listed under paper 19 in the supporting documents folder.

Key Issues for discussion:
Group to note findings and to agree to suggested actions.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed:
N/A

Link to the Trust's Key Objectives:
5. Achieve outstanding results in all our activities including financial position.

Purpose of Report

a) For Decision √
b) For information/noting ☐

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 6**

Report Title: Monthly Infection Prevention Summary

To be presented by: Mr. Steve McManus, Chief Operating Officer

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Executive Summary: This report includes the Trust's monthly mandatory reports of HCAI for October 2012.

It includes an update on selected activities and indicators and it highlights local infection prevention and patient safety issues.

Key Issues for discussion:

1. The Trust is below year to date thresholds for both MRSA blood stream infections (BSI) and *C. difficile* infections.

- There was one case of Trust-attributable MRSA BSI in October. There have been three cases year to date, compared to a threshold of seven cases. The annual set objective is nine.
- There were 10 cases of *C.difficile* infection in October. There have been 53 cases year to date, compared to a threshold of 63. The annual set objective is 110.

2. Winter preparedness activity
3. Developing improved systems for the surveillance of post-operative outcomes

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction

Assurance or management of risks associated with meeting key objective: Infection prevention and control as a core aspect of patient safety, hospital management and excellence in clinical care. The ongoing programme of infection prevention and control.

Purpose of Report

a. For Decision ☐
b. For information/noting √

Monthly Infection Prevention and Control Summary
November 2012
(October data)

Key Indicators

October 2012	Month 10: October		CPG						
	Threshold	Trust	1	2	3	4	5	6	PPs
MRSA BSI (>48hrs)	1	1	0	0	0	1	0	0	0
MSSA BSI (>48hrs)	n/a	3	0	0	2	0	0	1	0
Clostridium difficile (>72 hrs)	9	10	6	1	1	1	1	0	0
Hand hygiene compliance	100%	98%	98%	98%	98%	99%	98%	97%	100%

Year to Date 2012/13	YTD 2012/13			CPG						
	Threshold		Cases							
	Year	YTD	Trust	1	2	3	4	5	6	PPs
MRSA BSI (>48hrs)	9	7	3	1	0	0	2	0	0	0
MSSA BSI (>48hrs)	n/a	n/a	22	2	3	5	4	5	1	2
Clostridium difficile (>72 hrs)	110	63	53	27	6	5	10	5	0	0
Hand hygiene compliance	100%	100%	98 %	98%	98%	97%	98%	96%	97%	99%

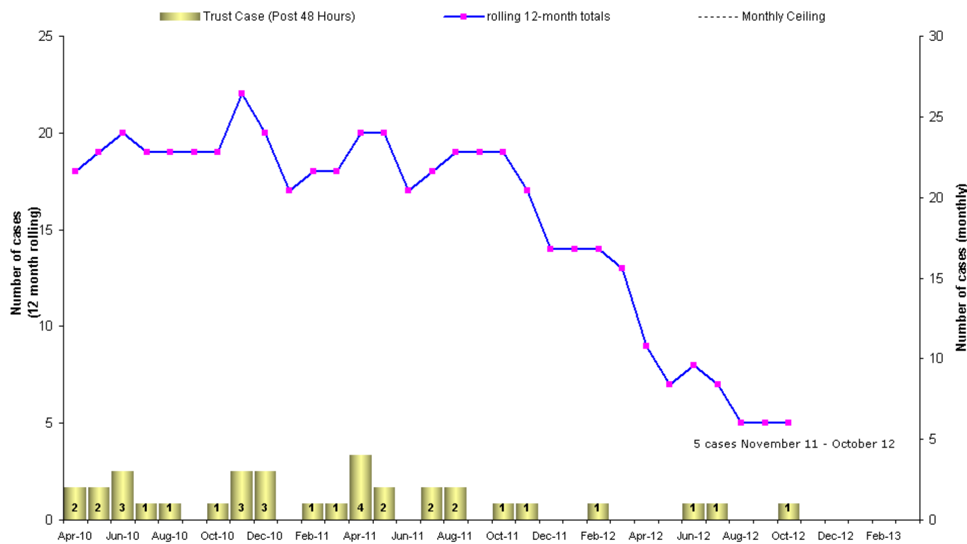
n/a = Not applicable

1. Meticillin Resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

For 2012/13 our 'MRSA objective' has been set at nine Trust-attributable cases of MRSA BSI. In October there was one Trust acquired MRSA BSI reported. Year to date we have reported three Trust-attributable cases; the first associated with temporary vascular access for dialysis (a Vascath line), the second related to biliary tract interventions and the third related to thoracic intervention for management of a pleural effusion.

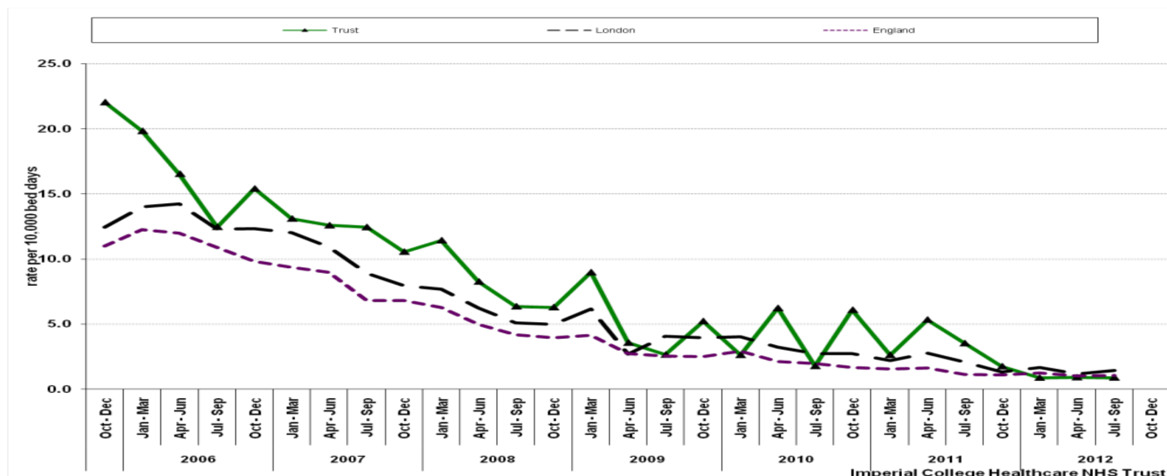
Update on key elements of the MRSA BSI prevention action plan:
The plan is underpinned by professional and personal accountability for all groups of staff through Clinical Programme Groups (CPGs) and by the promotion of local ownership at CPG, ward and unit level supported by information provision and communications.

Figure 1: Rolling 12-month and monthly number of Trust attributed MRSA BSI cases



Benchmarking Trust-attributable MRSA BSI rates
Provisional data presented by the Health Protection Agency (HPA) in figure 2 shows that the Trust had a quarterly rate of 0.88 per 100,000 bed compared to a regional rate of 1.39 and national rate of 1.02.

Figure 2: Trend in the Trust-attributable MRSA BSI rate compared to the national & London Region rates (rate/100,000 bed days)

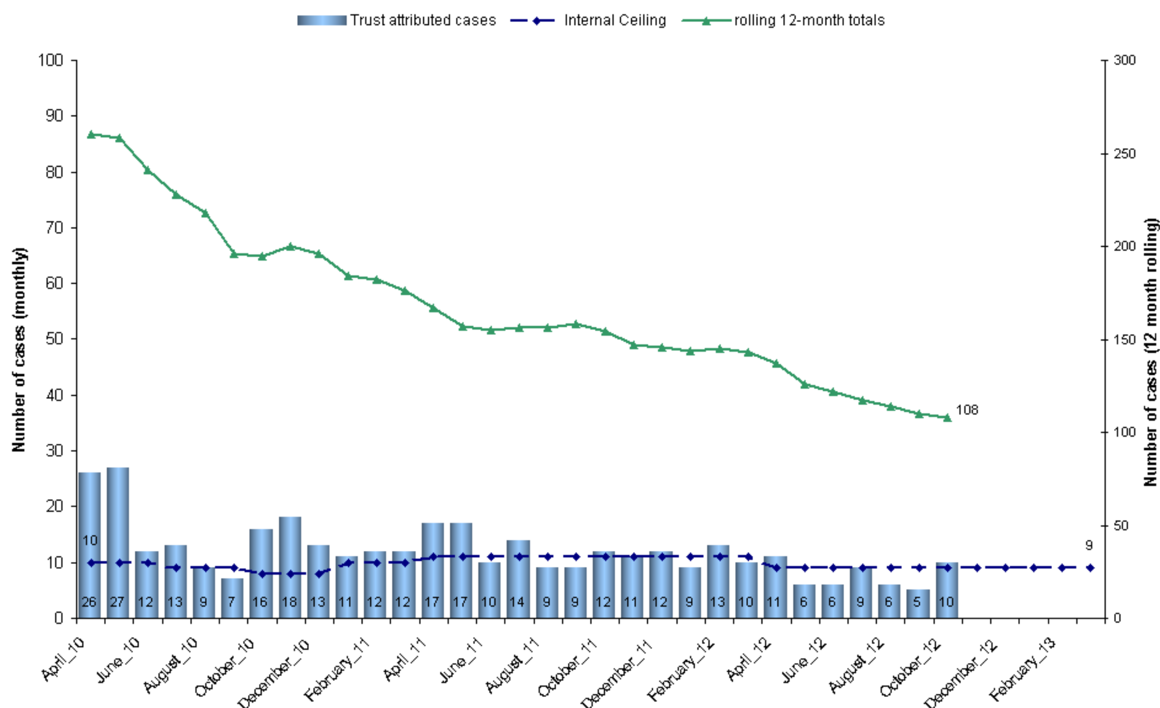


Source: HPA Trust reports Nov 2012

2. *Clostridium difficile* infections

For 2012/13, the Department of Health (DH) annual ceiling for the Trust is 110 cases of *C. difficile* infection (CDI). Year to date there have been 53. In October 18 cases of CDI were reported to the HPA of which ten cases were Trust attributable.

Figure 3: Trust attributable C.*difficile* infections and 12 month rolling total April 2010 – March 2013



The *C. difficile* action plan is focusing on:

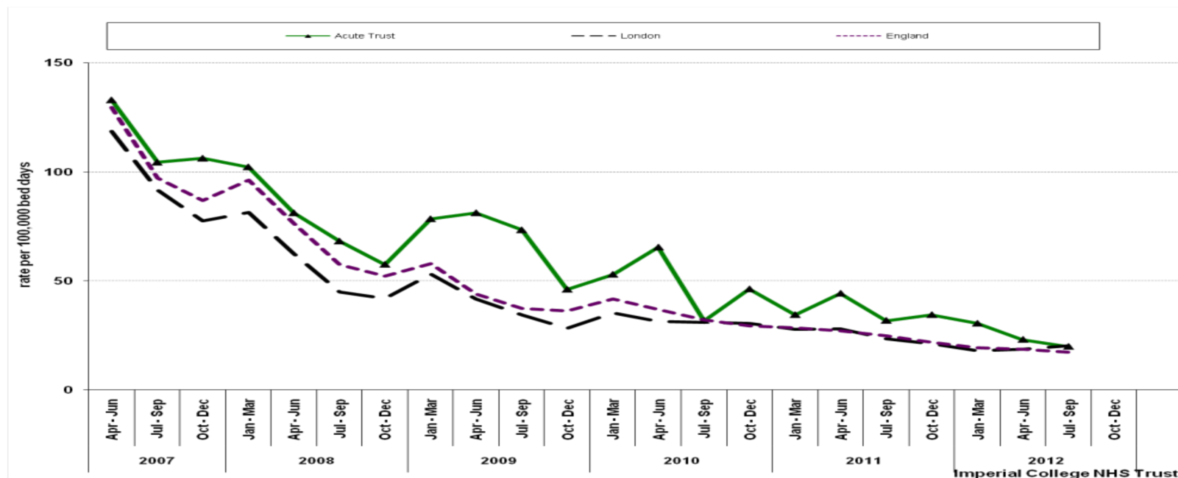
- Antibiotic stewardship, to optimise antimicrobial prescribing. This is supported by the work of the Consultant Infection Pharmacist (Mark Gilchrist) and a dedicated antibiotic stewardship strategy group, linking directly with the multidisciplinary Trust Antibiotic Review Group.
- Mobile technology will be further employed to support safe prescribing and decision support at the point of care.
- The national 'Start Smart then Focus' initiative is in use as a framework to refresh our local stewardship programme. Microbiology and infectious diseases clinicians continue to provide expert input on management of infections including the optimal use of anti-infectives.
- Continued Trust-based strain typing to enhance understanding of local epidemiology and potential transmission. This work has highlighted that individual cases are due to different strains and there is little evidence of transmission, further reduction depends on minimising individual antibiotic exposure.
- Sustained minimising the risk of cross-infection through enhancing hand hygiene and decontamination of equipment.

Update against plan:

- All new FY1 + 2 doctors have received protected 1 hour teaching on the prudent use of antibiotics
- The Trust's 'Start Smart Then Focus' antibiotic stewardship campaign was launched on 17 September. The aim of the campaign is to improve appropriate prescribing of antibiotics and to encourage regular review of patients who are taking antibiotics, with a view to reducing rates of healthcare associated infections, such as *C. difficile.* The pharmacy team will continue to measure performance against the policy and feed back results to clinical teams.
- To coincide with European Union Antibiotic Awareness Day (November 18th) both the Adult Treatment of Infection Policy and the smartphone app in use to support antibiotic prescribing have been updated; the app has also been developed to include prompts to think 'Start Smart then Focus' with antibiotic prescribing.

Benchmarking Trust-attributable *C. difficile* rates
Provisional data presented by the HPA in figure 4 shows that the Trust had a quarterly rate of 19.9 per 100,000 bed days compared to a regional rate of 20.2 and national rate of 17.4.

Figure 4: Trend in Trust-attributable CDI rate compared to national & regional rate (in 100,000 bed days)



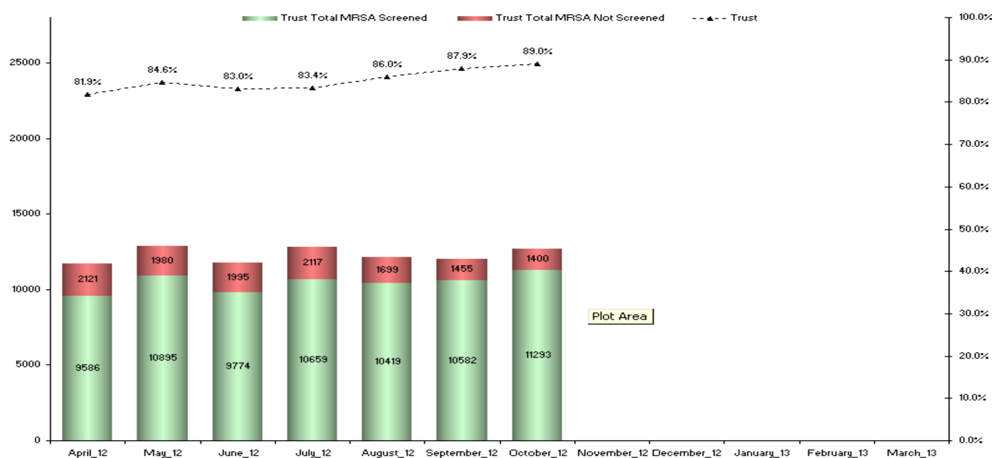
Source: HPA Trust reports Novemeber 2012

3. MRSA Screening

The Trust remains compliant with the DH population screening requirements.
Analysis at an individual patient level in October identified 12693 patient admitted who required screening of which 11293 (89 percent) patients were screened.

There has been a steady increase in screening rates, from 82 percent in April to 89 percent in October 2012.

Figure 5: Trust MRSA screen percentage (individual patient level)



4. Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI

Figure 6a: Monthly MSSA BSI cases

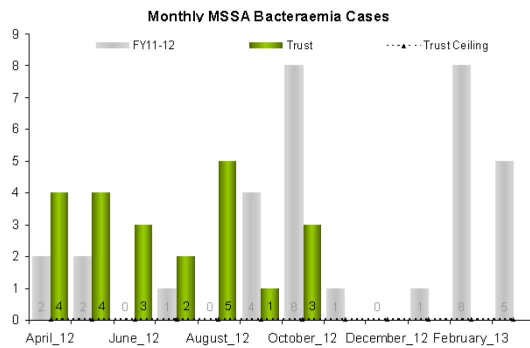
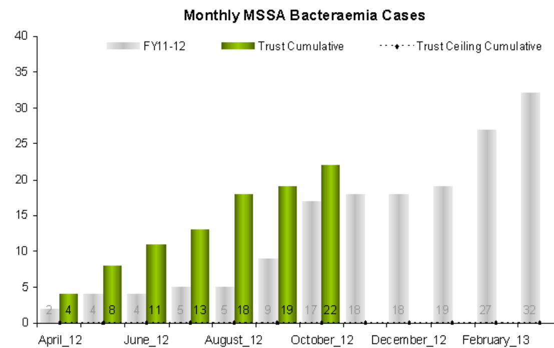


Figure 6b: Cumulative MSSA BSI cases



There is no threshold for this indicator at present. There are three Trust attributable and seven non-Trust cases in August. Of the Trust attributed cases reported, two occurred at Hammersmith Hospital on two separate wards and one occurred at Charing Cross Hospital.

5. *Escherichia coli (E. coli)* BSI

Mandatory surveillance of *E. coli* bloodstream infections commenced in June 2011.

There is no threshold for this indicator at present. There were seven Trust attributable cases (i.e. post 48 hours of admission), four cases at Hammersmith hospital, three cases at Charing Cross hospital and 21 non-Trust attributable cases.

Figure 7a: Monthly Trust-acquired *E. coli* BSI cases

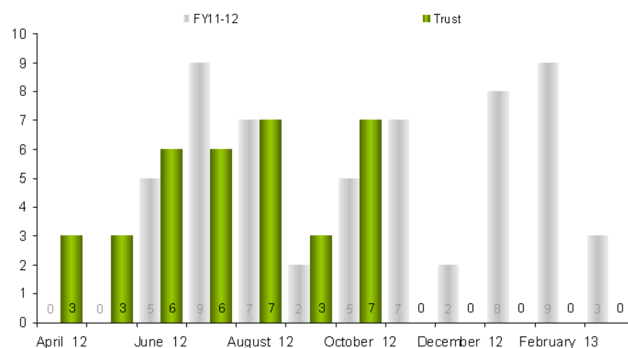
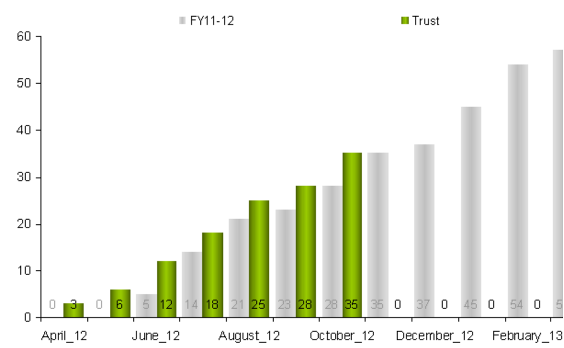


Figure 7b: Cumulative Trust-acquired *E. coli* BSI cases



6. Monitoring contaminated blood cultures

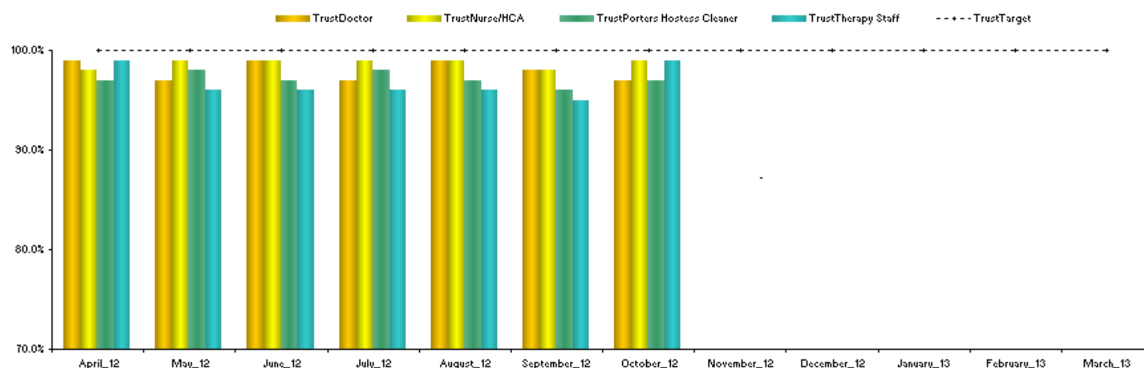
Blood culture contaminants are related to the technique in obtaining the sample. They give rise to significant unnecessary processing in the laboratory as well as to unnecessary antibiotic prescribing. In October 2157 blood cultures were taken in the Trust, 281 grew an organism, in 81 of these it was considered to be a contaminant from a surveillance perspective. Therefore the percentage of total blood cultures contaminated was three percent (total of positive blood cultures contaminated was 28.8 percent). It is recommended that no more than three percent of blood cultures should be contaminated.

The rate of contamination of blood cultures specimens has been estimated from microbiology laboratory data using standard methods, by counting the number of sets of cultures in which skin micro-organisms have been identified in one or more bottles. We are currently prospectively collecting standardised, detailed clinical data on patients in whom these potential contaminant organisms are cultured from blood. This will inform our data collection, feedback mechanisms and identify potential areas for targeted improvement in practice.

7. Hand hygiene compliance

In October, 88.8 per cent of clinical areas submitted a total of 6170 observations.
Hand hygiene compliance (as measured by the current Trust audit procedures based on a minimum of ten observations per ward) was 98.1 percent, and compliance with bare below elbows was 98.2 per cent. The yearly validation audit of the '5 moments' of hand hygiene using the World Health Organisation tool is taking place in November 2012 across all in-patient and acute ambulatory settings within the Trust. Data will be analysed in December for reporting in January 2013.

Figure 8: Staff group average performance of hand hygiene practice



8. ANTT

The Trust continues a rolling programme of the aseptic non-touch technique (ANTT) competency assessment programme at CPG level as part of the infection prevention plan, with all junior medical staff and trainers being assessed by the vascular access team. The number of assessments carried out per month has gradually plateaued, there is a refocus with individual CPG's to ensure that all staff assessed are entered onto the OLM system to support accurate monitoring of staff trained. Training is supported by information on how to arrange competency assessments and a DVD on ANTT is on *The Source.*

9. Other matters

9.1 Winter Diseases, Winter Planning and Flu Preparedness

There is increased activity of diarrhoea and vomiting in the local community and the Trust has now implemented a communication strategy focusing on awareness of norovirus and patient management. This strategy extends to strengthening and sustaining our communication channels with the Health protection Units and other local provider organisations. There have been no wards closed during October 2012.
A winter planning exercise was undertaken by the Trust in October to ensure preparedness and supportive actions were identified and put in place to ensure patient safety is maintained. Clinical advice and expertise on the management of infection and isolation room prioritisation during periods of increased capacity is provided by Infection prevention and control teams in and out of hours.
The Imperial Health at Work team launched the annual flu vaccination programme on 15th of October 2012. The target uptake is 3828 by the end of December. The team have exceeded the number of vaccinations at week 4 of the programme, by vaccinating 2016 members of staff compared to 986 last year, a 204 per cent increase on last year. The programme is being delivered in three phases; with the 1st phase being complete, the second phase is currently in progress and consists of drop-in clinics for staff, until November 30th. Thereafter phase three will commence where the team will continue to offer drop-in clinics according to demand and service capacity.

9.2. Post-operative surveillance

The Trusts surgical site infection (SSI) surveillance programme has now been extended to include neurosurgery, in order to compare and benchmark outcomes in this surgical speciality against national data as a part of a quality improvement initiative. Systematic surveillance of SSIs is already embedded in orthopaedic and cardiothoracic surgery and a strong surveillance team is now in place to drive the programme forward which includes lead clinicians, consultant microbiologists and surveillance nurses. SSI surveillance in cardiothoracic surgery continues with no SSIs reported for Q2 (July – Sept 2012).

9.3 Pertussis activity
Cases of pertussis (Whooping cough) reported to the HPA continue to increase in England and Wales with the highest numbers of confirmed cases in the first nine months of 2012 identified in the South East and the South West. An investigation was undertaken in October following identification of a member of staff with pertussis. The staff member had only been on duty once whilst symptomatic and contact tracing identified one patient and two members of staff who required follow up. The North West London Health Protection Unit was informed to ensure follow up of the patient in the community. The staff members were followed up by the Trust Occupational Health department.

9.4 Unplanned CQC visit to the Trust
The Western Eye Hospital was inspected by the CQC on 9 October 2012. The review was carried out as part of a routine schedule of planned reviews with the purpose of assessing the Trust's compliance with six outcomes including 'Outcome eight': cleanliness and infection control.
The Western Eye Hospital was judged to be meeting all the essential standards of quality and safety inspected and that people ''were protected from the risk of infection because appropriate guidance had been followed and that they were cared for in a clean, hygienic environment''.

9.5 Update on water hygiene monitoring
The Trust has implemented the advice set out in the Department of Health guidance issued in March 2012 on *Water sources and potential for Pseudomonas aeruginosa Infection from taps and water systems – Updated advice for augmented care units*. The guidance focuses on critical care areas and builds on existing water hygiene measures already in place at the Trust. A water safety plan has been developed which includes planned audit and testing arrangements for the water supply and details best practice regarding the use of hand wash sinks.
An increase in the laboratory identification of isolates of a waterborne organism (*Elizabethkingia*) in an ICU occurred sporadically between January and October 2012. Investigation has focussed on the preventative elements detailed in the water safety plan, a review of practice, strain typing and detailed surveillance.

9.6. World Health Organization Africa delegation visit
The WHO delegation from Centre Hospitalier Universitaire of Butare (CHUB), Rwanda, visited the Trust during the last week of October. The visit is part of the African Partnerships for Patient Safety (APPS) which is driven by the WHO region of Africa. The APPS vision is to provide safe health care in every country of Africa through sustainable partnerships. This was first reciprocal visit following the Trusts visit Rwanda in April this year, the key themes for the collaboration are:

- To support improvement in the prevention of healthcare associated infection, with particular focus on facilities for hand hygiene and education and training of healthcare staff
- To implement the WHO Safer Surgery checklist

Three representatives from CHUB visited the Trust to acquire and share knowledge in these areas, they worked alongside clinical staff and visited many of the wards and departments in the Trust. They also spent time with the members of the NIHR Centre for Patient Safety and Service Quality (CPSSQ), giving an opportunity to discuss the successes and challenges when trying to implement initiatives to improve patient safety in the hospital setting. Another visit to CHUB is being planned for early 2013, where Trust staff will be helping to launch a hospital wide hand hygiene programme.

9.7 The Hospital Epidemiology/Information Unit
There has been a new appointment that will strengthen this unit. Dr Georgios Ketsetsiz, Epidemiologist, Statistician and Health Economist from the Health Protection Agency and private industry has been appointed as the new Principal Healthcare Epidemiologist for Infection Prevention and Control. He will be leading the Epidemiology/information team for the service and will also be supporting the Health Foundation Corporate Programme (see below), and supporting applied research through the UKCRC National Centre for Infection Prevention and management (CIPM) at Imperial.

9.8. Options appraisal for the development of Integrated Infection Services at Imperial
An RCPath report commissioned by the Medical Director provided a review of the microbiology, infectious diseases and infection prevention services. The final report (published in June) recommended that the Trust's priority should be to develop integrated infection services through a merger of Medical Microbiology, Infectious Diseases and Infection Prevention and Control through an options appraisal. The development of options has been completed and shared with the Management Board on the 19th of November, and discussions will be completed on the 3rd of December.

10. Antibiotic Stewardship

Point Prevalence Results

The results for June 2012 antibiotic point prevalence survey are very encouraging for the Trust. Following the latest antibiotic prevalence (June 2012), the key performance indicators were:
Indicator 1: 92% compliant with prescribing anti-infectives within policy (Previous Target 90%)
Indicator 2: 88% of prescriptions had an indication documented on the drug chart or in notes (Previous Target 90%).
Indicator 3: 64% of anti-infectives had a stop/review date or duration. (Previous Target 50%)

- Indicator 1 is the highest it has ever been with indicator 2 close behind.
- Indicator 3 within the last 6 months has risen from ~ 30% to over 60% which is a great improvement in a short amount of time.
- In addition, the results showed that 85% of prescriptions were administered for a specified duration as recommended by Trust Policy.

Start Smart then Focus Campaign

The Trust launched in September 2012, the "Start Smart then Focus" initiative which aims to improve appropriate prescribing of antibiotics and to encourage regular review of patients who are taking antibiotics. The initiative is being led jointly by infection specialists in Microbiology, Infectious Diseases, Pharmacy and Infection Control.

The Antibiotic Quality Improvement Project (AQIP)

This continues to develop antibiotic indicators in line with the “Start Smart then Focus” campaign and is building on the current system of feedback in ‘real-time’.
The rolling Antibiotic Quality Indicator Project work also show the improvements seen in the Trust-wide Prevalence studies; for example in admissions areas across the Trust in September, the indicators reached the highest levels to date, with indications recorded for antibiotics or prescribing in accordance with policy in 96 – 100% per cent and stop/ review dates in 90 – 100% per cent.

Whilst the improvement to date in antibiotic stewardship is noted, this must be sustained and in November 2012, the prevalence survey will be repeated to reassess practice following the various interventions stated above.

11. Innovation, Education and Research

11.1. Imperial’s Health Foundation ‘Shared Purpose’ Corporate Award

Imperial’s Health Foundation funded programme on ‘Improving care quality through workforce analysis and planning’ concludes the six-month setup phase in December 2012. The two-year implementation phase commences in January 2013. Members of the ICU and PICU teams have participated in data workshops to identify workforce predictors and clinical outcomes for retrospective analysis. A principal epidemiologist/health economist has joined the team to support complex modelling and analysis of the data. The aim is to develop a workforce predictive toolkit that highlights risk areas and trends for piloting in these areas by June 2013.

11.2 The National Centre for Infection Prevention and Management (CIPM)

- The first joint UKCRC Centre’s meeting will be held 7th March 2014, hosted at the Hammersmith. The Research meeting will bring together CIPM at Imperial, the ‘Translational Infection Research Consortium’ at Cambridge and the ‘Electronic Self Testing for STIs’ Consortium at St George’s to discuss work and explore potential collaboration.

- A CIPM and Singapore partnership has been spearheaded by a ‘Collaborative Development Award’ from the Foreign and Commonwealth Office Global Partnership funds. The award has been granted to the Infectious Diseases Department at Tan Tock Seng Hospital (Clinical campus for Lee Kong Chian) to develop a research partnership with CIPM. Senior leads will visit Imperial in January 2013 to explore collaborative working with CIPM. The application of mobile technology to improve patient care, multidisciplinary and cross boundary working is an area of particular interest.

- A CIPM Course run to coincide with the EU Antibiotic Awareness Day: Promoting Pharmacists and Nurses as Educators in the Multi-Disciplinary Team (within the context of Antimicrobial Stewardship), Date: 22 Nov 2012, Hammersmith Hospital. CIPM and the Health Education Authority are running this single day course to challenge the traditional views of antimicrobial stewardship as a role of doctors and pharmacists alone.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 7**

Report Title: Cancer Remedial Action Plan

To be presented by: Mr. Steve McManus, Chief Operating Officer

Executive Summary:

The cancer performance issues are well known in the Trust, and early in 2012 there was a six month break in reporting to concentrate on the accuracy of waiting list management to address the reporting flaws. The process of review and revision has been extensive. It was apparent that there were problems in pathway closure with a large volume of patients remaining on the patient tracking list (PTL) that should have had their pathway closed as well as the Trust breaching cancer pathway targets. Thousands of notes have been validated, data bases trawled in order to be able to close pathways and to be able to deliver confidence in the data presented. It must be stated that patients, where a diagnosis of cancer has been confirmed, continued to receive treatment whilst recognising that for some patients their pathway of care has been slower than the standard we would expect. This lead to a number of external reviews which have been subject to the Trust Board discussion and scrutiny.

Additionally the emergence of the LCA (London Cancer Alliance) with a structured programme to consolidate services and increase integration across the pathways puts pressure on us to take a pro-active approach to developing our cancer strategy at a tumour site, service and AHSC level.

This paper summaries a number of the specific key actions relating to the management of cancer performance, patient experience and the developing cancer strategy. The actions set out in the cancer remedial action and implementation plan form the core programme of work in order to continue to improve cancer services for our patients in a sustainable manner. The actions address the shortcomings internally as well as used in responding to a Contract Query Notice issued by our Commissioners at the end of September 2012.

All 2 week wait (suspected cancer) referrals are tracked and monitored via the Cancer Delivery Group meeting that is held weekly and chaired by either the Chief Operating Officer or the Trust Lead Cancer Manager. Patients who turn out to be benign are then managed on an 18 week pathway at speciality level by the appropriate CPG. Management of the patient pathway is reported weekly at the Trust Waiting List Group chaired by the Chief Operating Officer to ensure that patients are treated appropriately and within target.

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The attached Cancer Remedial Action and Implementation Plan see Appendix 1 has broken down the issues into 6 key domains and is on track for delivery. Here are some key actions already complete

Generic Pathway Management

- Produced a Standard Operating Procedure (SOP) for Multi-Disciplinary Teams (MDTs) – endorsed by Dr Nick Sevdalis, International Researcher in Patient Safety and MDT workings.
- Held a MDT Educational Evening for all Clinical Leads
- Produced new cancer PTL

Tumour Site Specific Pathways

- Set up tumour specific MDT PLT meetings now held weekly

- Robust analysis at patient level detail per tumour site, reviewed at Cancer Delivery Group weekly
- Reduced the backlog of patients from 540 patients in August, to 233 in September down to 24 patients in November. All 24 patients have imminent plans such as OPD, Diagnostic or start of treatment date agreed.
- In the process of producing detailed demand and capacity plans per tumour site against the 8 national and one local standard
- Employed a Project Manager for the rollout of Somerset System which is a cancer database which allows real time tracking of patients. This database will be available in the Trust be mid-November to rolled out and implemented by mid-January 2013

Data Quality and Completeness

- Started work with Intensive Support Team (IST) to map out all tumour site specific pathways to identify delays in the system.

Patient Experience

- Sought guidance from external experts (National Cancer Director, Quality Health, Macmillan Cancer support and trusts demonstrating improvements in cancer patient experience performance.
- Governance and steer of patient experience at Executive level.
- Completed a variety of methods to better understand the detail form the patient's perspective including; ethnographic studies of day case chemotherapy care, senior nurse feedback rounds, real time monitoring and patient focused interviews
- Commenced a weekly analysis of real time monitoring with workforce data in key cancer areas
- Engaged the wide stakeholders in delivering cancer care by delivering a well attended MDT event on November 9th.
- Implementing a program to increase access to information resources on all sites.
- Delivering communication skills training and general cancer education both at ward level and in course format.
- Dedicating leadership and development support to all CNS, pan trust by Trust Lead Cancer nurse.

  Commenced pathway interventions to redesign oncology inpatient care services and environment, out patients services and the functionality of MDT

Strategy

- Wave 1 clinically led blueprints developed for breast, lung and upper GI. Work to commence on economic/financial implications as basis for delivery 'handshake'
- Wave 2 blueprint development underway covering the remaining service areas (chemo, urology, colorectal,gynae, head and neck, brain & CNS,haem,HPB and skin as well as radiology)
- Tumour and modality blueprints, supported by economic/financial analysis, will form the basis for decisions on the desired shape and site orientation of our cancer service

The Lead Cancer Team appointed at the end of September are working closely with strategy and the clinicians to ensure the development of the cancer strategy is integrated into the operational plans and patient experience improvement work.

The action and implementation plan are on track. The plan is being monitored by the Cancer Management Team and overseen by the Chief Operating Officer and the Director of Nursing. As a key output the current trajectory for the 8 national cancer standards and the one local standard will be met by quarter 4.

The action plan is paper 20 in the supporting documents. .

Key Issues for discussion:

In light of recent external reviews

- Does the Trust Board have sufficient assurance around cancer performance in terms of cancer waiting time standards and patient experience?
- Does the Trust Board require the Cancer Management Team to undertake any further actions particularly with a view to gain further external support and assurance around this programme of work?

Legal Implications or Review Needed

a. Yes ☐
b. No **X**

Details of Legal Review, if needed:

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safely and satisfaction.
2. Provide world-leading specialist care in our chosen field.
3. Conduct world-class research and deliver benefits of innovation to our patients and population.
4. Attract and retain high caliber workforce, offering excellence in education and professional development.
5. Achieve outstanding results in all our activities.

Purpose of Report:

- To update the Trust Board on specific actions in relation to cancer performance and patient experience
- To provide assurance to the Trust Board that cancer performance and patient experience is a priority.

Purpose of Report

a. For Decision ☐
b. For information/noting √

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 8**

Report Title: Patient Safety and Service Quality Report Q2

To be presented by: Professor Nick Cheshire, Medical Director

Executive Summary:

The Quarter 2 report analyses the Trust's performance in relation to regulatory compliance, patient safety, clinical effectiveness, patient experience (complaints), claims, Quality Accounts and service quality report from the National Reporting and Learning System (NRLS).

Headlines to note are:
The Trust remains registered without conditions by Care Quality Commission (CQC). There was a national privacy and dignity inspection carried out by CQC at the Charing Cross Hospital site. The Trust was found to be fully compliant with all requirements. The full report is included as paper 21 in the supporting documents folder.

To update Board members, recently there have been two further CQC inspections: planned inspections to support registration at the Western Eye Hospital and the Hammersmith Hospital site. Both inspections findings were very positive, the Trust was fully compliant with essential standards inspected and had no improvement actions noted. Full details will be included in the Q3 report.

Incident reporting rate has increased, moving closer to peer average and importantly the number of incidents resulting in major or extreme harm combined remains below the national average rate.

Falls are below the national average rate and reductions have been seen in incidents related to patient ID. The number of Serious Incidents (SI) reported in quarter has also decreased.

Incidents reported relating to staffing levels have increased, however the vast majority were graded as no harm, 83%. This area is being further reviewed with HR and senior nursing colleagues and will be included in establishment and local performance reviews.

A key safety area of focus is recognition of deterioration (failure to rescue). A number of improvement actions have been put in place including proactive reviews of high risk wards by the site management team out of hours, a further action is to review the systems and processes related to doctor's rotas and hospital at night.

There were no Never Events reported in Q2. The Board should note however, that a retained vaginal swab was reported in October. The findings of the investigation will be presented to the Board.

Numbers of formal complaints Trustwide have remained fairly static and equate to 0.48 complaints per 100 admissions. The response continues to be above the internal target at 93% responded to within 15 days.

Appendix 1 presents examples of improvements arising from incidents, complaints and claims top themes.

There was 100% compliance with partition in national clinical audits and an increase in the completion of actions arising from Trust designated priority clinical audits.

Nice compliance rate Trustwide is 85% against an internal target of 90%, with outstanding issues raised to Clinical Programme Group (CPGs) leads.

Quality Accounts:
Progress has been made in a number of indicators within the Quality Account scorecard. Appendix 2 presents full details which were reviewed by the Quality Accounts Delivery Group on the 22nd November.

Key Issues for discussion: The current performance across the indicators for patient safety and service quality.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision ☐
b. For information/noting √

Imperial College Healthcare NHS
NHS Trust

Patient Safety and Service Quality Report
Q2 2012/2013

The quarterly report analyses the Trust's performance in relation to regulatory compliance, patient safety, clinical effectiveness, patient experience (complaints), claims, Quality Accounts and service quality report from the National Reporting and Learning System (NRLS). (Data extracted as at 2nd October 2012 unless otherwise stated for key indicators).

1. REGULATORY COMPLIANCE

1.1 Care Quality Commission (CQC)

1.1.1 Registration
The Trust remains 'registered without conditions' across all sites.

1.1.2 Inspections
During Q2 there were was one CQC inspection, a national dignity and nutrition inspection at Charing Cross Hospital. The Trust was compliant in all areas reviewed and has received the final report which was very positive.

1.1.3 Trust Leadership Walkrounds – Key Themes
Leadership walkrounds involving multi – professional teams of Trust staff were carried out at QCCH, CXH, HH and WEH during Q2. A number of themes were identified including;

- Cleanliness of equipment and correct use of green stickers
- Food quality and choice
- Cleanliness of equipment
- Poor patient experience in some areas

Improvements have been seen as a result of the leadership walkround programme including, general cannula care, staff knowledge of infection control processes, infection control information boards, improved record keeping and compliance with policies and increased cleanliness in clinical areas.

1.1.4 CQC Quality and Risk Profile
There were no red or amber risk ratings for the 16 overall outcomes for essential standards. The Trust remains rated as 'low risk of compliance failure'.

1.2. NHSLA Risk Management Standards Level 3 Assessment
The Trust was awarded the 'gold standard of safety' (NHSLA level 3) for a consecutive three year period following a successful assessment conducted at the end of August 2012.

Performance was measured against 50 standards across the organisation, including 10 live record checks, undertaken on Charing Cross and Hammersmith Hospitals sites. 48 out of 50 standards passed, the areas highlighted as a focus for improvement were around the quality of documentation related to consent. While we provide good levels of information to patients, the documentation that the information

has been provided could be improved. The final standard where improvements are required is around supervision of medical staff in training.

2. HEADLINES

2.1 Patient safety

- The clinical incident reporting rate has increased from Q1 (5.8) to Q2 (6.2) compared to an updated NRLS benchmark of 6.9 incidents reported per 100 admissions across the Acute Teaching Trust cluster (our peers). note data was refreshed 21st November

- In Q2 we reported less no harm incidents and more minor and moderate incidents when compared to our peers. Notably, we reported less major and an equal amount of extreme incidents. note data refreshed 21st November

- Inadequate staffing incidents increased from Q1 to Q2 by 78%. Increases were noted at all sites except for CXH and all CPGs except for 6. It should be noted that the vast majority resulted in no harm. note data refreshed 21st November.

- Falls remain lower than the national average. A decrease in falls was noted from Q1 to Q2. However, falls from height, bed or chair have increased.

- The percentage of falls that resulted in no harm has remained the same across Q1 and Q2 (66%). No falls resulted in major or extreme harm in Q2.

- Inadequate response to change in patient status (failure to rescue) incidents have increased from Q1 to Q2. Increases are noted in CPGs 2, 3 and 5. note data was refreshed 21st November

- Patient identification incidents have decreased by 25% from Q1 to Q2. No incidents resulted in extreme, major or moderate harm.

- From the 429 medication incidents in Q2 none resulted in either major or extreme harm. 2.3% of the incidents resulted in moderate harm, 27.7% in low harm and 69.9% in no harm

- There has been a reduction in SIs. In Q2 there were 17 SIs. This compares to 21 in Q1. The top themes for SIs Trustwide in Q2 were unexpected admission to the neonatal unit (4), maternal admission to intensive care unit (3), neonatal death (3) and grade three Trust acquired pressure ulcer (3).

- There were no Never Events in Q2 2012/13. This compares to one retained vaginal swab in Q1.

- 44 new claims were opened in Q2 2012/13. This compares to 60 in Q2 of 2011/12 and 51 in Q1 2012/13. The area with the greatest increase was CPG5. The area with the greatest decrease in claims received was CPG6.

- 12 claims were settled in Q2 2012/13. This compares to 8 in Q2 of 2012/13 and 9 in Q1 2012/13.

- For the NRLS 347,066 incidents were reported by NHS Organisations in Q2. This shows an increase of 7.2% compared to Q2 of 2011/12.

2.2 Clinical effectiveness

- Trust compliance with NICE guidance for Q2 is 85.4%. This compares to 86.7% compliance in Q1.

- 100% of CAS alerts have been closed to deadline.

- In Q2 there was 100% reported participation in National clinical audits listed by the DH as eligible for the Quality Account 2013.

- 66.7% of priority clinical audits were completed to deadline and 83.3% of actions from priority clinical audits due for completion in Q2 have been completed. All outstanding items have been escalated to the respective CPGs for immediate action.

2.3 Patient experience

- The number of complaints received in Q2 was 226 (2 complaints per 1000 occupied bed days and 0.48 complaints per 100 admissions).This compares to 235 complaints in Q2 of 2011/12 and 221 in Q1 2012/13.

- The response rate within 15 days was 93%, against an internal target of 90%

- The key themes for complaints Trustwide were:

1. All aspects of clinical treatment
2. Communication/information to patients
3. Appointment delay/cancellation

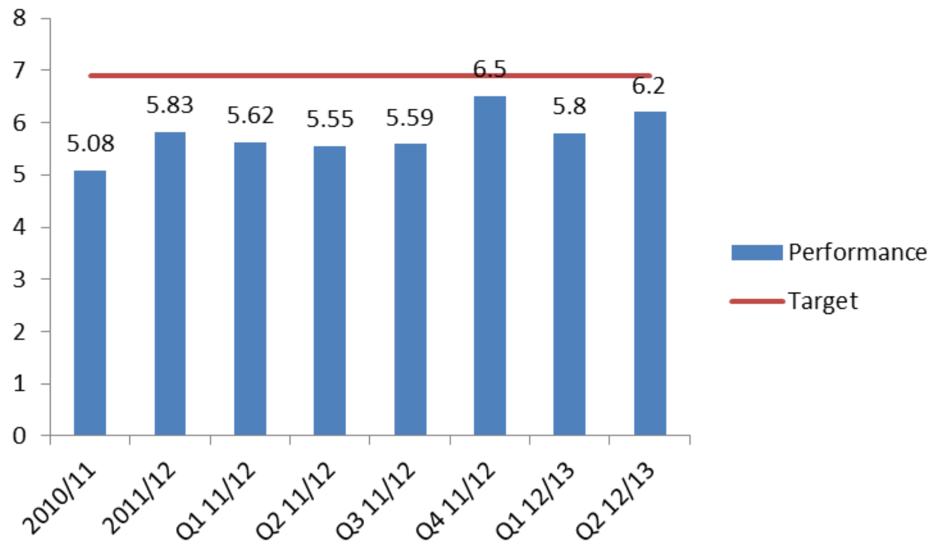
- The number of re-opened complaints was 46. Versus 37 in Q1.

2.4 NRLS: Service Quality

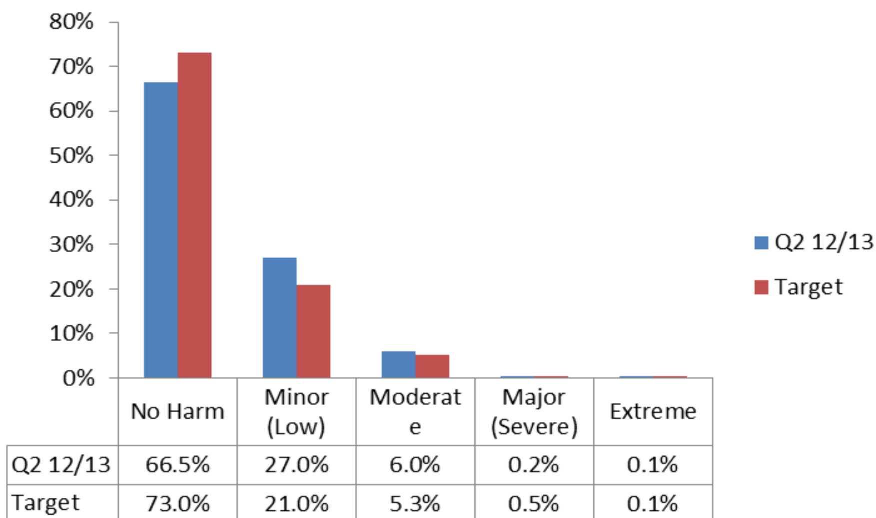
- The NRLS Team has successfully and timely performed, managed and delivered all agreed NRLS functions and outputs for the quarter against the performance schedule proposed in the Memorandum Of Understanding (MOU)

3. PERFORMANCE

Graph 1. Clinical Incident Reporting Rate against NRLS Peer Rate

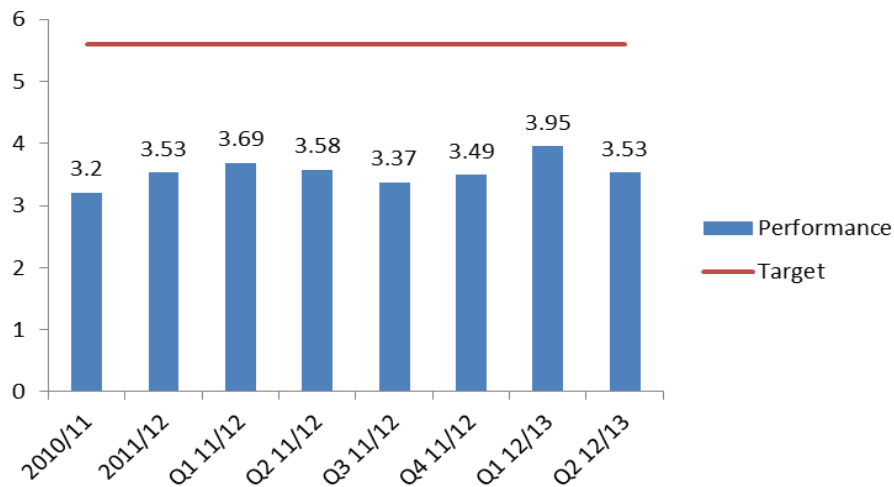


Graph 2. Clinical Incidents by Degree of Harm against NRLS Peers

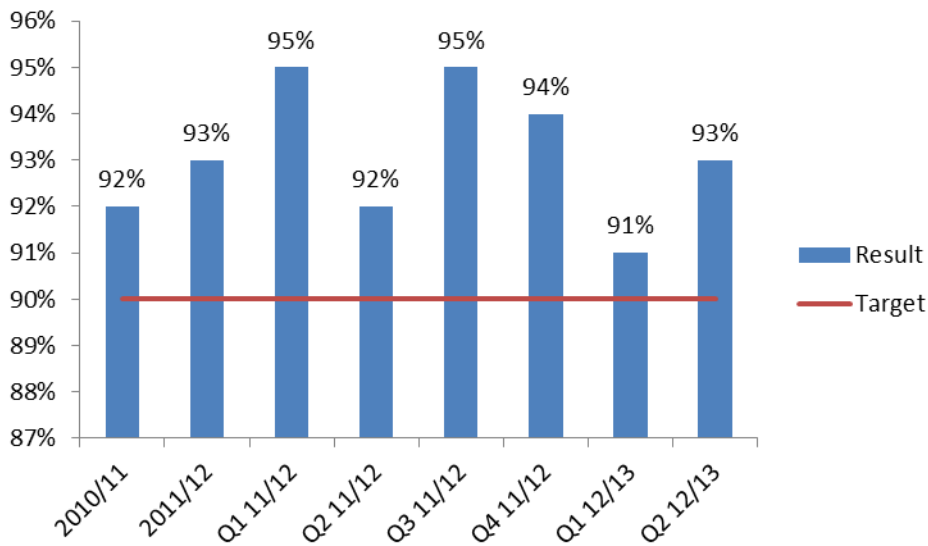


	No Harm	Minor (Low)	Moderate	Major (Severe)	Extreme
Q2 12/13	66.5%	27.0%	6.0%	0.2%	0.1%
Target	73.0%	21.0%	5.3%	0.5%	0.1%

Graph 3. Falls per 1000 Occupied Bed Days against NRLS National Average



Graph 4. Complaints Response Rate against Internal Target

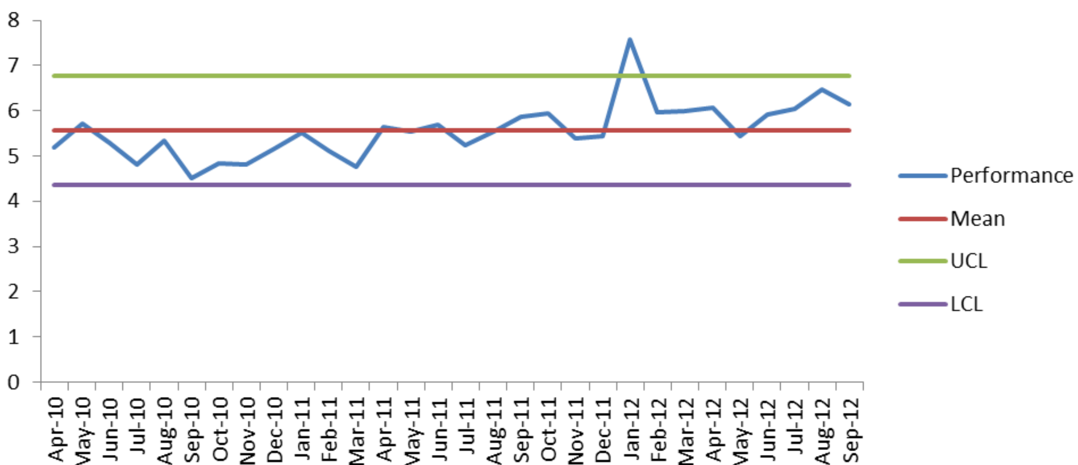


4. TRENDS OVER TIME USING STATISTICAL PROCESS CONTROL (SPC)
SPC charts were created for each individual indicator to look at variation over a period of 30 months (the data included for analysis is by month for 2010/11, 2011/12 and Q1 and Q2 2012/13).

4.1 Introduction to SPC
The purpose of the SPC analysis is to identify significant variation against background, routine or “normal” variation, to ensure that important effects and trends are investigated and that resources are targeted at making improvements in areas of need. The upper control limit (UCL) represents three standard deviations above the mean and the lower control limit (LCL) represents three standard deviations below the mean.

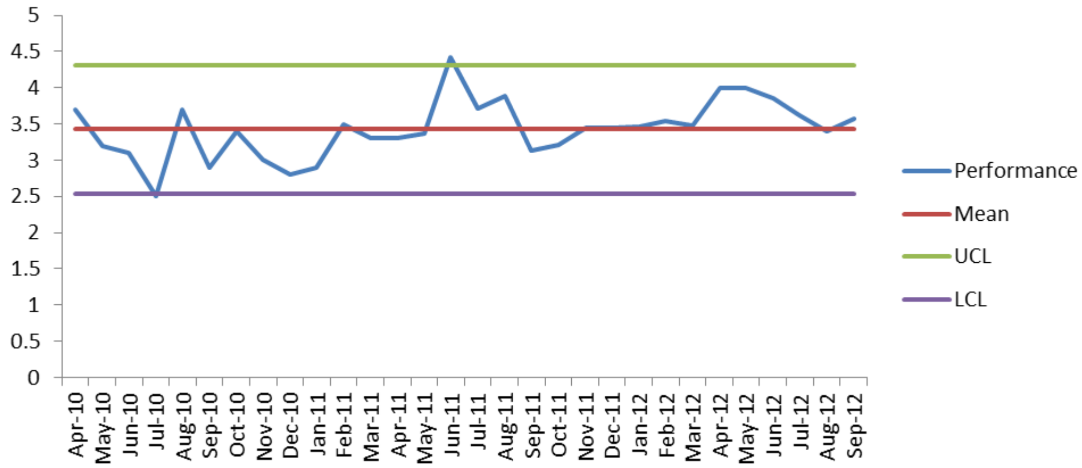
4.2 Patient safety

Graph 5. Clinical Incident Reporting Rate April 2010 – September 2012



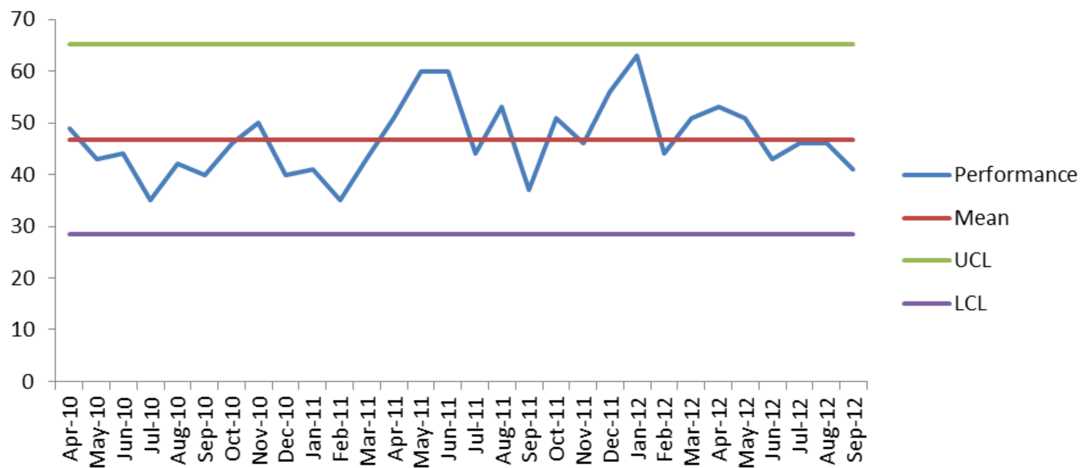
At Q2 the graph shows that from April to September all data points have fallen above the centre line, indicative of increased reporting. However, from August to September there was a reduction in reporting.

Graph 6. Falls per 1000 Occupied Bed Days April 2010 – September 2012



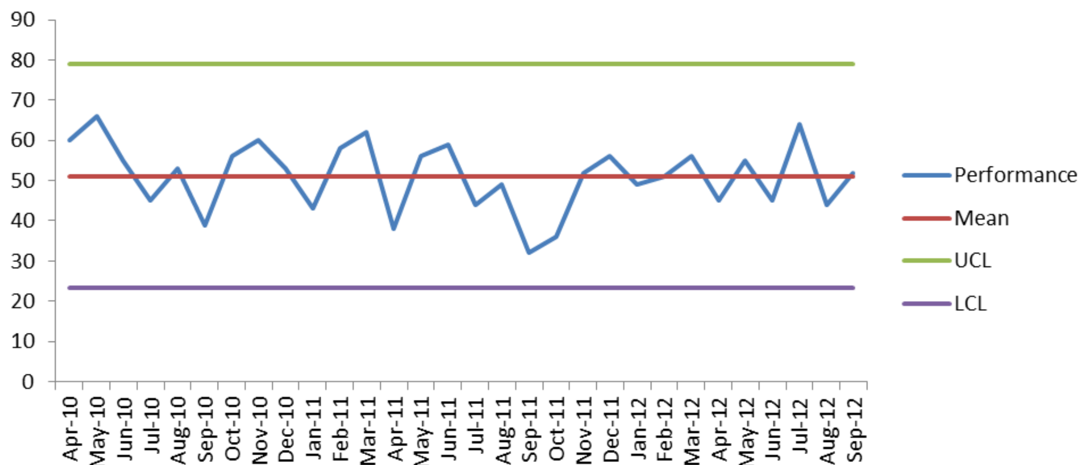
At both June and July there had been 8 consecutive points above the centre line. Falls rate decreased from July to August but has risen very slightly from August to September.

Graph 7. Falls with Harm April 2010 – September 2012



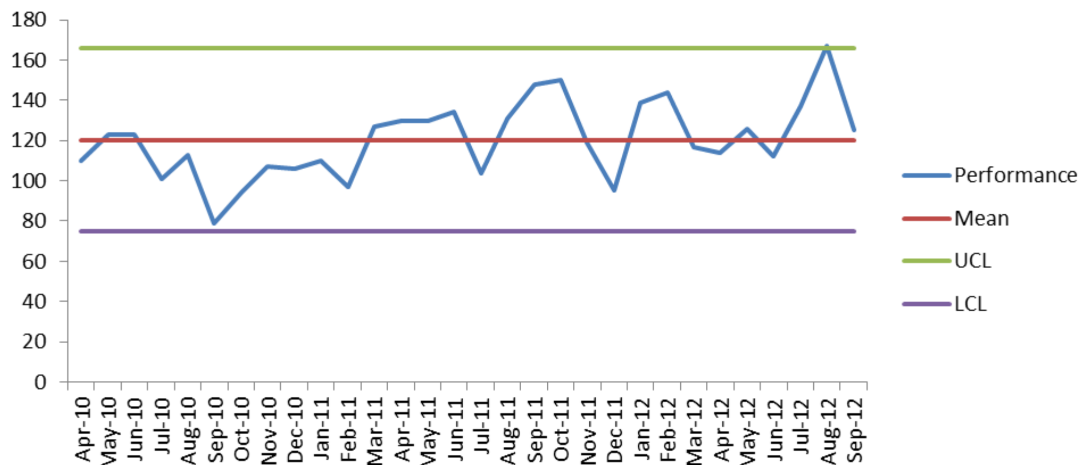
Since May 2012 all data points have fallen below the centre line showing a decrease in the number of falls with harm in Q2 compared to Q1.

Graph 8. Falls from Height, Bed or Chair April 2010 – September 2012



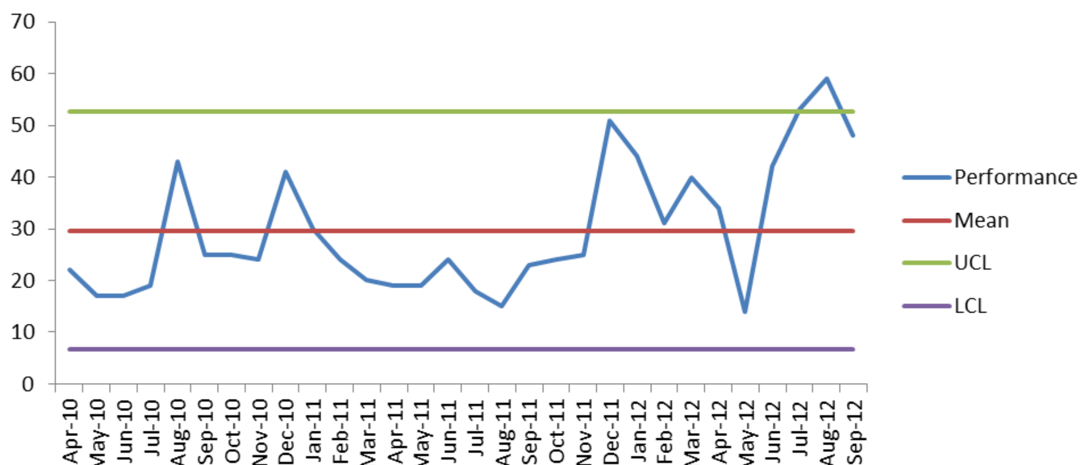
Falls from height, bed or chair remain at a consistent rate.

Graph 9. Medication Errors April 2010 – September 2012



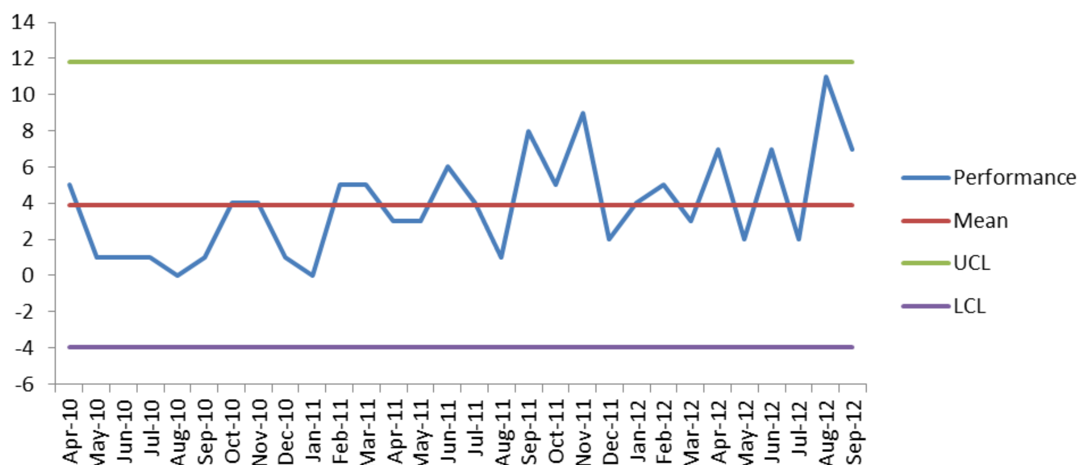
In August 2012 medication errors exceeded the upper control limit. However, it is notable that from August to September they have reduced considerably.

Graph 10. Inadequate Staffing Incidents April 2010 – September 2012



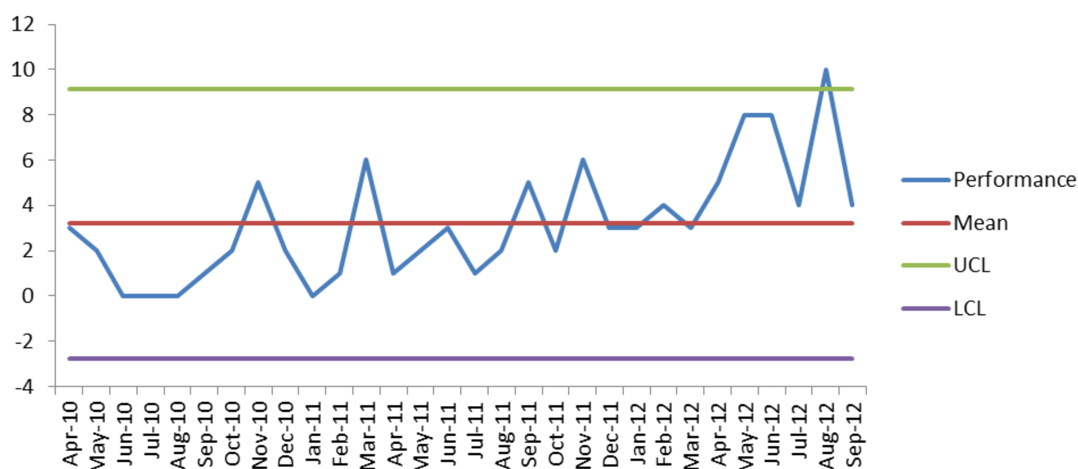
In both July and August inadequate staffing incidents exceeded the upper control limit.

Graph 11. Inadequate Response to Change in Patient Status Incidents April 2010 – September 2012



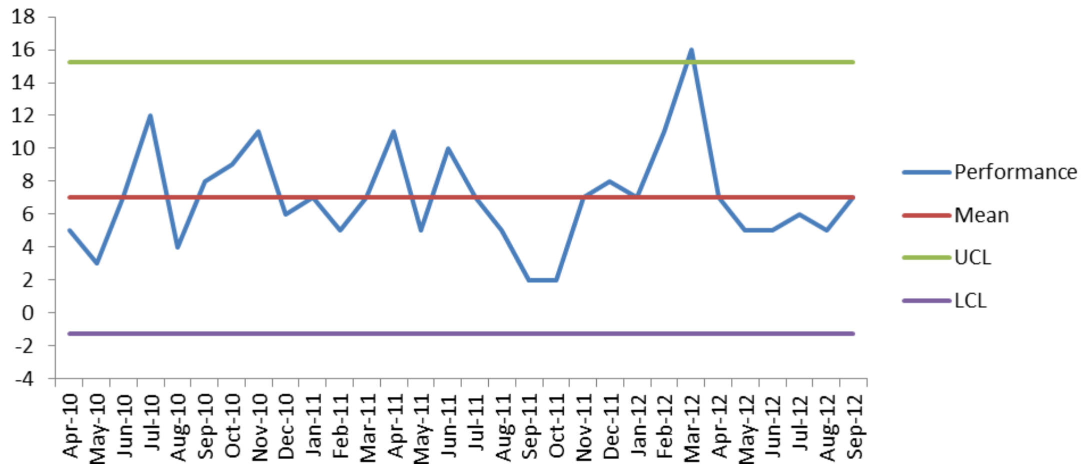
There has been a decrease from August to September following an increase from below to above the centre line between July and August.

Graph 12. Patient Identification Incidents April 2010 – September 2012



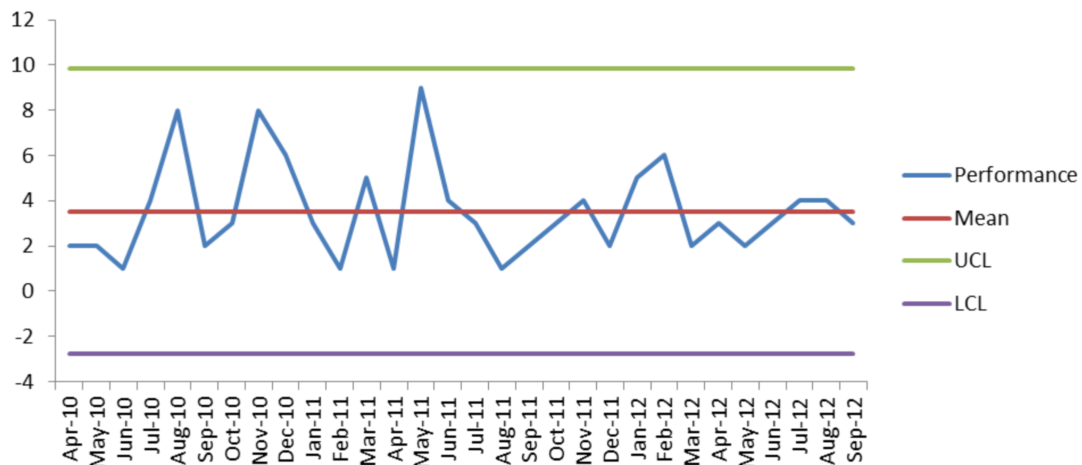
In Q1 patient identification incidents were increasing. A review to identify common themes was completed; failure to follow procedure, Pi related errors, and transcription errors. Actions have also been taken to raise awareness of the identification policy and review ongoing training requirements. From June to July there was a notable decrease in incidents however in August exceeded the upper control limit. From August to September the number of incidents decreased though remain above the centre line.

Graph 13. SIs April 2010 – September 2012



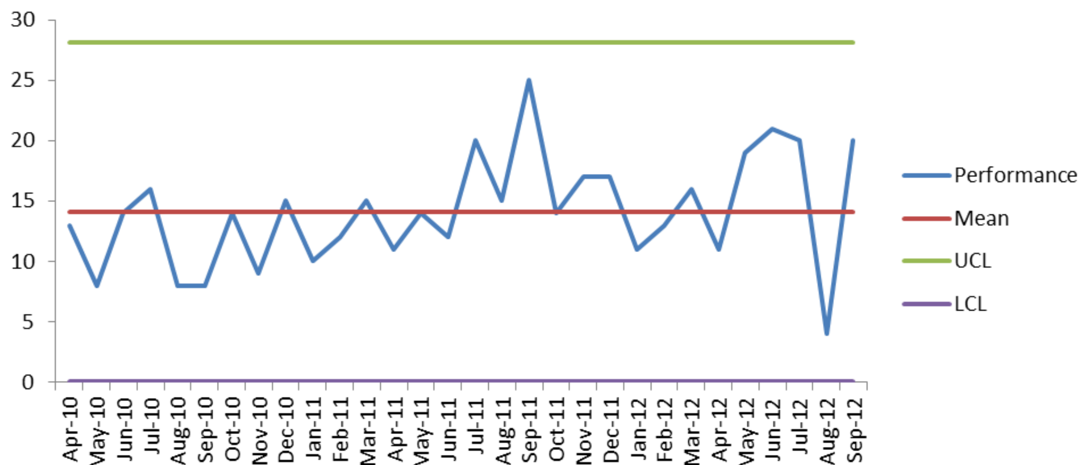
In March 2012 the number of Sis exceeded the upper control limit. This process has remained below the centre line since May of this year. However, it is notable that in September the data point sits exactly on the centre line and has increased.

Graph 14. Maternity SIs April 2010 – September 2012



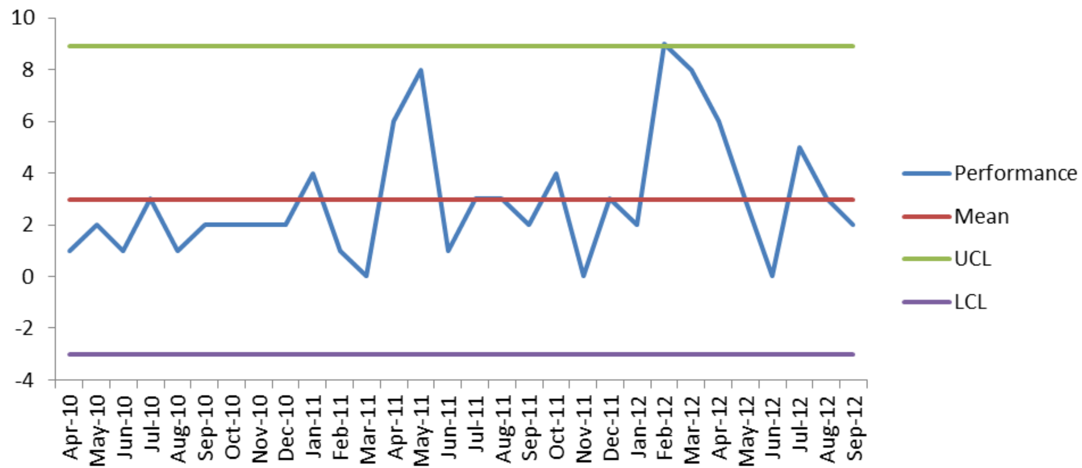
In Q2 maternity SIs moved from above the centre line to below it.

Graph 15. New Claims April 2010 – September 2012



At September, 4 out of the last 5 data points were above one standard deviation higher than the centre line. It is notable that in August there were a particularly low number of new claims submitted.

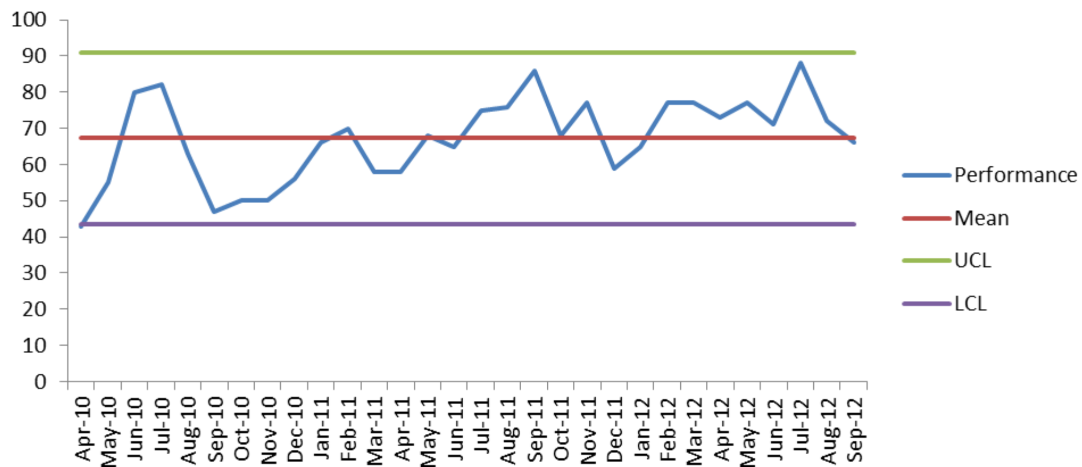
Graph 16. Settled Claims April 2010 - September 2012



From Q1 there was a downwards trend and in June 2012 settled claims fell below the centre point. From June to July settled claims increased above the centre line. For Q2 there has been a decrease in settled claims, to below the centre line.

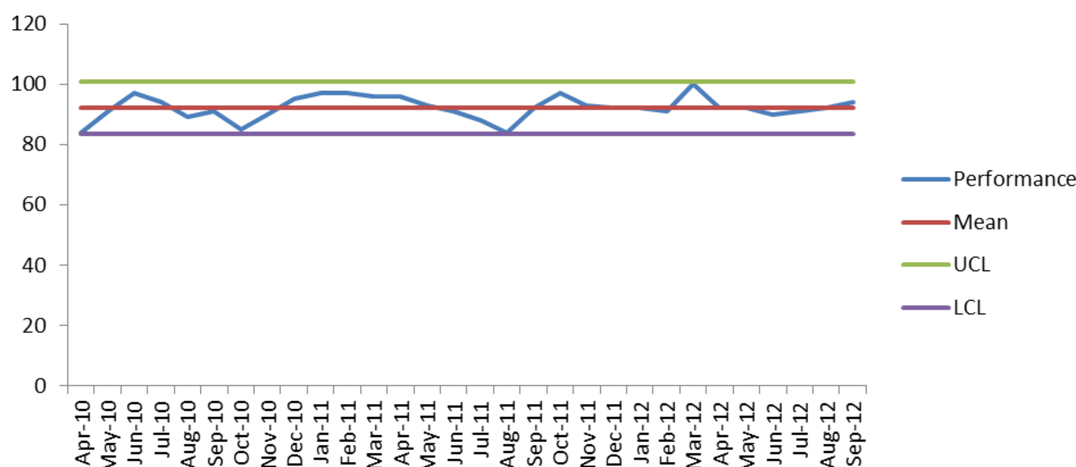
4.3 Patient experience

Graph 17. Complaints April 2010 – September 2012



Q2 numbers decreased and at September complaints fell below the centre line.

Graph 18. Complaints Response Time (%) April 2010 – September 2012



This process is in statistical control. A continuous increase in complaint response rate from below to above the centre line is evident between June and September.

5. DETAILED ANALYSIS OF Q2 DATA

5.1 Patient safety

5.1.1 Incident Reporting

The NRLS publishes six monthly public reports on the number and type of clinical incidents at each Trust. The average incident reporting rate across our peers - Acute Teaching Trusts is 6.9 per 100 admissions.

The Trust clinical incident reporting rate for Q2 is 6.2 per 100 admissions.

The incident reporting rate has increased from Q1 2012/13 when it was 5.8 per 100 admissions. Further work in promoting incident reporting will take place throughout the reporting counts ‘walkrounds’ conducted by the Quality and Safety Team.

Please note this data was refreshed on the 21st November.

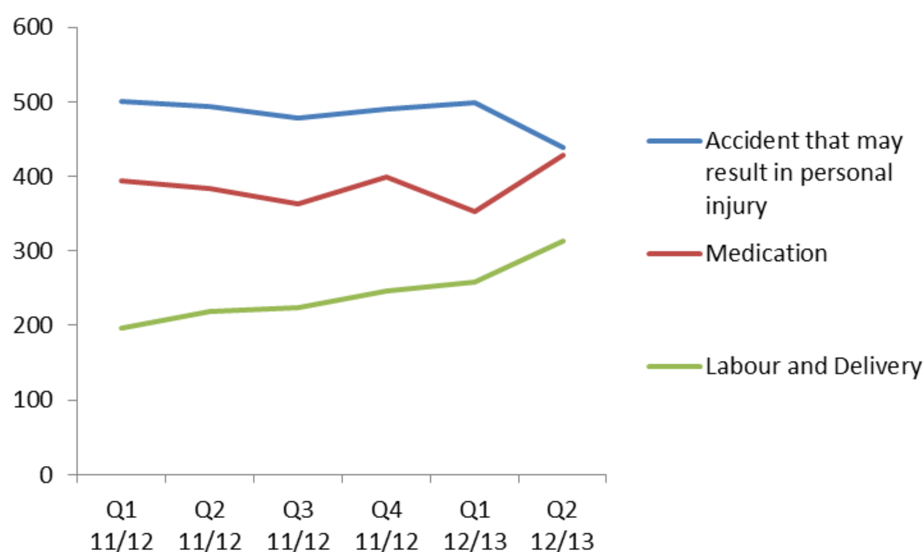
5.1.2 Severity (grade of harm) Reported Incidents

The most frequently reported category of harm for incidents remains ‘no harm’ at 65.93% for Q2, with minor harm reported in 27% of all incidents, moderate harm at 6%, major at 0.2% and extreme at 0.1%.note data was refreshed 21st November.

5.1.3 Incident Themes

In Q2 there has been no change in the top three categories of incidents reported. The top three themes are Accident that may result in personal injury, Medication and Labour and Delivery.

Graph 19. Top Three Themes for Clinical Incidents



From Q1 to Q2 incidents categorised as accident that may result in personal injury decreased. Across the same time period, medication and labour and delivery incidents both increased. It is worth noting that the difference in totals between the highest and second highest theme was just 10 incidents.

Table 1. Accident that may result in personal injury top three by sub category

Sub-classification	Total 10/11	Total 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13
Slips, trips, falls and collisions	87.8%	85.2%	82.8%	84.1%	88.8%	86.2%	89.0%
Accident caused by some other means	9.1%	8.9%	11.1%	10.9%	5.5%	7.8%	7.0%
Needle stick injury or some other injury connected with sharps	1.0%	2.9%	3.6%	2.1%	2.9%	4.0%	3.0%
Total all incidents in category	21.0%	17.9%	18.9%	18.3%	15.5%	18.4%	15.7%

It is notable that the top theme is consistently slips, trips, falls and collisions.

The most recent NRLS benchmarking data shows this is the top theme for our peers (23.1%).

Table 2. Medication by sub-category

Sub-classification	Total 10/11 I	Total 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13
Administration or supply of a medicine from a clinical area	43.5%	47.5%	47.5%	51.4%	47.3%	46.9%	52.0%
Medication error during the prescription process	16.4%	20.6%	17.8%	18.1%	21.8%	16.5%	20.0%
Preparation of medicines /dispensing in pharmacy	11.8%	11.4%	11.1%	13.9%	8.8%	10.7%	13.0%
Other medication error	18.6%	10.4%	13.1%	8.2%	11.5%	13.9%	5.0%
Total of all incidents in this category	14.1%	14%	14.7%	13.9%	12.6%	13%	15.0%

In Q2 no medication incidents resulted in either major or extreme harm. 2.3% of the incidents resulted in moderate harm, 27.7% in low harm and 70% in no harm to the patient.

Table 3. Labour and delivery top three by sub category

Sub-classification	Total 10/11	Total 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13
Labour or delivery - other	39.5%	25.5%	32.9%	18.8%	23.2%	17.8%	14.0%
Injury or poor outcome for the mother	7.0%	13.9%	12.8%	15.6%	16.1%	24.5%	12.0%
Post-partum haemorrhage > 1,000ml	16.5%	18.6%	14.6%	19.6%	18.7%	15.8%	11.0%
Shoulder dystocia	7.2%	10.7%	11.9%	12.1%	8.1%	9.3%	8.0%
Total of all incidents in this category	8.5%	8.1%	8.5%	8.5%	7.8%	9.6%	10.9%

There is no available national benchmarking data for these categories

See appendix one for improvement actions linked to the Trustwide top three themes.

Site Specific Top Themes for Incidents

St Mary's Hospital: medication, accident that may result in personal injury and labour or delivery.

Charing Cross Hospital: accident that may result in personal injury, medication and clinical assessment (investigations, images and lab tests).

Hammersmith Hospital: accident that may result in personal injury, medication and access, appointment, admission, transfer, discharge.

Queen Charlottes and Chelsea Hospital: labour or delivery, medication and treatment, procedure.

Western Eye Hospital: infrastructure or resources (staffing, facilities and environment), medical device/equipment and patient information (records, documents, test results, scans).

Renal Satellite Units: clinical assessment (investigations, images and lab tests) accident that may result in personal injury and medical device/equipment.

5.1.4 Other Incident Types

Inadequate staffing reports have increased from Q1 2012/13 (90) to Q2 2012/13 (160) by 78%.

SMH has reported the most incidents of this type 80 (50%), followed by HH 31 (19%). The same pattern was seen in Q1.

CPGs 1 and 5 reported the most incidents in relation to staffing. CPG 1 reported 52 incidents (36%) and CPG 5 reported 37 incidents (19%). SMH and CXH reported the most incidents of this type in Q1. To note that 83% of all these incidents in Q2 were graded no harm. This matter will be further reviewed in CPG performance meeting and in establishment reviews. note data refreshed 21st November 2012

Slips, trips and falls are the most frequently occurring incident nationally (NPSA, 2011). In Q2 there were 389 patient falls reported. This compares to 448 patient falls reported in Q1 representing a decrease of 13%.

The Trust has continued to report fewer falls compared to the national average of 5.6 falls per 1,000 occupied bed days. The Q2 rate was 3.53, compared to 3.95 falls per 1000 occupied bed days in Q1.note this data was refreshed 21st November 2012.

CPG1 consistently report the highest number of falls; this is possibly due to the nature of patients treated.

In Q2 there were 160 (41%) falls from height. This compares to 143 (32%) in Q1.

Inadequate response to change in patient clinical status (failure to rescue):

In 2011-12 a total of 52 FTR incidents were reported across the Trust, of which 48 were graded as resulting in all levels of harm, 92%. (NRLS grading). For Q1 and Q2 a total of 36 FTR incidents were reported.

In Q1 there was 1 reported case graded as extreme/severe harm and in Q2 there were 5 cases graded as extreme/severe harm.

There are site specific differences in numbers and types of FTR reported cases. Historically the Charing Cross site (CXH) reports the highest number of FTR incidents (Q1 n= 7, Q2 n=10). In part this is felt to be related to the proactive input of the CXH based critical illness team who actively look for cases, and possibly due to higher activity levels at the CXH.

Although CXH has the highest number of reported FTR incidents in Q1 and Q2, none of the incidents were graded as major or extreme harm. 12 of the 17 total incidents were graded no or low harm and 5 were graded moderate harm. No cases were considered as meeting SI criteria.

At the SMH site 4 of the total 11 incidents for Q1 and Q2 – occurring in September, were graded as extreme harm and 4 caused moderate harm. 3 of the incidents were graded as no or minor harm. Failure to rescue incidents were reviewed to address contributory factors resulting in a series of meetings and immediate actions to minimise recurrent events. These included; site team proactive ward visits to high risk areas, review of medical rotas, inclusion of cases in future training for junior doctors, highlighting the need for progress around rationalising critical care/outreach services across the Trust and continued awareness raising. Additional actions approved for long term improvements include; a hospital at night improvement and change programme, increase support for junior doctors, immediate interim collaborative working model for critical care/outreach services, creation of an effective handover tool and further engagement of CPGs. note data was refreshed 21st November 2012.

Patient Identification: There were 18 incidents in Q2, a decrease of 25% from Q1. None of the incidents were classified as extreme, major or moderate. 3 were classified as having minor harm and 15 no harm. All incidents related to patients wrongly identified are reviewed monthly at the Clinical Risk Committee to identify any themes and Trust wide learning.

5.1.5 Serious Incidents (SIs)

In Q2 there were 17 SIs. This is a decrease on Q1 total of 21. It is notable, however, that SIs classified under both Maternity Service and Pressure Ulcers have increased.

The top themes for SIs Q2 were unexpected admission to the neonatal unit (4), maternal admission to intensive care unit (3), neonatal death (3) and grade three Trust acquired pressure ulcer (3).

5.1.5.1 Actions arising from investigated SIs

Of the 17 SIs that occurred in Q2, 5 investigations are complete with 100% compliance with NHS London investigation deadlines. The remaining 12 are within deadline and are currently under investigation, within deadlines.

The total number of completed actions at Q2 were 4 out of 11 which represents 100% completed to deadline.

Data is refreshed monthly, since Q1 6 further SIs have been reported relating to incidents in Q1 2012/13. The figure of 15 SIs that was stated in the Q1 report has now been updated to 21 SIs. The additional SIs are:

- Two maternity service
- Two communicable disease
- One communication issue
- One C-Difficile outbreak

Compliance with the being open policy in Q2 was 100%, all patients where appropriate received a letter informing them that an investigation was being undertaken, were offered a copy of the report and a meeting with clinical staff.

5.1.6 Never Events

Never Events are often serious, largely preventable patient safety incidents that should not occur. They are reportable events to the Commissioners and to NHS London. They include: retained swabs, wrong site surgery, wrong procedure and mis-placed naso – gastric tube. The date of reporting the event is based on when the

Never Event was identified and in the case of retained swabs may be some months post initial procedure. Never Events and all other types of performance notices are reviewed by the Commissioners with the Trust at monthly meetings. No never events were reported in Q2. This compares to one vaginal swab in Q1.

5.1.7 Claims

There were 44 new claims received during Q2 and 12 claims settled.

New Claims top theme Trustwide and within the SMH and CXH sites was failure to recognise complication of treatment. The top theme for CPG1 was failure to diagnose/delay in diagnosis. All other CPGs and sites had no overall theme due to low numbers of claims received in Q2.

Settled Claims top theme Trustwide and at the SMH site was failure of follow-up arrangements. All other CPGs and sites had no overall theme due to low numbers of claims settled in Q2.

Table 4. Top three themes for new clinical claims

	2010/11	2011/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13
Failure to diagnose/delay in diagnosis	16%	22%	21%	18%	21%	17%	17%
Failure to recognise complication of treatment	13%	11%	8%	11%	15%	11%	9%
Fail/ Delay Treatment	11%	9%	2%	9%	9%	8%	6%
Totals:	118	161	48	45	33	36	35

NB Some claims have multiple themes

Table 5. Top three themes for new non-clinical claims

	2010/11	2011/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13
Slips, trips, falls and collisions	46%	48%	42%	67%	33%	40%	22%
Lifting accidents	8%	9%	8%	0	17%	13%	11%
Injury caused by physical or mental strain	4%	9%	8%	0	17%	13%	0
Totals:	24	23	12	3	6	15	9

Appendix one shows improvement actions from two of the settled claims

5.1.7.1 Risk Management Reports

One risk management report was received from the NHSLA in Q2. No recommendations were made.

5.2 Clinical effectiveness

5.2.1 NICE Guidance

Table 6. NICE Guidance Q2

	2011/12 Year end	Q1 2012/13	Q2 2012/13
Number of 'live' NICE guidance	750	759	776
Not applicable to ICHT	235 (31.3%)	234 (31%)	237 (31%)
Applicable to ICHT	515	525	539
Compliant	417 (81.0%)	420 (80%)	431 (80%)
Partially Compliant	33 (6.4%)	34 (7%)	34 (6%)
In progress	15 (2.9%)	16 (3%)	18 (3%)
Blanks (awaiting confirmation of compliance)	50 (9.7%)	55 (11%),	56 (10%)

A specific programme of work to address partially compliant NICE clinical guidelines older than 3 years continues, with the Clinical Effectiveness Manager requesting meetings with key clinical leads. A further escalation process has been implemented, to address blank compliance and unknown clinical leads via the CPG Directors and with escalation to the Medical Director where required.

5.2.2 CAS alerts (National Safety Alerts)

There have been 921 CAS alerts issued since 2004. 99.8% of these have been closed to deadline. For Q2 100% of alerts have been closed to deadline. All NPSA and EFA alerts have been closed.

5.2.3 Clinical audit

National Clinical Audits

The National Clinical Audit Programme, as outlined by HQIP and the DH and included as an indicator in the Quality Account, consists of 59 projects, of which 16 are not currently active and a further 3 are not applicable to the Trust. As at Q2, the Trust is participating in the remaining 40 audits (100%).

Trust Priority Clinical Audits

The 2012/13 CPG Priority Clinical Audit Programme has commenced. Each project has been given an anticipated date of completion and so far, 66.7% of priority clinical audits have been completed to deadline in Q2. Recommendations are monitored for implementation status following audit completion. As at Q2, 83.3% of actions from priority clinical audits due for completion in Q2 have been completed. All overdue items have been escalated to the respective CPGs for immediate action.

Local Clinical Audit

The registration of local clinical audit continues. Since April 1st 2012, in addition to National audits and local priority audits, a further 80 local clinical audits have been registered on the Clinical Audit Projects Database.

5.3 Service quality (Patient experience)

5.3.1 Complaints

This reflects data as of 08/10/12. A total of 259 formal complaints were received in Q2 – 226 were formally investigated and 33 low risk grade cases were investigated by PALS. The numbers of formal complaints managed by the Complaints Department in Q2 is similar to Q1 (221 formal complaints).

5.3.1.1 Number of complaints per CPG

CPG2, CPG3, CPG4, and 'others' all saw a fall in the number of formal complaints received in Q2.

CPG1 formal complaints increased 39%, in part due to an increase in complaints concerning acute medicine, up from 3 to 8. Service improvements following the formal complaint investigation includes:-

- To help speed up the discharge process Pharmacy has reviewed how they send different types of medication to the ward when fulfilling liver prescriptions so that they are delivered at the same time
- Medical staff have now been reminded how to correctly cancel blood tests if they are no longer required
- Electronic discharge training has now been undertaken for nursing staff
- Estates are in the processes of reviewing the shower facilities on the Acute Assessment Ward to help prevent water pooling and so reduce the risk of slipping
- Staff have been reminded that to help protect patients confidentiality they should hand over to their colleagues at the bedside quietly and sensitively, without the need to repeat a date of birth or diagnosis.

CPG5 complaints increased by 56% (27 to 42) due to an increase in complaints concerning obstetrics/maternity at both SMH and QCCH which rose from 12 to 23. Service improvements following the formal complaint investigation includes:-

- Both maternity sites to pilot a pressure ulcer assessment tool (with input from TVN's and infection control teams) for patients admitted to recovery / HDU
- All midwifery staff reminded to document the condition of pressure areas daily
- Ward based training sessions have taken place to ensure cannulation packs used and documentation improves within recovery and ward.
- The administrative team will now escalate to the Ultrasound Manager when there are no available scanning appointments for women before they reach 13 weeks of their pregnancy, we now intend to ensure that women have appointments for their combined screening test before they are 13 weeks into their pregnancy.
- The appointment of a senior midwife to help improve leadership in the Delivery Suite.

- The importance of reporting faulty equipment immediately to the Estates Department and taking faulty equipment out of use has been highlighted to all staff via the maternity newsletter.
- Women who have suffered bereavement will not be asked to attend routine phlebotomy clinics.

CPG6 saw complaints rise by 60% from 10 to 16. The biggest area of increase was in clinical haematology, which had an increase from 2 to 6. Service improvements following the formal complaint investigation includes:-

- Clinical nurse specialists have been asked to be more explicit in explaining to patients the importance of informing the department of any investigations or procedures that may contraindicate their medication.

5.3.1.2 Response rate

The Trust has set an internal target of responding to 90% of complaints within a timescale agreed by the complainant. The Trust can ask for one extension of this timescale. Complaint responses sent out after the response date (if not extended) or after the extended response date are recorded as a 'breach' of this target. For Q2 93% of all formal complaint responses were completed within the agreed timescale.

5.3.1.3 Top Themes

The top three themes for Q2 were all aspects of clinical treatment, communication/information to patients and appointments, delays/cancellation (outpatients). The same pattern was seen in Q1 2012/13.

Table 7. Top three themes complaints

Theme	2010/11	2011/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13
All aspects of clinical care	46%	46%	53%	38%	57%	43%	51%
Communication / Information to patients	5%	12%	8%	20%	19%	24%	17%
Appointments, delays / cancellation (outpatients)	16%	12%	12%	8%	10%	19%	8%

Table 8. All aspects of clinical care top three sub-categories by CPG

CPG	1st Sub Category	2nd Sub Category	3rd Sub Category
CPG1	Poor Clinical Care (9)	Poor Nursing Care (7)	Misdiagnosis (3)
CPG2	Poor Clinical Care (9)	Ineffective treatment (2)	Infection following surgery (2)
CPG3	Poor Clinical Care (14)	Poor Nursing Care (4)	Ineffective treatment (2)
CPG4	Poor Clinical Care (4)	Poor Nursing Care (1)	Infection following surgery (1)
CPG5	Poor Nursing Care (10)	Poor Clinical Care (8)	Misdiagnosis (3)
CPG6	Results not available (2)	Poor Nursing Care (1)	Poor Clinical Care (1)

Table 9. All aspects of clinical care top three sub-categories by site

Site	1st Sub Category	2nd Sub Category	3rd Sub Category
Charing Cross	Poor Clinical Care (14)	Poor Nursing Care (7)	Ineffective treatment (3)
Hammersmith	Poor Clinical Care (10)	Poor Nursing Care (2)	Lack of Treatment (1)
Queen Charlotte	Poor Nursing Care (5)	Poor Clinical Care (2)	Misdiagnosis (1)
Satellite	Poor Clinical Care (2)	N/A	N/A
St Mary's	Poor Clinical Care (18)	Poor Nursing Care (12)	Misdiagnosis (4)
Western Eye	Misdiagnosis (1)	Ineffective Treatment (1)	N/A

Table 10. Communication/information to patients top three sub-categories

Sub-Category	Q2
Other staff information	68%
Information not given to patient	13%
Incorrect information given to patient	11%

Table 11. Appointments, delays/cancellation (outpatients) top three sub-categories

Sub-Category	Q2
Delay in follow up appointment	42%
Delay in first appointment	21%
Appointment cancelled – not notified	16%

The top themes of complaints for each site in Q2 were:

SMH, **CXH**, **HH** and **QCCH** displayed the same top two themes with the Trustwide, the third top theme was attitude of staff.

WEH displayed the same pattern as the Trust wide top themes.

5.3.1.4 Severe Complaints

There are three high risk grade complaints in Q2 that are currently under investigation:

CPG3 - Being investigated as an SI (alleged poor clinical care)
CPG3 - Possible SI (alleged poor clinical care)
CPG4 - Possible SI (alleged poor clinical care)

5.3.1.5 Second Stage Reviews

Complainants can request that the Associate Director of Service Quality to review their complaint if they remain dissatisfied with the outcome of their complaint investigation. One request for a second stage request occurred in Q2.

Appendix one provides further examples of improvement actions from complaints

6. RISK PROFILE

The risk profile analyses the top theme for incidents, complaints and claims at Trust level, at individual CPG level and at individual site level.

Trustwide the top themes for incidents and complaints have not changed from those identified in Q1. For new claims the top theme has changed from failure to diagnose/delay in diagnosis to failure to recognise complication of treatment. For settled claims the top theme has changed from failure to recognise complication of treatment to failure of follow up arrangements. These issues will be reviewed for learning and improvement at the Clinical Risk Committee in December 2012.

Incidents top themes are the same in comparison with Q1 except for CPG4, where accident that may result in personal injury has been replaced with medication.
The top themes per site are unchanged since Q1 except for the HH and WEH sites. They have changed from accident that may result in personal injury and treatment, procedure to medication and infrastructure or resources (staffing, facilities, environment) respectively.

Complaints top themes are the same in comparison with Q1 except for CPG6, where all aspects of clinical treatment has been replaced with

communication/information to patients and WEH, where appointment, delay, cancellation (outpatients) has been replaced with all aspects of clinical care. The Trustwide Q2 theme of all aspects of clinical treatment was seen in CPGs 1-5 and all sites, the exception being CPG6 who had communication/Information to patients as their top theme.

New Claims top theme Trustwide and within the SMH and CXH sites was failure to recognise complication of treatment. The top theme for CPG1 was failure to diagnose/delay in diagnosis. All other CPGs and sites had no theme due to low numbers of claims received in Q2.

Settled Claims top theme Trustwide and at the SMH site was failure of follow-up arrangements. All other CPGs and sites had no theme due to low numbers of claims settled in Q2.

Improvement actions are to be agreed at the Clinical Risk Committee.

7. QUALITY ACCOUNTS

Appendix two presents the Trust Quality Accounts scorecard. The Q2 scorecard contains performance against all agreed targets excluding those where the data is annual or bi annual.

Data for emergency readmissions is now available for benchmarking however the national average will not be known until the end of the year when the Department of Health publish it. SHMI data is only available up until March 2012.

In Q2 a number of priorities are on or above target including VTE, falls, C-difficile rates, MRSA rates, pressure ulcers, incidents graded as major and extreme and the 3 patient experience questions.

There are a number of priorities which are not meeting targets.

Following the latest antibiotic prevalence (June 2012), the key performance indicators are shown below:

Indicator 1: 92% compliant with prescribing anti-infectives within policy (previous target of 90%)

Indicator 2: 88% of prescriptions had an indication documented on the drug chart or in notes (Previous Target 90%)

Indicator 3: 64% of anti-infectives had a stop/ review date or duration (Previous Target 50%)

The Trust launched in September 2012, the "Start Smart then Focus" initiative which aims to improve appropriate prescribing of antibiotics and to encourage regular review of patients who are taking antibiotics. The initiative is being led jointly by infection specialists in Microbiology, Infectious Diseases, Pharmacy and Infection Control. Furthermore, the Antibiotic Quality Improvement Project (AQIP) continues to develop antibiotic indicators in line with “Start Smart then Focus” campaign and is building on the current system of feedback in ‘real-time’ and within existing resources. Whilst we acknowledge the improvement to date in antibiotic stewardship, we must not be complacent, and in November 2012, the prevalence survey will be repeated to reassess our practice following the various interventions stated above.

The patient experience priority to reduce delays in outpatients is currently showing as red, the target of 85% is a trajectory target with all three sites aiming to reach 85% by year end. A number of initiatives are being implemented across the sites throughout the year to allow improvements to be made. St Mary's the first site to take these inititatives forward continues to see an improvement going from 79.52% in Q1 to 81.37% in Q2. HH has also seen improvement from 55.87 to 68.1%

The outpatient teams are also working to encourage patients to participate in the Patient Reported Outcome Measure Scheme (PROMs). Two of the PROMs measures are above 100% this is because the number of hip and knee operations carried out at the Trust has increased since the Trust merged, all patients who have these procedures are encouraged to participate in the scheme and more patients responded than was expected. CPG3 is in discussion with the PROMs organisation to amend this. Q2 figures are not yet available from the national data source.

The Trust is currently below the national average for the patient safety reporting rates. There are site specific differences for reporting rates. Reporting rates are being addressed via the Quality and Patient Safety Team walkarounds to promote the importance of incident reporting and identify barriers to reporting. The next one takes place on the 7th December 2012. See actions related to this indicator.

8. NRLS SERVICE QUALITY REPORT

From April 2012 The Trust took over the operational management of the NRLS for a 2 year period. The NRLS team are based within the Governance department.

The following reflects NRLS Team's performance during the period between 01/07/2012 and 30/09/2012 against agreed performance targets with the NHS Commissioning Board.

8.1 Key Updates

- During Q2 of 2012/13 NHS Organisations reported 347,066 incidents to the NRLS; It is an increase of 7.2% above 2011/12 Q2;
- The NRLS Team has successfully and timely performed, managed and delivered all agreed NRLS functions and outputs for the quarter against the performance schedule proposed in the Memorandum Of Understanding (MOU)
- Professor Sir Liam Donaldson joined the NRLS Team on the 1st September 2012 as an honorary consultant.
- A senior statistician and an information analyst were successfully recruited and joined the NRLS team.
- The 2012/13 NRLS staff appraisals were completed and the NRLS Team skills matrix has been updated. A list of new development opportunities has been identified and staff development support activities are taking place.

8.2 National Incident Reporting

During Q2 of 2012/13 NHS Organisations reported as a total 347,066 incidents to the NRLS. This shows an increase of 7.2% compared to Q2 of 2011/12.

Appendix One: Example improvement actions from incidents, complaints and claims

Examples of improvement actions from reported incidents linked to top three themes

Accident that may result in personal injury

CPG 1

- Compliance with risk assessments and keeping them up to date
- Compliance with bed rails policy
- Area being clutter free
- Use of bed and chair alarms
- Use of specials
- Positioning of the patient on the ward (either in a quiet area if they are mobilising due to disturbances, or nearer the nursing station to keep a closer eye)
- There was an identification that falls in one area appeared to coincide with handover times, therefore handover always takes the walk-round format

CPG 2

- Falls review and incidents are now discussed at handovers
- Staffing has been increased on the 6th floor for the complex cancer patients
- History of falls is also discussed at handover so that early referral to physio and medics can occur

CPG4

- Education for staff concerning documentation
- Documentation round by the ward manager and lead nurse to review documentation at the bedside with the nurses
- Back to basic initiative; engage with the physios to provide further education and training on falls prevention and mobility.

Medication

The Medication Safety Review Group (MSRG) have been increasing the awareness of the importance of reporting medication incidents, with the aim of increasing the number of reported medication incidents, so that trends can be identified and actions put into place to prevent them from occurring.

In response to omitted and delayed doses:
- A flowchart detailing what a nurse should do if a drug is not available on a ward has been created, added to the Source and distributed to all staff through InBrief. This flowchart has also been dissemination through CPG's by their representative on the MSRG.
- Information on the Source regarding access to medicines has been distributed to all staff. This information includes the opening hours of the pharmacy departments; the Trust guidance describing the options available for obtaining medicines when the pharmacy departments are closed; the stock lists of the emergency drug cupboards on each site; and stock that is available on all wards in the Trust.

Following an incident with potassium permanganate soaks, the formulary status has been changed, with restrictions put into place as to who can prescribe or recommend the use of this treatment. In addition the pharmacy department are no longer splitting packs of potassium permanganate and are adding “for external use only” stickers when dispensing this medication.

Following an audit undertaken looking at the access to adrenaline for anaphylaxis, the location where adrenaline for anaphylaxis is stored on the wards has changed so that they are more easily accessible in an emergency.

Processes have been amended to ensure that if a patient is prescribed any medication that is on the North West London Red List on either an outpatient prescription or on discharge, the patient is provided will enough medication until their next hospital appointment and that follow up appointments have been booked. The MSRG are trying to get an alert added onto the Trust EDC system, so that when a drug on the North West London Red List is prescribed on discharge, this is highlighted on the system to the prescriber.

The policy for amending chemotherapy prescriptions on CTIS (the software for prescribing chemotherapy) has been changed, so that hand amendments will not be accepted by pharmacy if it is possible for the prescriber to amend the prescription on CTIS.

A new Trust heparin policy has been introduced, unifying practice across all sites, as well as making the infusion calculations easier.

The Trust injectable medicines guide website has been updated to reflect the recommendations in the 'Consensus guide on identification of potential high risk injectable medicines' which was published in December 2011, following NPSA alert 20, 'Promoting safer use of injectable medicines'.

Labour and Delivery

- Training sessions have taken place with junior doctors regarding episiotomies when performing instrumental deliveries
- Consultant has raised documentation issues identified with junior doctors as part of teaching

Example improvement actions from complaints linked to top three themes

All Aspects of Clinical Care

- The importance of communicating medication changes to patients' GPs has been reinforced.
- All members of the vascular team involved in Trauma cases will be taught to look for both major and minor injuries in patients. Teaching will be undertaken during their M&M meeting.
- Staff will take further steps to encourage patients to mobilise as appropriate following procedures, and to document every episode of non-compliance.
- The Trust has appointed an extra breast reconstruction consultant last year and will be appointing another surgeon.
- Nursing staff have been reminded to use the acute pain and nausea assessment charts.
- All clinical staff will be reminded to ensure that any complications in care provided are to be documented in the patient's health records.
- A review of the pathway by which patient's come to thermal ablation procedures, particularly looking at the role of MDTs, post-procedural visits and discharges, will be conducted.

Communication/Information to Patients

- Cover arrangements have been reviewed on GIC and more flexible working is now in place in order to cover annual leave and emergency leave more effectively.
- Staff in the Admissions Office have been reminded to telephone patients if their admission date is booked at short notice and there is a high likelihood that a letter informing them about the details of their admission will not be delivered in time.
- Oncology nursing teams will advise patients and family members when procedures are due to take place over holiday periods.
- Any temporary secretary will need approval of the office manager before submitting and posting clinic letters to ensure that quality and safety standards are met.
- Secretaries within Oncology have been moved into teams to allow greater flexibility and cover for annual leave and sickness.
- The nurses in the Outpatients Department are currently formulating an action plan based on the results of the latest patient feedback results to ensure that patients and their escorts feel valued and comfortable and encourage staff to greet patients and escort them to and from cubicles.

Appointments, delays/cancellation (outpatients)

- Chemotherapy schedules will be discussed with the pharmacy team at the next meeting. All current procedures will be reinforced to ensure treatment is delivered on time.
- Reception teams will ensure that they give the maximum available information to patients concerning any delayed sessions, including ensuring that reception teams follow an appropriate escalation process via their line manager.
- Patients on the Riverside Wing are now allocated time slots to come in. This will prevent overcrowding in the waiting areas and give the doctors and anaesthetist more time to assess and examine patients prior to surgery.
- New stamps have been ordered to ensure that any patient deemed urgent is not lost in the treatment pathway. This will allow anyone dealing with health records to easily identify those patients that are on an urgent or cancer pathway.

- The rota for staffing of clinics is checked and confirmed by the rota coordinator and consultant's medical secretary at least two weeks prior to the clinic date to ensure adequate levels of staffing and alert the consultant and managers of any issues.
- A wider review of outpatient clinic activity in all Cardiology Outpatient clinics is being undertaken to ensure that the clinics are run efficiently and effectively and to improve the patient experience. This includes a review of all duties of the consultant and clinical staff. If required, changes will be implemented to ensure sessions are allocated efficiently.

Two settled claims had improvement actions in Q2:

Failure of follow-up arrangements

- In addition, teaching sessions have also been held in the A&E Department for all staff.

Surgical foreign body left in situ: Implemented following complaint investigation and completion of SUI report:

- The swab count policy was reviewed and updated.
- The use of Ray-tec swabs was reviewed.
- Clear swab bags with five individual pockets were introduced for swab counts.
- The Intensive Care Unit and Radiology Department explored the usefulness of a daily ward round to review patient imaging films.
- Details of the incident were added to the plain film reporting exam for radiologists.

Quality Accounts 2012/13
Quarter 2 Trustwide Performance

Quality Account Priorities

Ref	Measures	Freq	Target	Q2 target	Q1 total	Q2 total	Q3 total	Q4 total	Year Total	Year End Target/Comparative Comparative	Status	Date update
Patient Safety												
PS1	Safety Thermometer - 90% of all inpatients assessed for VTE Risk	Q	90%	90%	91.10%	91.11%				90% of all inpatients risk assessed		
PS2	Safety Thermometer - remain below the national average rate of reported falls	Q	<5.6%	<5.6%	3.95%	3.53%				Below 5.6%		
PS3	Safety Thermometer - reduce the number of patient falls that result in severe harm	Q	<9	<2.25	0	0				Less than 9 cases		
PS4	Safety Thermometer - To reduce the number of pressure ulcers	Q	<22	5.5	2	3				Less than 22		Data on this scorecard is data as of 5th November 2012
PS5	Safety Thermometer - Urinary catheter related infections (to begin reporting)	A	NA	NA	Current requirement is to begin reporting data only					Awaiting further national guidance		
PS6	To reduce cases of C.difficile infection (less than 110 cases)	Q	<110	<27.5	23	20				Less than 110 cases		* Data is refreshed each month and due to additional reporting and
PS7	To reduce cases of MRSA (less than 9 cases)	Q	<9	<2.25	1	1				Less than 9 cases		
PS8	To ensure compliance with trust policy for appropriate use of anti-infectives 90% compliance	Bi-annual	>90%	>90%	Bi-annual	81%				Bi-annual audit		1. Falls previously Q1 was 3.7% and Q2 was 3.47% - 30th October
PS9	Remain above the peer average for patient safety reporting rates	Q	>6.9%	>6.9%	5.80%	6.21%				Above 6.9%		2. Severe harm comprises NRLS graded incidents extreme and
PS10	Remain below the peer average for incidents graded extreme	Q	<0.1%	<0.1%	0.0%	0.1%				Less than 0.1%		3. Reporting rates previously Q1 was 5.8% and Q2 6.1%
PS11	Remain below the peer average for incidents graded major	Q	<0.5%	<0.5%	0.2%	0.2%				Less than 0.5%		4. Incidents graded extreme for Q1 was previously 0.15%
PS12	Failure to rescue total incidents (improving recognition of deterioriation)	Q	<52	<13	16	20				Less than 52		
Clinical Effectiveness												
CE1	Below the national average for mortality rates SHMI	Q	Data not yet available	Data not yet available	Data not yet available	Data not yet available				Awaiting confirmation of national average		
CE2	To reduce the number of emergency readmissions to hospital within 28 days of discharge	Q	National average tbc		6.63%	6.58%				Awaiting confirmation of national average		
CE3	To increase patient satisfaction as measured by PROMs and increase participation rate to 80% and above (	Q	80%	80%	53.33%	National data not yet available				80% and above		
	To increase patient satisfaction as measured by PROMs and increase participation rate to 80% and above (	Q	80%	80%	111.00%	National data not yet available				80% and above		
	To increase patient satisfaction as measured by PROMs and increase participation rate to 80% and above (	Q	80%	80%	177.00%	National data not yet available				80% and above		
	To increase patient satisfaction as measured by PROMs and increase participation rate to 80% and above (	Q	80%	80%	54.00%	National data not yet available				80% and above		
Patient Experience												
PE1	To reduce delays in outpatient clinics by the end of the year (target is a trajectory to improve by year end to 85%)	Q	85%	85%	SMH - 79.52%	SMH - 81.37%				85%		
			85%	85%	CXH - 69.76%	CXH - 69.08%				85%		
			85%	85%	HH - 55.87%	HH - 68.1%				85%		
PE2	To improve the patient experience related to discharge 75% compliance with policy	A	75%	75%	Annual Audit (results available Nov 12)					Awaiting data		
PE3	To improve the responsiveness to inpatients needs - 1. Involvement in care	Q	>87.13	>87.13	87.56	88.31				Above 87.13		
	To improve the responsiveness to inpatients needs - 2. Worries and Fears	Q	>80.30	>80.30	80.11	81.46				Above 80.30		
	To improve the responsiveness to inpatients needs - 3. Privacy	Q	>91.86	>91.86	92.15	92.38				Above 91.86		
	To improve the responsiveness to inpatients needs - 4. Medication side effects	A	National average comparison		Annual Survey (results available at the end of year)					Above the national average		
	To improve the responsiveness to inpatients needs - 5. Contact information	A	National average comparison		Annual Survey (results available at the end of year)					Above the national average		
PE4	To remain above the national average for staff who would recommend the Trust to friends/family needing ca	A	Annual	Annual	Annual Survey (results available at the end of year)					Above the national average		

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 9**

Report Title: Performance Report Month 7

To be presented by: Mr. Steve McManus, Chief Operating Officer

Executive Summary:
This report for the Trust Board summarises the Trust's Performance against Key Indicators. Accompanying this report is the Month 7 Trust Performance Scorecard which shows performance and monthly run-charts for all key indicators.
In October 2012 the Trust continued to achieve good performance in:
- National waiting time targets for non-admitted patients and patients on incomplete pathways.
- Maintaining year to date position of having zero mixed sex accommodation breaches.
- Achieving above target for providing national care standards for stroke and maternity patients.
- Venous Thromboembolism assessment rates: achieving a 92.03% rate against a 90% target.
- Achieving the national diagnostics waiting time target.
- Remaining within the threshold for patients whose transfer of care was delayed.
- Sustained good scores for patient feedback.
- Maintained position below the maximum trajectory for MRSA and Clostridium Difficile cases.

Areas identified as underperforming are:
- The A&E 4 hour wait for type 1 monthly performance in October was 94.91%, against the 95% national target.
- The 90% standard for admitted patients waiting less than 18 weeks, achieving 86.57%.
- The Trust achieved 4 out of the 8 national Cancer targets for September (Cancer targets reported one month in arrears).

Against the Department of Health 2012-13 Acute Trust Performance Framework for Month 7 the Trust is defined as
'performance under review'.
Against the Monitor Framework aggregate score the Trust would receive 4 points for Month 7 and be rated red in month
and red thus far for quarter 3. However this is provisional predicted performance pending cancer performance being
uploaded onto Open Exeter in December 2012.

Legal Implications or Review Needed
a. Yes
b. No ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report
a. For Decision
b. For information/noting ✓

Executive Performance Report

Imperial College Healthcare NHS Trust

Month 7: October 2012 **Paper:**

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Changes and Updates

Quarter 2 Clinical Trials participation results now published on page 9 of the performance scorecard.
Data that is submitted to the NHS Information Centre as part of the NHS Safety Thermometer is now published on page 10 of the scorecard.

Quality

Mortality The Trust continues to have one of the lowest mortality rates in England, based upon the Hospital Standardised Mortality Rate and Standardised Hospital Mortality Indicator.	**Scorecard Page 3**
Patient Experience The Trust continued to receive positive feedback, scoring 83% or more on core questions in October. All scores improved from the previous month's position. Patient experience results and improvement plans at ward level are discussed in detail during the monthly Clinical Programme Group Performance Reviews and progress is monitored by the Trust's Patient Experience Team.	**Scorecard Page 4**
Infection & Prevention Control For 2012/13 the Trust MRSA objective set by the Department of Health is a maximum of 9 Trust attributable cases in a year. MRSA incidents are escalated to the most senior management level in the Trust and are treated as a priority by the Infection Control and Prevention team. In October there was one reported case of Trust acquired MRSA infection bringing the year to date total to 3 cases, compared with 11 cases being reported at the same time last year 2011/12. The Trust remains within its trajectory to stay below the maximum 9 MRSA cases for the year. A root cause analysis has been completed for the case occurring in October and a series of recommendations from the Infection Control team are being put into action which includes revised guidance for clinical staff to follow to reduce the chance of similar occurrences. For Clostridium Difficile there were 10 cases reported in October 2012 bringing the year to date total to 53. The Trust remains within its trajectory to stay below the maximum 110 cases for the year.	**Scorecard Page 5**
Eliminating Mixed Sex Accommodation (EMSA) In October the Trust sustained its year-to-date achievement of zero mixed sex accommodation breaches.	**Scorecard Page 6**

Quality (continued)	
Stroke Care The Trust achieved above both national stroke care targets in October 2012. This performance has been sustained since the beginning of the financial year and the Trust expects this to be maintained. The Trust's Stroke Services also scored first in the country under the Stroke Improvement National Audit Programme (SINAP), published last month.	**Scorecard Page 7**
Venous Thromboembolism The Trust achieved above its target of 90% for the 7th consecutive month, achieving a score of 92.03% in October 2012. The Trust expects to sustain this performance.	**Scorecard Page 8**
Research and Development The quarter 2 results reported by the Joint Research Office show enrolment of patients onto clinical trials increased 11% from the same period last year. This is significantly above the initial target of a 1% increase set by the Trust at the beginning of the year.	**Scorecard Page 9**
Safety Thermometer The NHS Safety Thermometer is a improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It provides a quick and simple method for surveying patient harms and analysing results to measure and monitor Trust improvement and harm free care over time. From July 2012 data collected using the NHS Safety Thermometer was part of the Commissioning for Quality and Innovation (CQUIN) payment programme. During the first 4 months of this programme, the Trust has performed extrememly well against peers and has one of the best rates of Harm Free care in comparison to the Shelford Group.	**Scorecard Page 10**
Operations	
Accident & Emergency - 4 Hour maximum waiting time The 4 hour maximum waiting time in Accident and Emergency for the 'type 1' target of 95% was missed by 0.1% in October, achieving a performance of 94.9%, with Charing Cross and St Mary's Hospitals below target. All sites achieved over the 95% target for 'all types'. However currently the quarter 3 performance for type 1 remains above 95%. As Winter approaches the Trust's A&E teams are focussing on ensuring timely decision making and careful management of inpatients to reduce delays in A&E and improve patient experience and outcomes.	**Scorecard Page 11**
Accident & Emergency - Clinical Quality Indicators Total time spent in A&E remained below the 240 minute ceiling across all sites and the 'left without being seen' rate and 're-attends' performance remained below the 5% threshold. The time to treatment overall was above the 60 minute threshold and the time to initial assessment rose in October at St Mary's Hospital. The A&E teams have been working to deliver the A&E Performance Improvement Plan which is intended to support delivery of A&E performance through Quarter 3 and Quarter 4 and seeks to address areas such as capacity, response by specialty teams and time to treatment. Work on ambulatory care pathways continues with the development of both clinical and operational groups and the Trust has also joined the national Ambulatory Emergency Care Network.	**Scorecard Page 12**
Cancer Waiting times In October the Cancer Performance Standards for September were published showing the Trust achieved 4 of the 8 National Cancer Standards, including maintaining performance of the 2 week wait for urgent cancer referrals, as well as achieving the 62 day wait for first treatment from consultant screening and the 31 day wait for chemotherapy and radiotherapy. This is a marked improvement from the August position where only 2 out of the 8 national standards were achieved. A number of the cancer remedial action plan initiatives have been implemented. The previously reported positions for July and August have changed due to the validation programme approaching completion and now includes closed historic pathways. The performance remains volatile with a trajectory for sustained achievement of all 8 measures not until quarter 4. Trust board will also receive the detailed remedial action plan for cancer.	**Scorecard Page 13**

Elective Access - Referral to Treatment The Trust achieved 86.57% against the 90% target for patients waiting less that 18 weeks admitted pathways, 96.39% against the 95% target for patients waiting less than 18 weeks on non-admitted pathways and 93.05% against a target of 92% for patients waiting less than 18 weeks on incomplete pathways. All three referral to treatment (RTT) standards improved from last month. The number of patients waiting over 52 weeks fell from 100 in September to 42 in October 2012. The Trust continued to deliver ahead of its RTT improvement Trajectory in October for treating long waiters. A further important measure is that the overall admitted 'backlog' of patients waiting over 18 weeks fell from 1,352 in September to 1,183 in October.	**Scorecard Page 14**
Diagnostic Waiting times The Trust maintained its year to date performance in October, achieving over 99% performance, with 5 reported waiting time breaches out of 7978 diagnostic pathways. 3 breaches were in Urodynamics, 1 in Cystoscopy and 1 in Peripheral Neurophysiology. The Quarter 2 performance, which includes additional diagnostic tests, was published at the end of last month showing the Trust had 6 diagnostic breaches in total for the quarter.	**Scorecard Page 15**
Maternity The maternity service continued to achieve the 90% target for pregnant women see a midwife within 12 weeks and 6 days of pregnancy, at 97.3% in October 2012.Maternity NHSLA Level 3 rating awarded. The Trust Board scorecard Maternity 12+6 indicator shows the first booking appointments completed by 12 weeks and 6 day target (12+6) as a percentage of total booking appointments that month for referrals received before 10 weeks and 6 days (10+6) only. This indicator therefore eliminates the impact of both late referrals (those received past 12 weeks and 6 days into the pregnancy) and those received from the eleventh to the end of the twelfth week and therefore this indicator gives an accurate indication of organisational performance. The Trust's maternity services were awarded level 3 accreditation by the NHS Litigation Authority last month. This is the highest accreditation available.	**Scorecard Page 16**
Delayed Transfer of Care The Trust continued to remain below the 3.5% threshold for patients whose transfer of care was delayed, achieving good performance for the month and quarter 2.	**Scorecard Page 17**
Quality, Innovation, Productivity and Prevention The Cost Improvement Programme is driving the delivery of savings as a result of improved efficiencies in key productivity indicators, including staffing, diagnostic demand management, theatre and bed utilisation and outpatient productivity.	**Scorecard Page 18**
Workforce	
Progress against the Workforce key performance indicators are in the Performance Report.	**Scorecard Page 19**

Trust Board Performance Report
Report Period Month 7
(to end October 2012/13)

Presented at the Trust Board on 28th November 2012

Contents

Section	Code	Indicator	Page
Quality	QLTY 1	Mortality	Page 3
	QLTY 2	Patient Experience - key questions from National Survey	Page 4
	QLTY 3	Infection Prevention Control (MRSA and Clostridium Difficile)	Page 5
	QLTY 4	Eliminating Mixed Sex Accomodation	Page 6
	QLTY 5	Stroke care	Page 7
	QLTY 6	Venous Thromboembolism	Page 8
	QLTY 7	Research & Development	Page 9
	QLTY 8	Safety Thermometer	Page 10
Operations	OPS 1	Accident & Emergency - 4 hour maximum waiting time	Page 11
	OPS 2	Accident & Emergency - Quality Indicators	Page 12
	OPS 3	Elective Access - Cancer Waiting Times	Page 13
	OPS 4	Elective Access -Referral to Treatment	Page 14
	OPS 5	Elective Access - Diagnostics	Page 15
	OPS 6	Maternity	Page 16
	OPS 7	Delayed Transfer of Care	Page 17
	OPS 8	Quality, Innovation, Productivity and Prevention	Page 18
Workforce	WF 1	Bank and Agency Spend	Page 19
	WF 2	Pay Expenditure	Page 19
	WF 3	Vacancy Rate	Page 19
	WF 4	Turnover	Page 19
	WF 5	Sickness Absence	Page 19
	WF 6	Appraisals	Page 19
	WF 7	Statutory Mandatory Training and Local Induction	Page 19

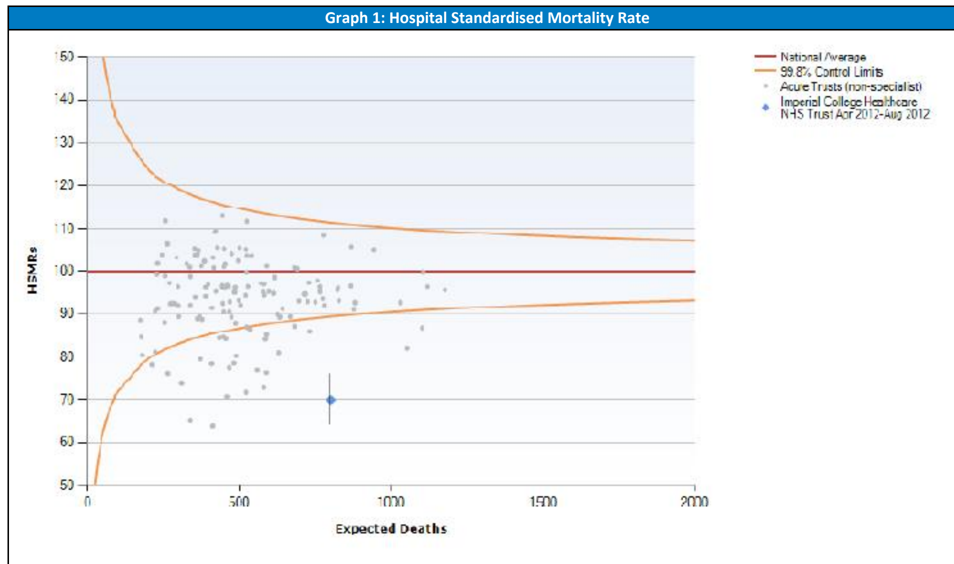
QLTY 1: Mortality - Supports compliance with Care Quality Commission Outcome 4

Domain	Indicator	National average	Unit	Quarter 1	Year to date
Mortality	Hospital Standardised Mortality Rate (HSMR) (*) Trust Board Performance Report	100	number	70 ●	70 ●

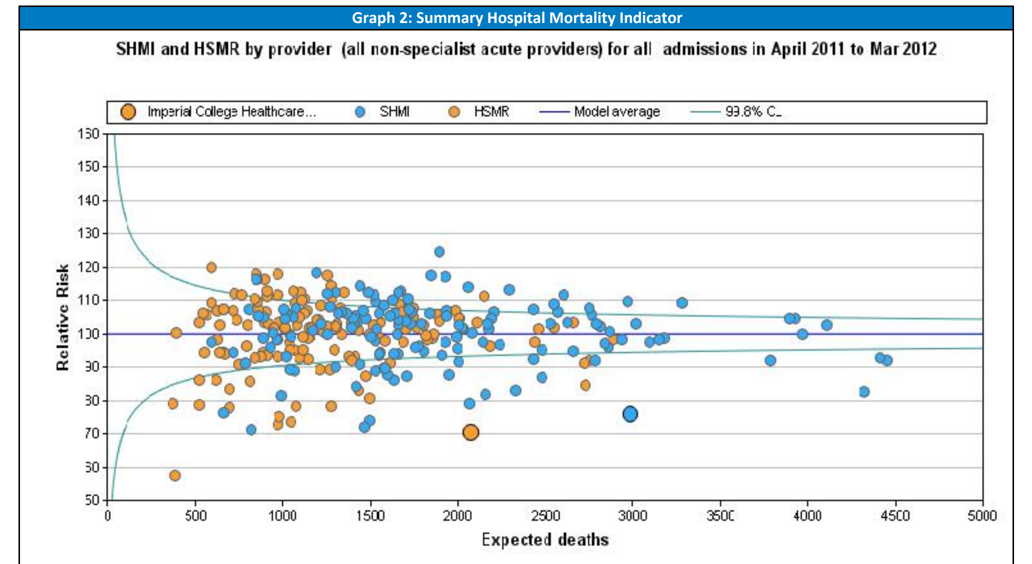
Indicator	National average	Unit	2011-12 Year end
Summary Hospital Mortality Indicator (SHMI)	100	number	75.8 ●

(*) - Data available to Month 5, Q2 not available yet

Graph 1: Hospital Standardised Mortality Rate



Graph 2: Summary Hospital Mortality Indicator

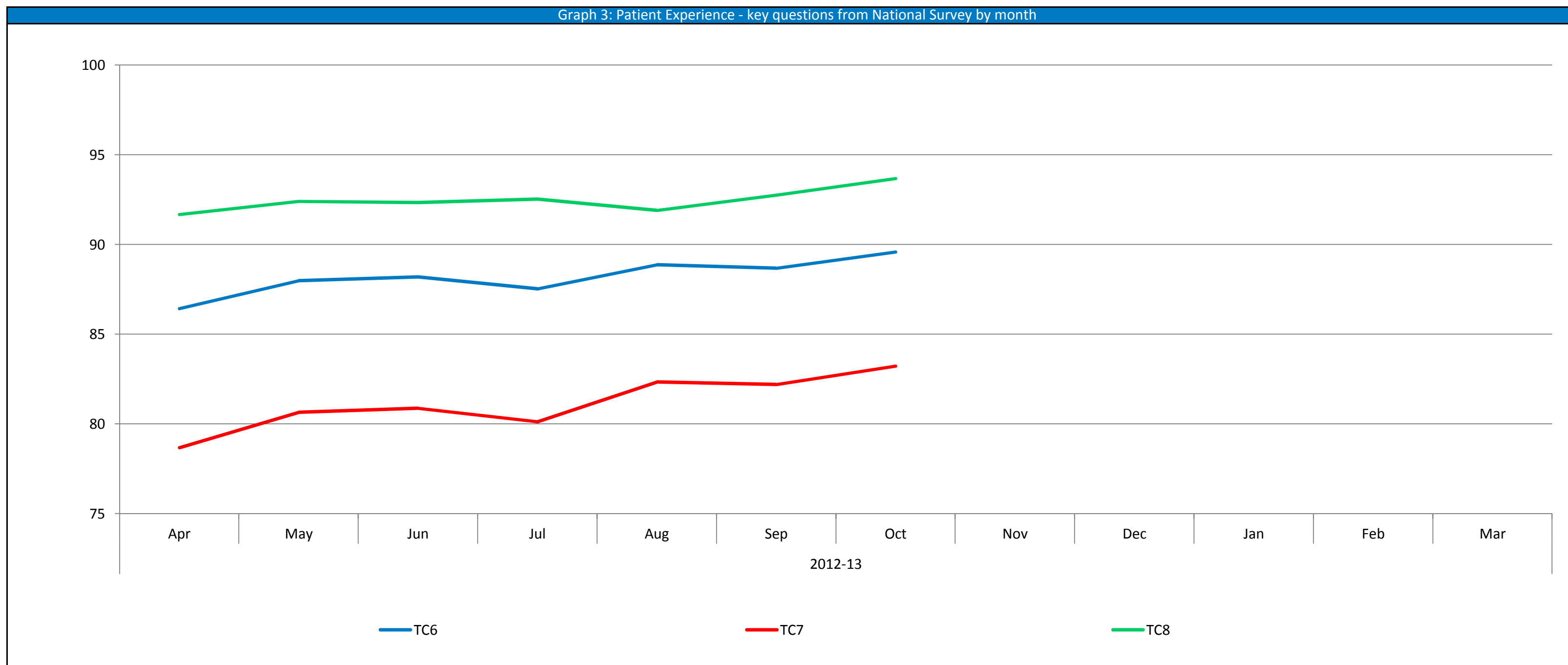


Source: Dr. Foster Intelligence

QLTY 2: Patient Experience - key questions from National Survey

- Supports compliance with Care Quality Commission Outcome 16 and 17

Core Question	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
TC6: Were you involved as much as you wanted to be in decisions about your care and treatment?	86.4	88.0	88.2	87.5	88.9	88.7	89.6					
TC7: Did you find someone on the hospital staff to talk to about your worries and fears?	78.7	80.6	80.9	80.1	82.3	82.2	83.2					
TC8: Were you given enough privacy when discussing your condition or treatment?	91.7	92.4	92.3	92.5	91.9	92.8	93.7					



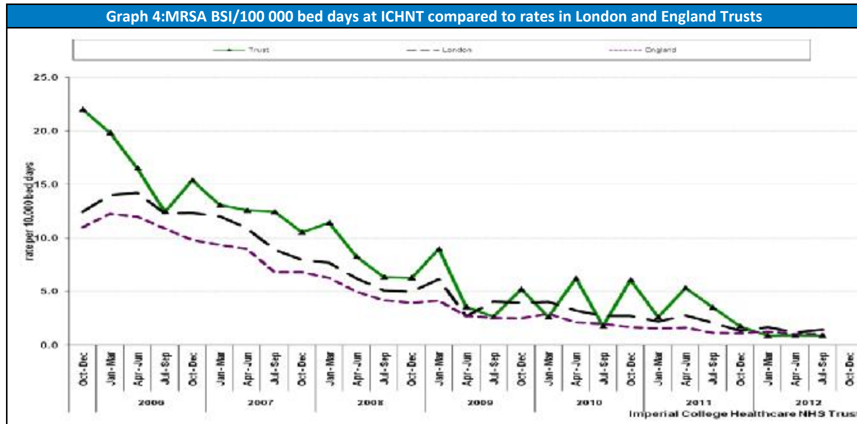
Source: iTrack

QLTY 3: Infection Prevention Control - NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 8

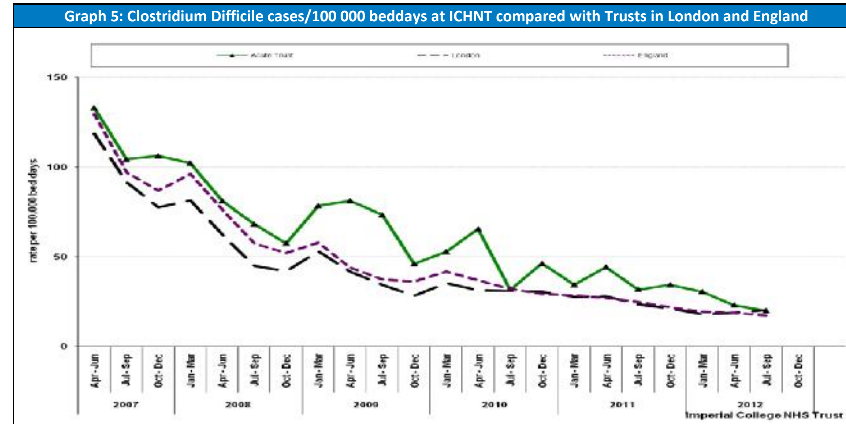
Domain	Indicator	Annual Trust Ceiling	Unit	Month 7		Year to date	
Infection Prevention and Control	Methicillin-Resistant Staphylococcus Aureus (MRSA) Bloodstream Infection (BSI) Bacteraemias	<=9	Cases	1	●	3	●
	Clostridium Difficile (C-Diff) post 72 Hours - Enzyme Immuno-Assays (EIA) - (Nationally Monitored)	<= 110	Cases	10	●	53	●

Trust Board Performance Report

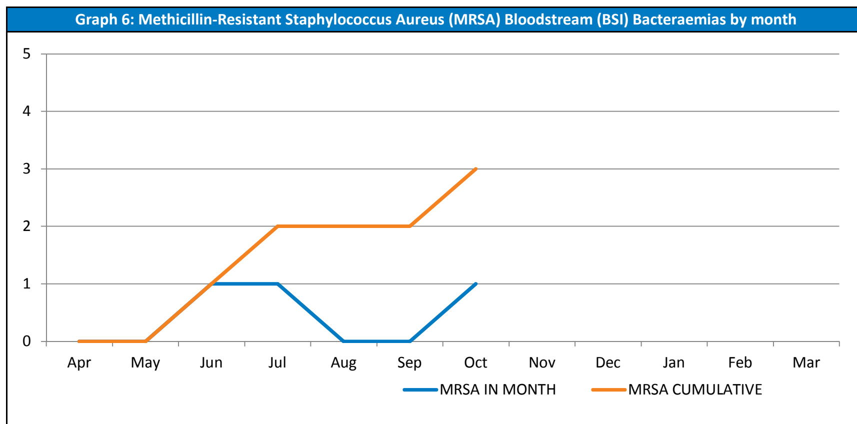
Graph 4:MRSA BSI/100 000 bed days at ICHNT compared to rates in London and England Trusts



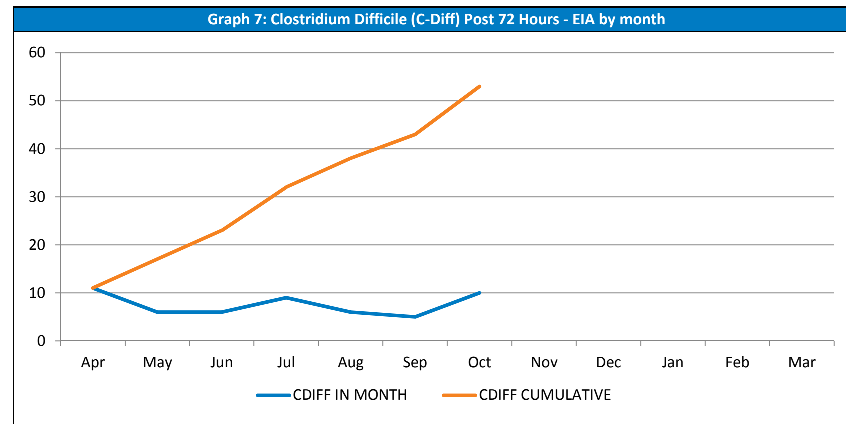
Graph 5: Clostridium Difficile cases/100 000 beddays at ICHNT compared with Trusts in London and England



Graph 6: Methicillin-Resistant Staphylococcus Aureus (MRSA) Bloodstream (BSI) Bacteraemias by month



Graph 7: Clostridium Difficile (C-Diff) Post 72 Hours - EIA by month

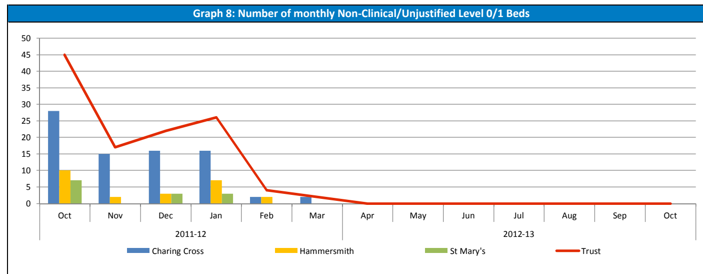


Source: Health Protection Agency & Infection Prevention Control Team

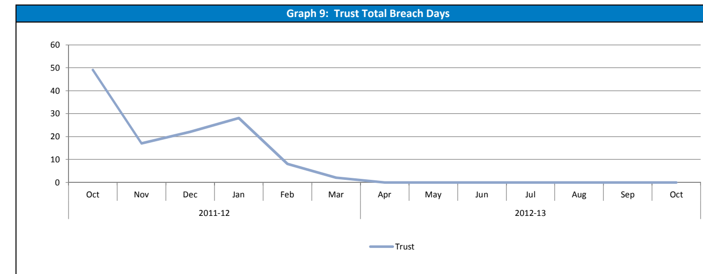
QLTY 4: Eliminating Mixed Sex Accommodation - EMSA - NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4

Domain	Indicator	Threshold	Unit	Month 7		Year to date	
Eliminating Mixed Sex Accommodation	Trust - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Trust - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Trust - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	Trust Board Performance Report						
	Charing Cross- Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Charing Cross - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Charing Cross - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	Hammersmith - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Hammersmith - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Hammersmith - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	St Mary's - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	St Mary's - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	St Mary's - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●

Graph 8: Number of monthly Non-Clinical/Unjustified Level 0/1 Beds



Graph 9: Trust Total Breach Days

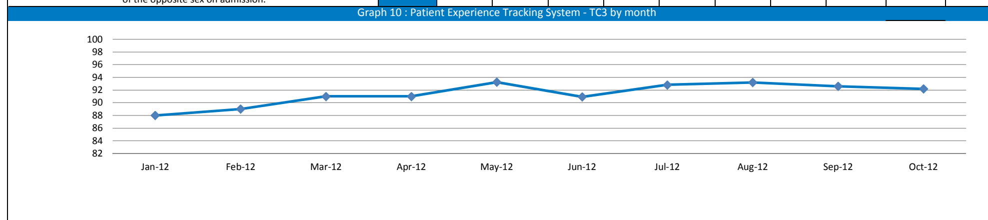


Source: Information Team

Patient experience (data take from iTrack - Trust's Patient Experience Tracking System)

		Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
TC3: When you were first admitted to a bed on this ward, did you share a sleeping area, for example a room or a bay, with patients of the opposite sex? This table shows the % of patients who thought that they did**not** share a sleeping area with a member of the opposite sex on admission.	Trust	88	89	91	91	93	91	93	93	93	92

Graph 10 : Patient Experience Tracking System - TC3 by month



Source: iTrack

QLTY 5: Stroke Care - **Supports compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 7		Year to date	
Stroke Care	Patients with high risk of Stroke who experience a TIA and are assessed and treated within 24 hours	60.0	%	100.0	●	99.3	●
	Patients who spend at least 90% of their time in hospital on a Stroke Unit	90.0	%	98.8	●	99.5	●

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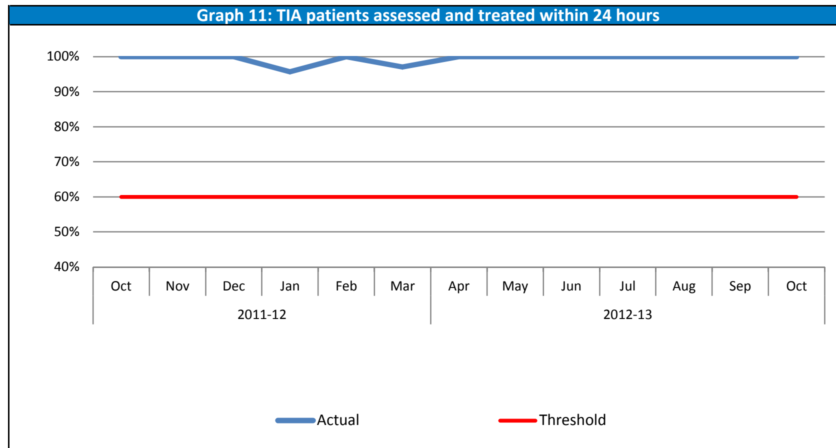
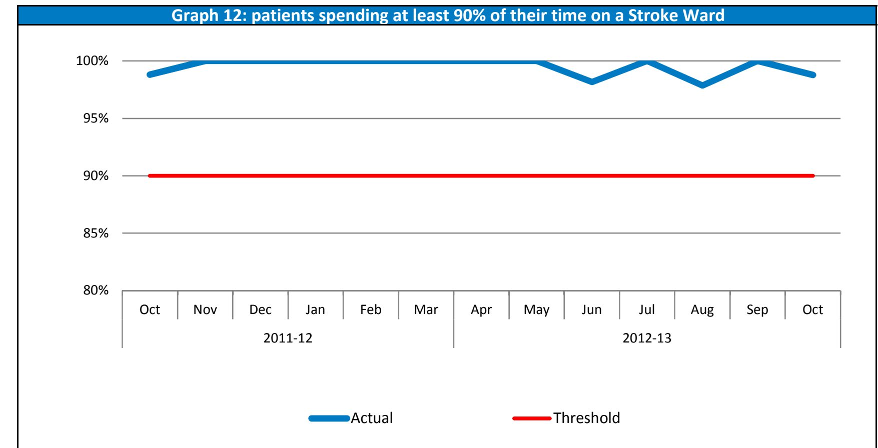




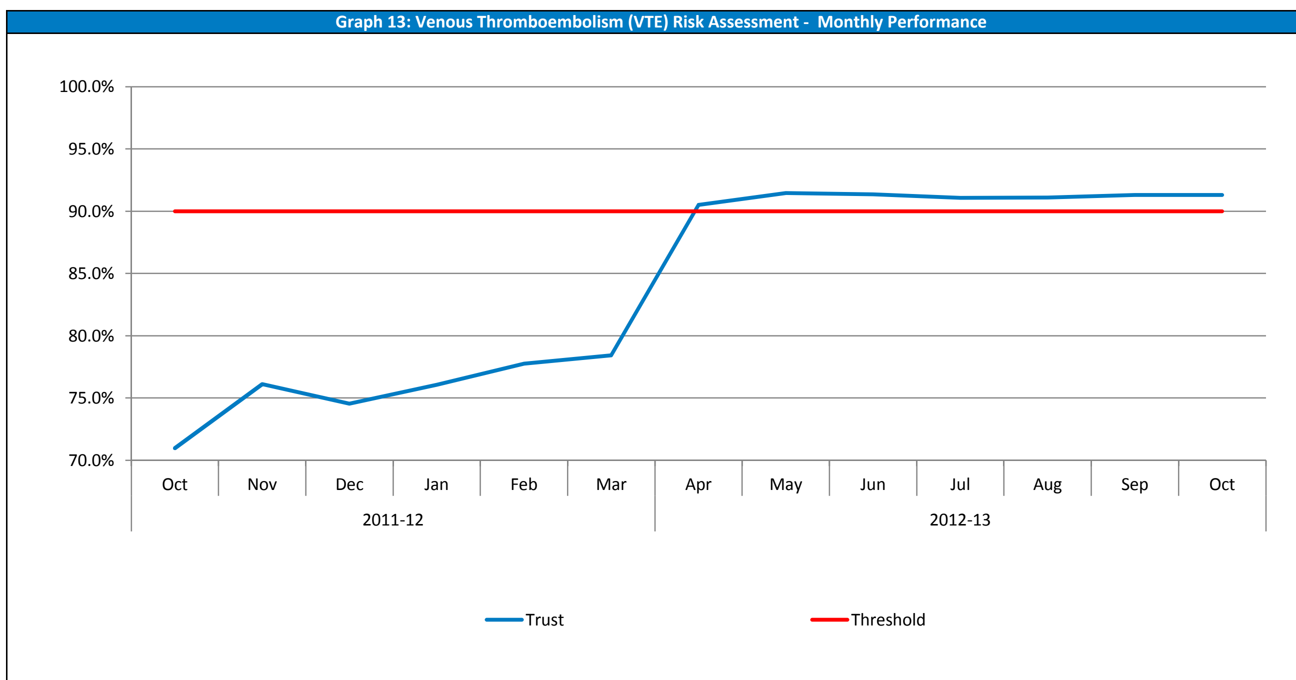
Source: Information Team

QLTY 6: Venous Thromboembolism - NHS Performance Framework 2012/13 Indicator & Supporting Compliance with Care Quality Commission Outcome 4

Domain	Indicator	Threshold	Unit	Month 7	Year to date
Venous Thromboembolism (VTE) Risk Assessment	Adult Inpatients who have had a Venous Thromboembolism (VTE) Risk Assessment	90.0	%	92.0 ●	91.3 ●

Trust Board Performance Report

Graph 13: Venous Thromboembolism (VTE) Risk Assessment - Monthly Performance

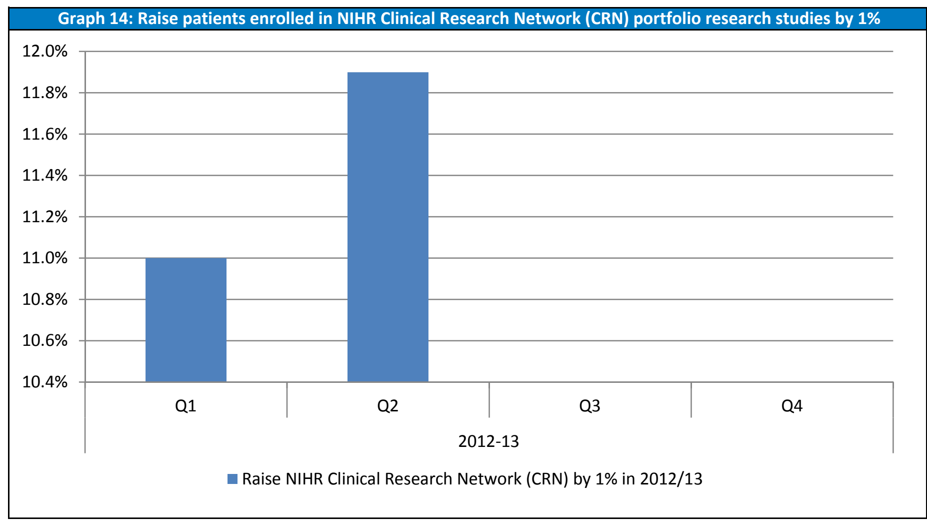


Source : Information Team

QLTY 7: Research & Development - **Supporting Compliance with Care Quality Commission Outcome 14**

Domain	Indicator	Target	Unit	Quarter 2	Year to date
Research & Development	Raise the proportion of patients enrolled in NIHR Clinical Research Network (CRN) portfolio research studies by 1%	Increase by 1% from 11/12	%	12.0 ●	11.5 ●

Trust Board Performance Report



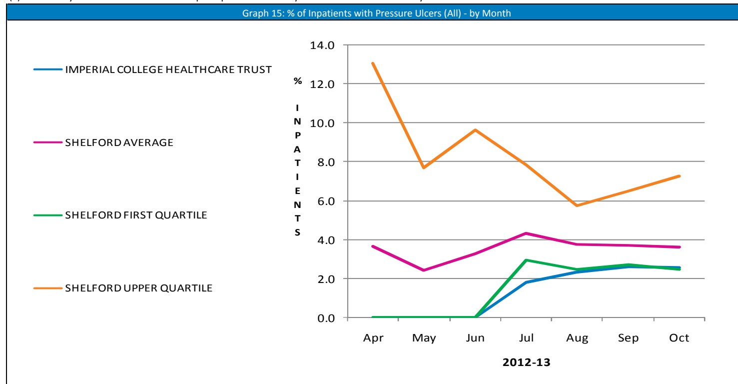
Source: Joint Research Office

QLTY 8: Safety Thermometer - Supports Compliance with Care Quality Commission Outcome 4

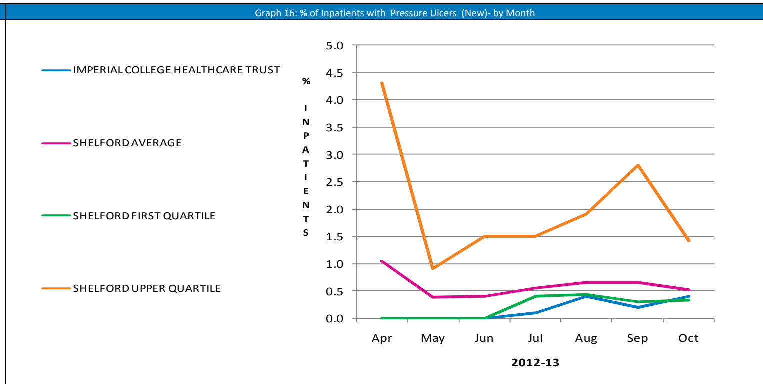
Domain	Indicator	Threshold	Unit	Month 6	Year to Date
Safety Thermometer	Harm free	-	%	96.25	96.30
	Pressure Ulcers - All	-	Number	28	73
	Pressure Ulcers - New	-	Number	6	15
	Trust Board Performance Report	-	Number	1	5
	Catheter's & UTI	-	Number	8	24
	Catheter's & New UTI	-	Number	5	11
	New VTE's	-	Number	5	22

(*) - The Safety Thermometer is based on a point prevalence survey exacted the first Wednesday of each mont

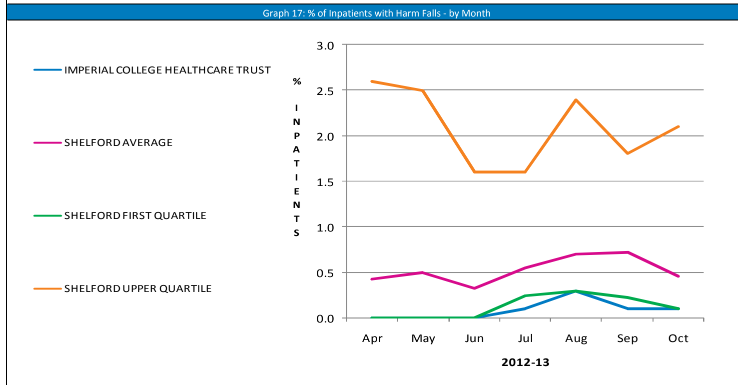
Graph 15: % of Inpatients with Pressure Ulcers (All) - by Month



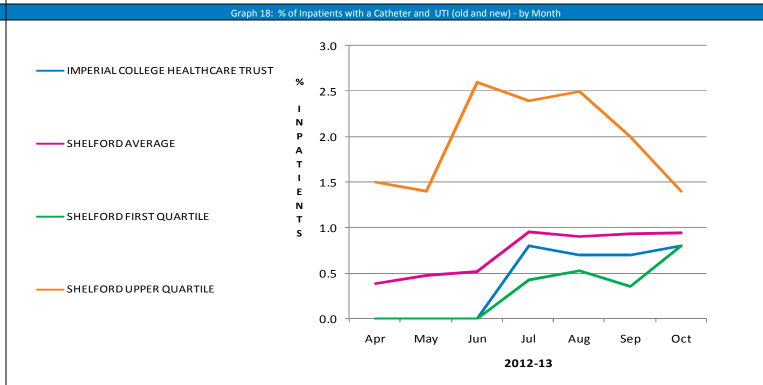
Graph 16: % of Inpatients with Pressure Ulcers (New)- by Month



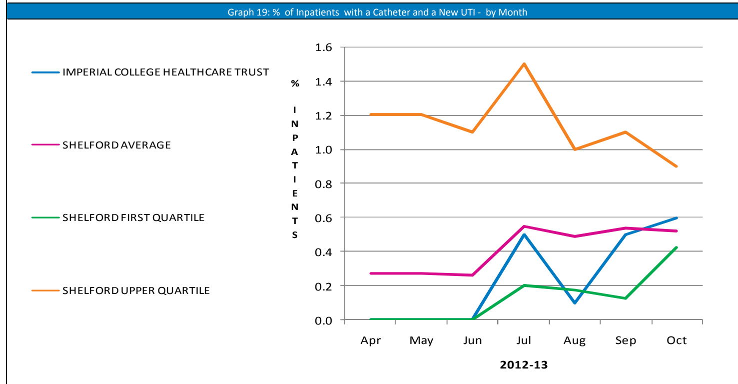
Graph 17: % of Inpatients with Harm Falls - by Month



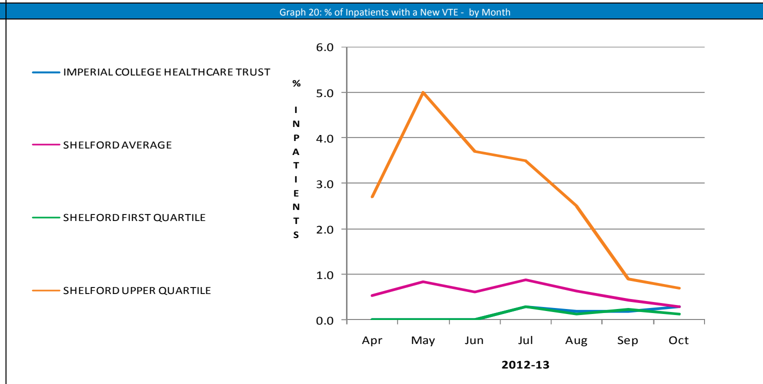
Graph 18: % of Inpatients with a Catheter and UTI (old and new) - by Month



Graph 19: % of Inpatients with a Catheter and a New UTI - by Month



Graph 20: % of Inpatients with a New VTE - by Month



OPS 1: Accident & Emergency - 4 hour maximum waiting time - NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4

Domain	Site and type		Threshold	Month 7	Year to date
4 hour maximum waiting time In Accident & Emergency	Trust	All (Type 1,2,3)	95.0%	97.2%	97.9%
	Trust	Type 1	95.0%	94.9%	95.5%
	Hammersmith	Type (1,2,3)	95.0%	98.4%	98.4%
	Trust Board Performan	Type (1,2,3)	95.0%	97.8%	98.1%
	St Mary's	Type (1,2,3)	95.0%	96.5%	97.1%
	Hammersmith	Type 1	95.0%	96.1%	97.3%
	Charing Cross	Type 1	95.0%	94.9%	97.2%
	St Mary's	Type 1	95.0%	94.7%	95.6%
London Ambulance Service (LAS) Handover	London Ambulance Service Patient Handover - within 60 Minutes		100%	98.9%	99%
	London Ambulance Service Patient Handover - within 30 Minutes		95.0%	96.5%	98.5%
	London Ambulance Service Patient Handover - within 15 Minutes		85.0%	89.0%	94.6%
	London Ambulance Service Breaches Handover > 60 Min		0		0

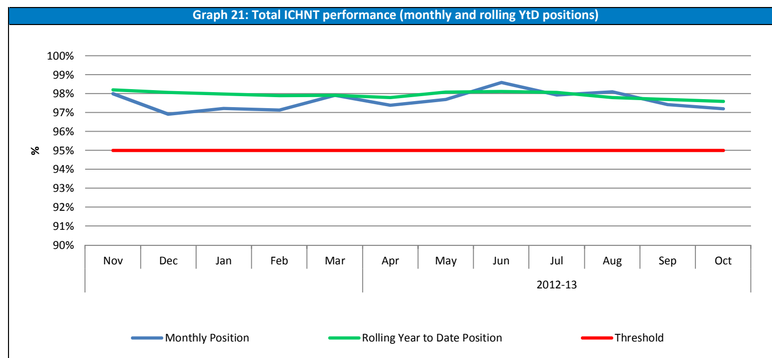
Key

Type 1 = A consultant led 24 hour service with full resuscitation facilities (known previously as 'Majors') ie those patients who attend the main emergency departments across all 3 sites

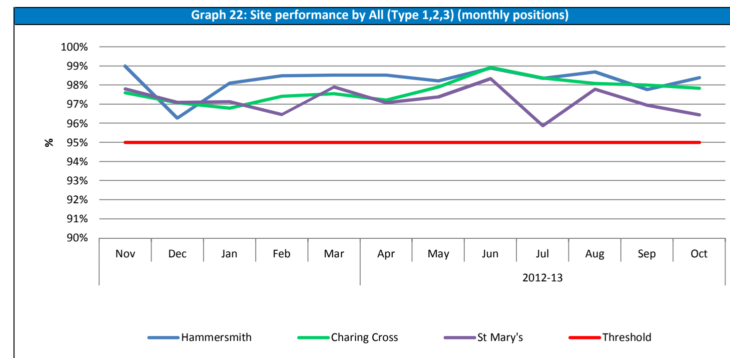
Type 2 = A consultant led single specialty accident and emergency service ie Western Eye for Ophthalmology patients

Type 3 = Other type of A&E/minor injury units (MIUs), Urgent Care Centre. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community

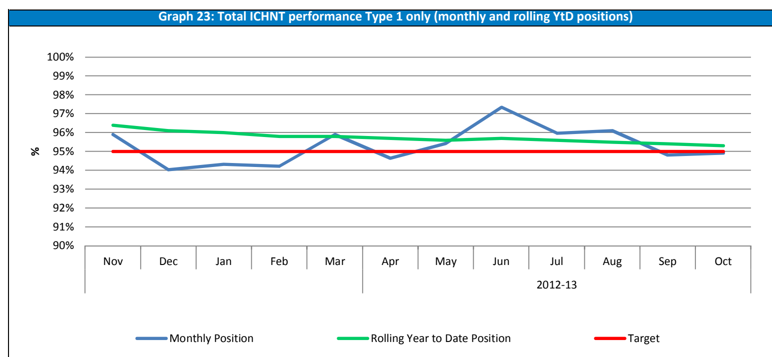
Graph 21: Total ICHNT performance (monthly and rolling YtD positions)



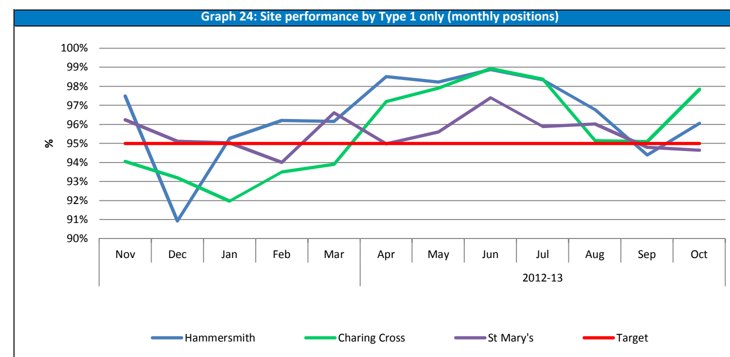
Graph 22: Site performance by All (Type 1,2,3) (monthly positions)



Graph 23: Total ICHNT performance Type 1 only (monthly and rolling YtD positions)



Graph 24: Site performance by Type 1 only (monthly positions)



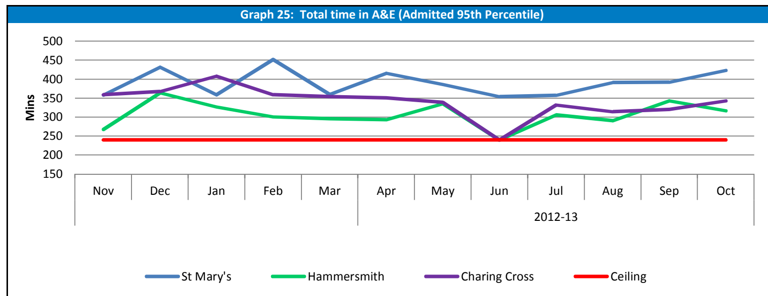
Source: Emergency Medicine

OPS 2: Accident & Emergency - Quality Indicators - Supports Compliance with Care Quality Commission Outcome 4

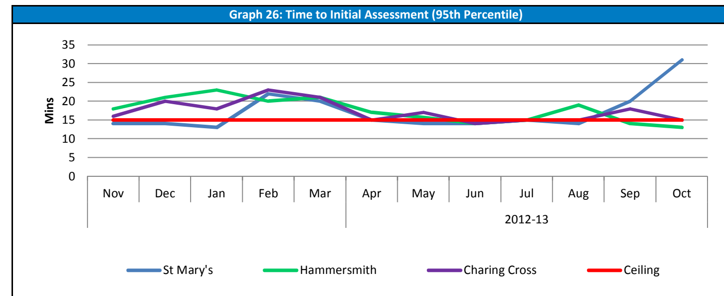
Domain	Indicator	Ceiling	Unit	St Mary's Month 7		St Mary's Year to date		Hammersmith Month 7		Hammersmith Year to date		Charing Cross Month 7		Charing Cross Year to date	
Accident & Emergency - Quality Indicators	**Unplanned re-attendance at A&E within 7 days (*)**	5	%	3.81%	●	3.88%	●	3.21%	●	3.19%	●	4.66%	●	4.57%	●
	Total time spent in A&E														
	Trust Board Performance Report	240	Minutes	235	●	235	●	228	●	224	●	217	●	214	●
	Admitted - 95th Percentile	240	Minutes	423	●	390	●	317	●	316	●	343	●	327	●
	Admitted - Longest Time	360	Minutes	697	●	924	●	563	●	768	●	694	●	725	●
	Non-Admitted - Median Time	240	Minutes	132	●	134	●	92	●	82	●	102	●	109	●
	Non-Admitted - 95th Percentile	240	Minutes	239	●	238	●	234	●	233	●	230	●	229	●
	Non-Admitted - Longest Time	360	Minutes	801	●	1248	●	407	●	495	●	627	●	836	●
	Left Department Without Being Seen Rate	5	%	3.63%	●	4.06%	●	1.05%	●	0.96%	●	1.20%	●	1.79%	●
	Time To Initial Assessment (ambulance cases only)														
	Median Time	15	Minutes	6	●	4	●	3	●	4	●	4	●	4	●
	95th Percentile	15	Minutes	31	●	18	●	13	●	15	●	15	●	15	●
	Longest Time	15	Minutes	151	●	254	●	30	●	169	●	192	●	192	●
	Time To Treatment In Department														
	Median Time	60	Minutes	77	●	73	●	64	●	59	●	62	●	65	●
	95th Percentile	60	Minutes	185	●	180	●	171	●	169	●	172	●	185	●
	Longest Time	60	Minutes	451	●	451	●	298	●	317	●	394	●	447	●

(*) - Type 1 indicators for Re-attendance are pre validated prior to April 2012

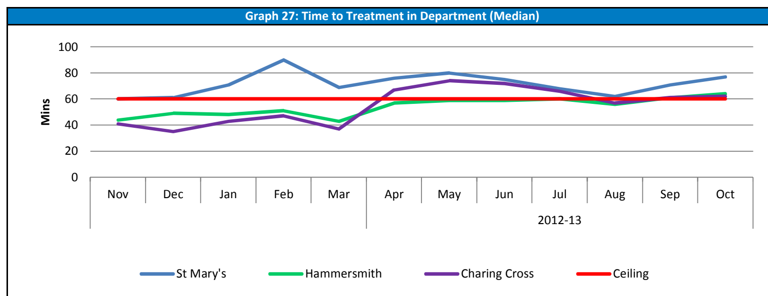
Graph 25: Total time in A&E (Admitted 95th Percentile)



Graph 26: Time to Initial Assessment (95th Percentile)



Graph 27: Time to Treatment in Department (Median)

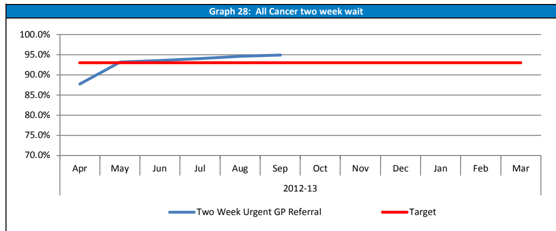


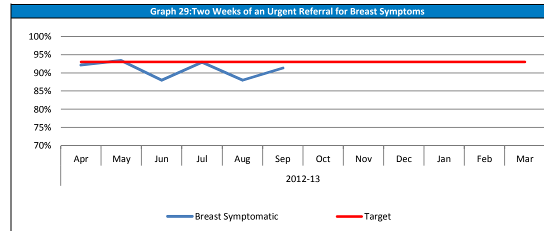
Source: Emergency Medicine

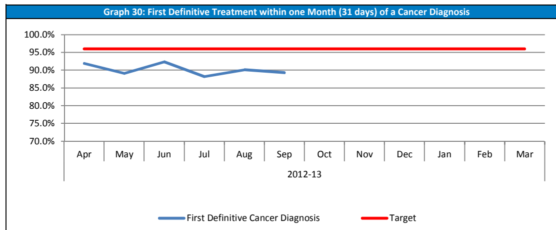
OPS 3: Elective Access - Cancer Waiting Times - NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4

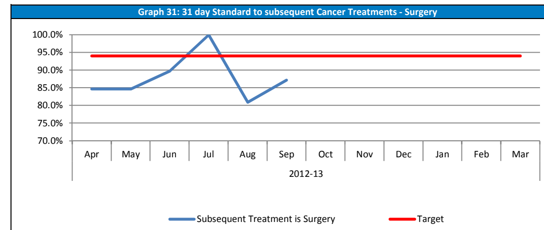
Domain	Indicator	Target	Unit	Month 6	
Elective Access - Cancer Waiting Times (*) (**)	All Cancer two week wait	93	%	94.9	●
	Two week GP referral to 1st outpatient - Breast Symptoms	93	%	91.4	●
	Trust Board Performance Report	96	%	89.3	●
	31 day Standard to Subsequent Cancer Treatments - Surgery	94	%	87.2	●
	31 day second or sebsequent treatment - Drug	98	%	100	●
	Proportion of patients waiting no more than 31 days for second or subsequent cancer Treatment - Radiotherapy Treatment	94	%	97.6	●
	All Cancer Two Month Urgent Referral to Treatment wait	85	%	67.7	●
	62-Day wait for First Treatment following referral from an NHS Cancer Screening Service	90	%	100.0	●

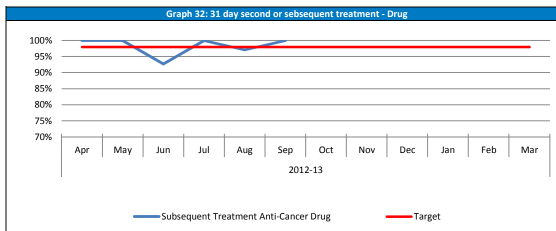
* Cancer data reported one month in arrears
** Month 4 and Month 5 performance updated in Month 7

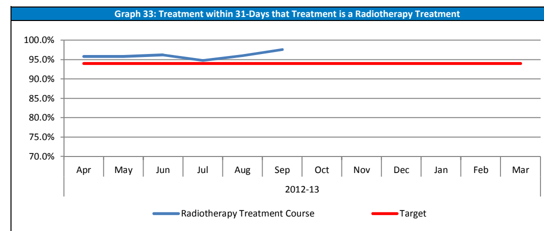


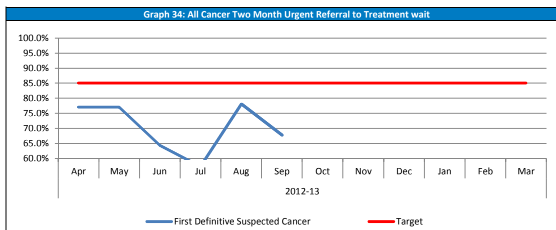


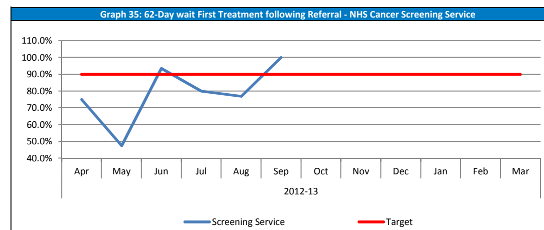










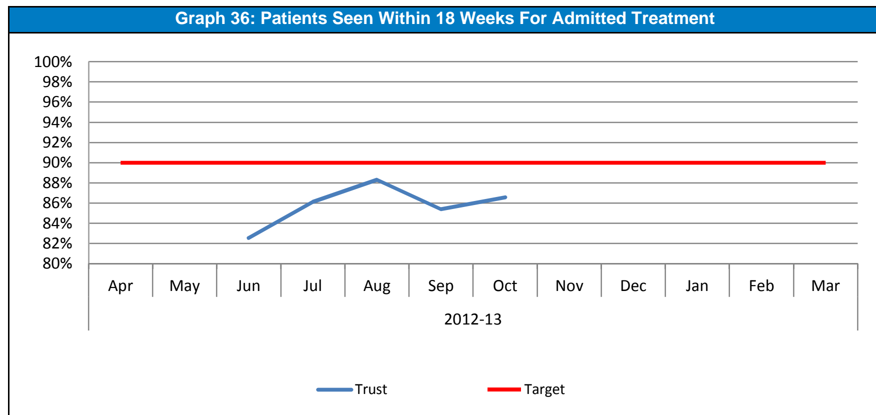


Source: Cancer Services

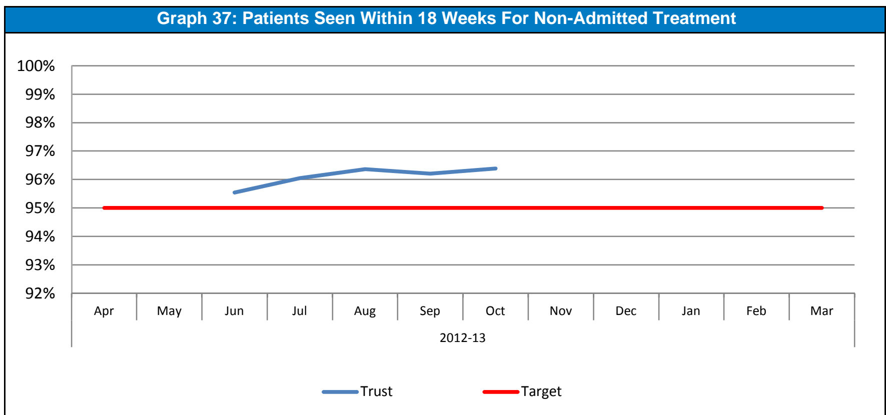
OPS 4: Elective Access - Referral To Treatment - NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4

Domain	Indicator	Target	Unit	Month 7		Treatment Functions Not Achieving Target M7
Elective Access - Referral To Treatment	Total number of completed Admitted pathways - waiting 18 weeks or less	90.0	%	86.57	●	6
	Total number of completed Non-Admitted pathways - waiting 18 weeks or less	95.0	%	96.39	●	6
	Incomplete pathways where patients waiting less than 18 weeks	92.0	%	93.05	●	7
	Trust Board Performance Report	<=20	Number	-		8

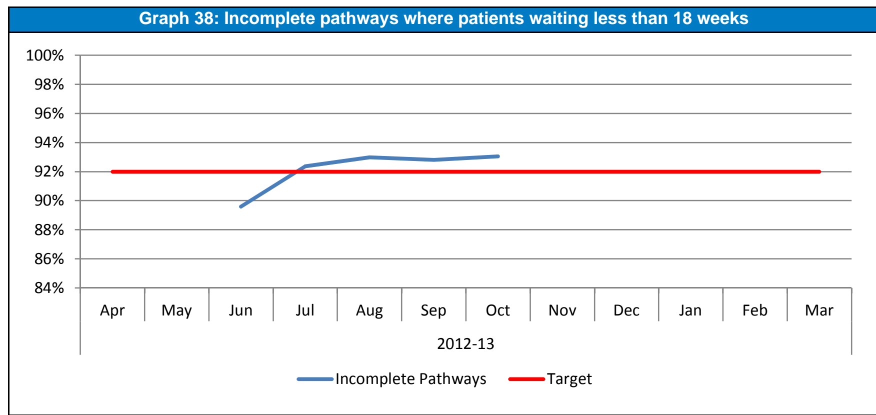
Graph 36: Patients Seen Within 18 Weeks For Admitted Treatment



Graph 37: Patients Seen Within 18 Weeks For Non-Admitted Treatment



Graph 38: Incomplete pathways where patients waiting less than 18 weeks



Source: Information Team

OPS 5: Elective Access - Diagnostics - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 7
Elective Access - Diagnostics	Patients waiting 6 weeks or more for a diagnostic test	<1	%	0.06 ●

Graph 39: Patients waiting 6 weeks or more for a Diagnostic Test

Source: Information Team

Diagnostic waiting list and Breaches waiting more than 6 weeks

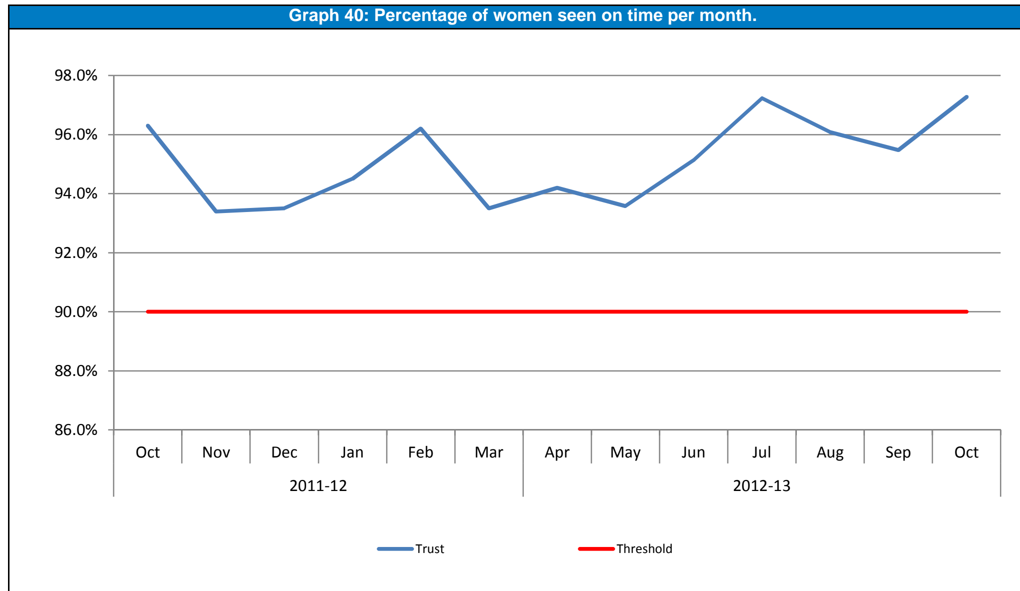
April		May		June		July		August		September	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches
7379	8	7393	3	7287	3	7237	4	7632	6	7057	6

October		November		December		January		February		March	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches
7978	5										

OPS 6: Maternity - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 7		Year to Date	
Maternity Access - by 12 weeks and 6 days	Women who have seen a Midwife by 12 weeks And 6 days of pregnancy who were referred on time	90.0	%	97.3	●	95.6	●

Trust Board Performance Report



Source: Information Team

OPS 7: Delayed Transfer of Care - **NHS Performance Framework 2012/13 Indicator & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Quarter 2	Year to date
Delayed Transfer of Care	Average number of Acute patients (aged 18+) per day whose transfer of care was delayed	3.5	%	1.62 ●	2.07 ●

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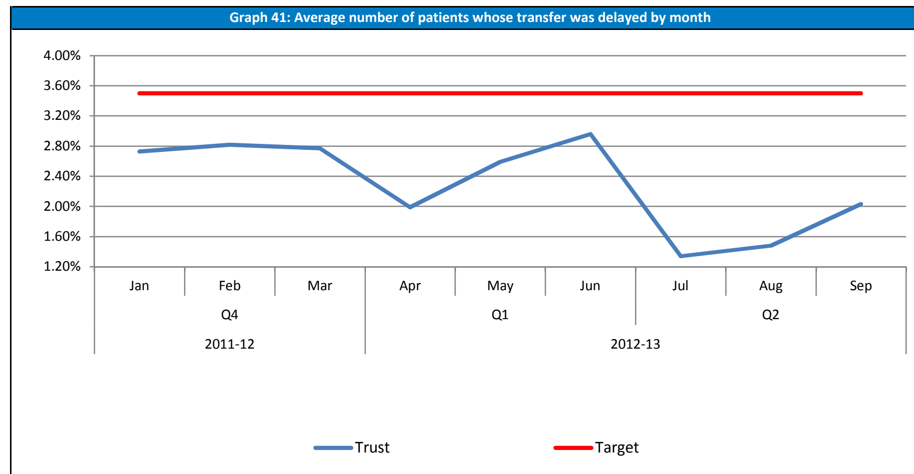


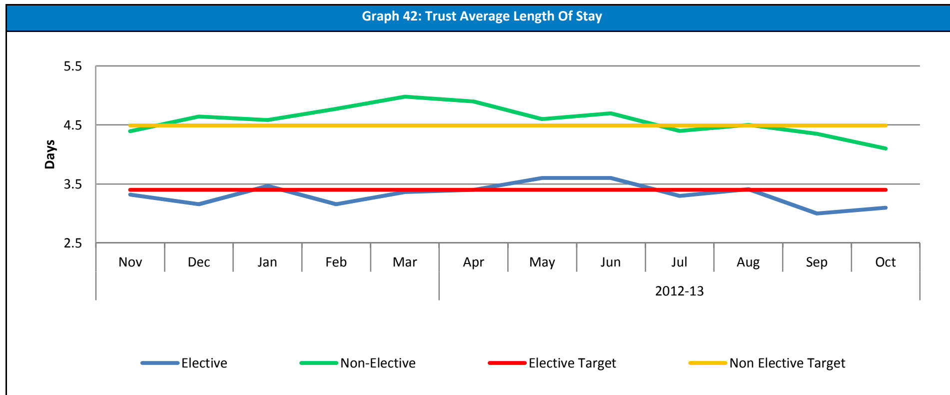
Source: Discharge Team, Clinical Site Management Team & Information Team

OPS 8: Quality, Innovation, Productivity and Prevention - **Supports Compliance with Care Quality Commission Outcome 4**

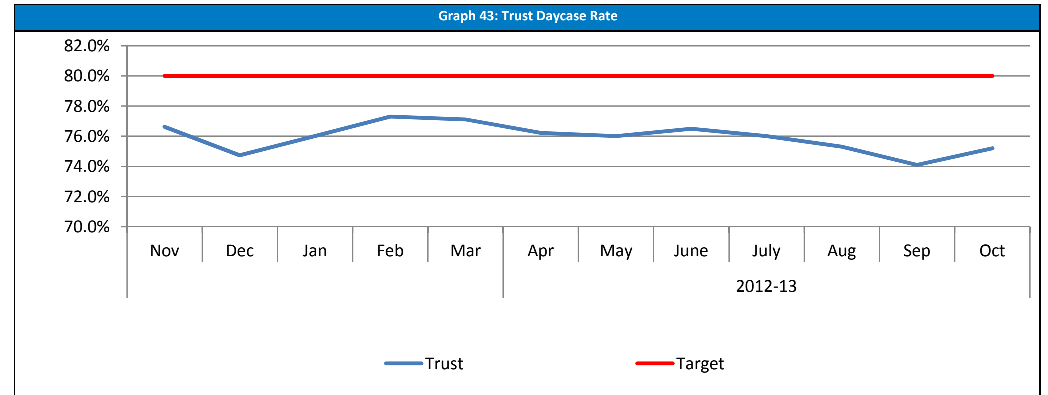
Domain	Indicator	Target	Unit	Month 7		Year to date	
Productivity	Average Elective Length of Stay	3.40	Days	3.60	●	3.30	●
	Average Non-Elective Length of Stay	4.49	Days	4.60	●	4.60	●
	Daycase Rate	80.0	%	76.51	●	75.9	●
	New to Follow Up Outpatient Ratio	1.67	Ratio	2.37	●	2.38	●
	Theatre Utilisation Rate	>= 81	%	80.43	●	78.6	●

Trust Board Performance Report

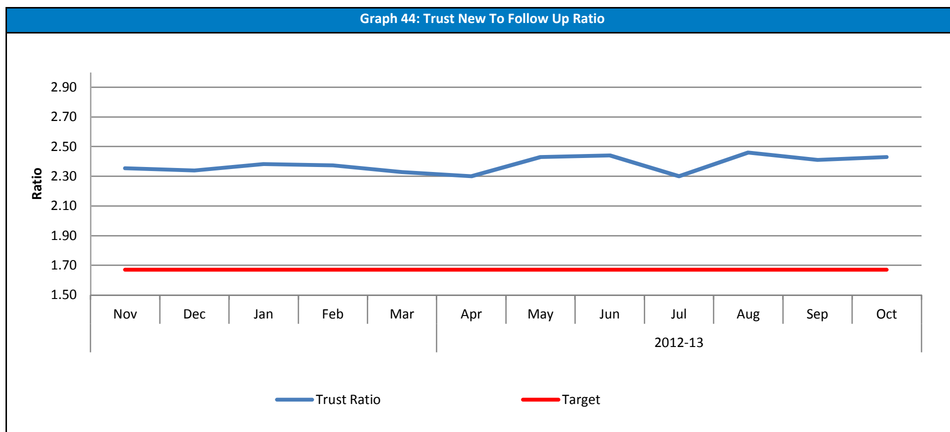
Graph 42: Trust Average Length Of Stay



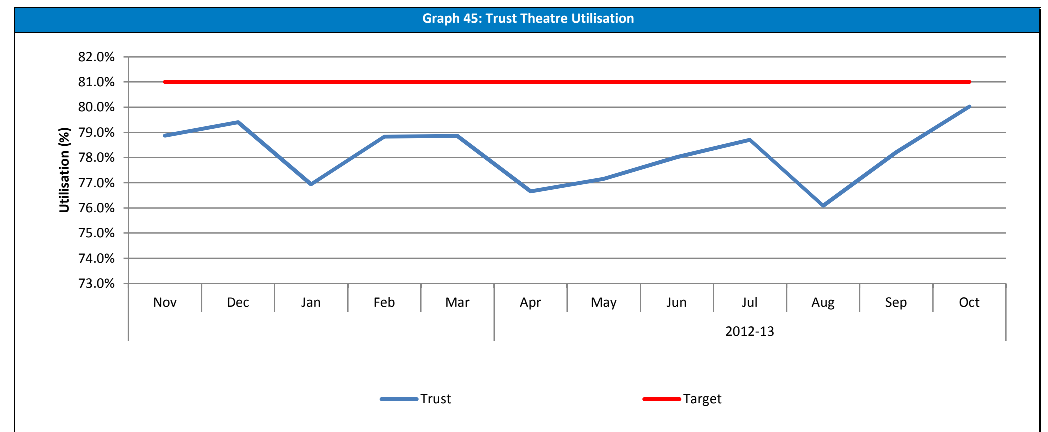
Graph 43: Trust Daycase Rate



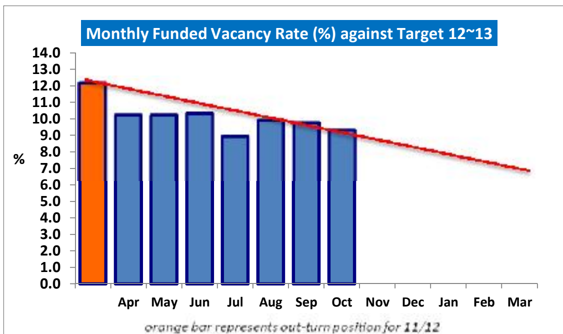
Graph 44: Trust New To Follow Up Ratio



Graph 45: Trust Theatre Utilisation

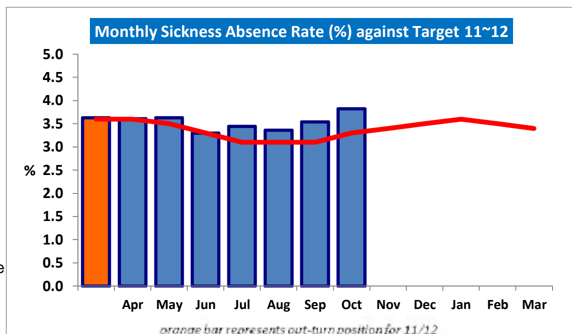


Source: Information Team, Finance Team & Theatre's Team



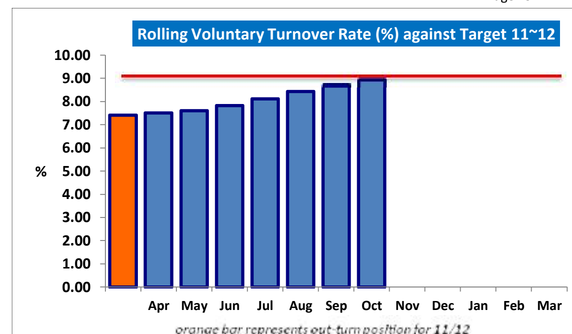
VACANCY RATE TARGET (YEAR-END)	<7.0%
In month POSITION against target	9.3%

vacancy rate derived from GL WTE and ESR staff inpost WTE



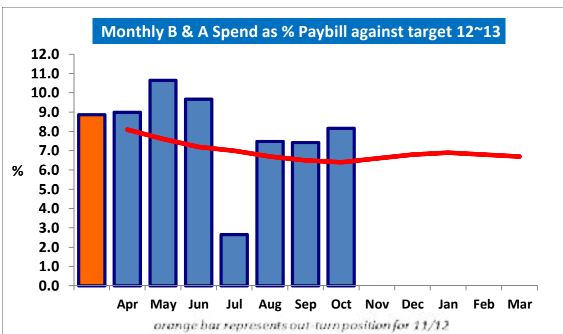
SICKNESS RATE TARGET (YEAR-END)	<3.4%
CURRENT in-month POSITION against target	3.8%
12 Month Rolling POSITION	3.7%

sickness rate respresents % of contracted hours lost to sickness

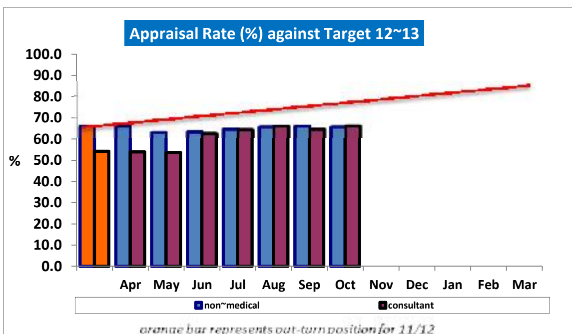


TURNOVER RATE TARGET (YEAR-END)	<9.0%
12 Month Rolling POSITION against target	8.9%

note that from April 2012, 'retirement' is now included in voluntary turnover

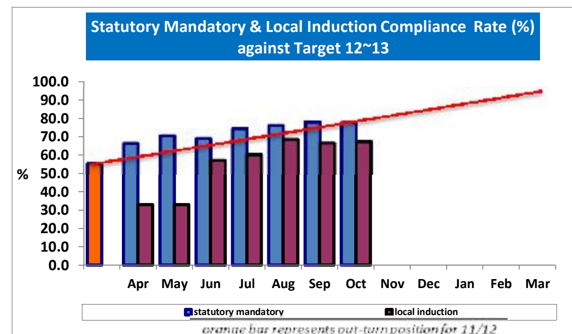


B&A SPEND as% PAYBILL TARGET (YEAR-END)	<7.0%
CURRENT in-month POSITION against target	8.2%
12 Month Rolling POSITION	8.1%



APPRAISAL RATE TARGET (YEAR-END)	>85.0%
NON~MEDICAL STAFF ~ CURRENT POSITION	65.6%
CONSULTANT APPRAISAL ~ CURRENT POSITION	66.1%

% of current staff who have had an appraisal in the last 12 months



EWTD COMPLIANCE RATE TARGET	>95.0
STATUTORY MANDATORY ~ CURRENT POSITION	77.3%
LOCAL INDUCTION ~ CURRENT POSITION	67.0%

Staff Numbers: Substantively employed staffing numbers at the end of October were 8708 WTE; this is 195 WTE fewer than at the end of March 2012 (2.19% reduction). Within the staff groups, this reduction is seen as follows; A&C/Snr.Mgr = 49 WTE, AHP/S&T/PHA = 61 WTE, M&D = 32 WTE, N&M = 53 WTE.

Bank & Agency Spend: YTD bank and agency spend accounts for £22.14m or 8.1% of the total YTD paybill, against full-year target of 7.0%. Of the spend in Month 7, £1.59m is attributable to agency spend with £1.84m attributable to bank spend. When comparing the YTD position to the same period last year, we see a reduction of 16.5% (£4.39m) in total bank and agency expenditure.

Pay Expenditure: Total pay expenditure in Month 7 was £42.08m against a pay budget of £42.41m giving an underspend of £326k. The YTD pay spend against budget position is a favourable variance of £5.35m.

Vacancy: The vacancy rate against the funded WTE establishment (as stated on the General Ledger) was 9.3% at the end of October, the equivalent of 889 WTE; most of which are covered by locums / temporary staff leaving 119 WTE unfilled (1.24% of the total funded WTE).

Turnover: There were a total of 79 voluntary leavers on October, bringing the 12-month rolling position to 8.9%; remaining just within the 9.0% target for the year. With the ending of enforced retirement at 65, retirees have been included in the voluntary turnover figures since April 2012; contributing to the increase in the turnover rate. It is expected that the year-end position will be in the region of 10.0%.

Sickness: Recorded sickness absence increased in October from 3.54% to 3.82%; an increase of 7.9% (an additional 3,864 working hours lost). In October, a total of 54,774 working hours were lost to sickness absence (of which 28% is attributable to long-term illness); the equivalent of 336 WTE. The recorded levels of sickness absence attributable to Cold and Respiratory illness, has doubled in October; an increase of 37% was seen during the same period last year. Against target, the 12-month rolling position for sickness absence is now at 3.7% and is significantly above the 3.4% target for this year. A new attendance management policy was agreed this month which is designed to improve our control in this area.

Appraisal: The non-medical appraisal rate rose by one point to 65.6% with CPG's ranging from 52 to 85% and Corporate Directorates from 0 to 90%. The appraisal rate for Consultant staff remains at 66%; ranging from 44 to 85% within the CPG's. The year-end target for both measures is 85%. Both The HRD an COO are reviewing the action required to achieve our year-end target.

Statutory Mandatory & Local Induction: Statutory Mandatory training compliance for non-medical staff remains on target at 77%. Local Induction compliance stands at 67.0% in month and remains below target at present. The year-end target for both measures is 95%.

* the figures and information contained in this analysis relates to CPG/Corporate/Private Patients only

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 10**

Report Title: Finance Performance Report

To be presented by: Mr. Bill Shields, Chief Financial Officer

Chief Financial Officer's message:

The Trust had a surplus in month of £2,163k, of which £1,549k is non recurrent income relating to the overage on disposal of the lease of Acton Hospital. Overall a favourable variance of £499k against the plan was reported in month; which means the year to date position, at month 7, is a surplus of £5,120k against a planned surplus of £3,322k. The continued recurrent improvement reflects the cost reduction achieved across the Trust.

CIP delivery is now ahead of plan by £1,442k year to date. Despite this good performance the remainder of the year is more difficult and has a higher percentage of CIPs to be delivered. The CIP Board will continue to monitor performance supported by the CIP Delivery Board.

Key Issues for discussion:

Continued improvement required in future months through improved performance against CIPs.

Legal Implications or Review Needed

a. Yes ☐
b. No ✓

Details of Legal Review, if needed

N/A

Link to the Trust's Key Objective

5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision ☐
b. For information/noting ✓

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FINANCE REPORT - OCTOBER 2012

1 Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 31st October 2012.

1.2 The narrative report is intended to provide a more focussed statement of the main drivers of the financial performance and direct the audience to the appendix for further explanation.

1.3 This month's finance report includes the agreed forecast surplus of £5.4m with NHS London. The forecast Income & Expenditure figures reflect the half yearly accounts submitted to the Department of Health adjusted for the non-recurring income for the overage on the lease of Acton Hospital. The forecast outturn will be reviewed and updated at the end of quarter3.

2 Overview of Financial Performance (Pages 1, 2, 3)

2.1 **Statement of Comprehensive Income (I&E Account)** - The Trust's financial position for the month is a **surplus** of £2,163k, with a year to date surplus of £5,120k.The Trust achieved a **favourable variance** of £499k in month.

2.2 **PCT Service Level Agreement (SLA) Income**–The PCT SLA contract monitoring report for the month of October was calculated using the month 6actual data and adjusted for the new planned monthly profile within the SLA.

2.3 **Other Income**- Other Income includes funding from the SHA for Cerner & Project Diamond of £1,750k and £3,500k respectively; final confirmation of funding is still awaited. In addition this month includes a non recurrent gain of £1,549k for the sale of the lease of Acton Hospital.

2.4 **Expenditure**- Pay expenditure shows a **favourable** variance of £5,132k year to date. Non pay expenditure for drugs and clinical supplies is showing a **favourable** variance year to date of £9,086k, this mainly relates to a favourable variance for non-PbR drugs. The adverse variance on Other Non-Pay relates to provisions for additional anticipated cost pressures and the re-mapping of pay recharges.

2.5 **Non resident payments**– a revised policy has been approved which ensures the Trust is following the latest national guidance on ensuring patients who are not entitled to free NHS care are invoiced for their care.

3 Monthly Performance (Page 4& 5)

3.1 The performance of the CPGs and Corporate Services reflect the agreed budget allocations. The focus is on the forecast outturn and reducing run rates of expenditure rather than just the position against the plan.

3.2 There needs to be continued focus on CIP delivery thereby reducing unit costs and securing a reduction in the current expenditure run rate, which is key to delivering the financial plan for the year.

3.3 The Corporate Directorates' expenditure is, on the whole, in line with the plan. A CIP phasing is, however, more heavily weighted towards the end of the year, the focus needs to be to continue to ensure expenditure reduction in line with CIP achievement.

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4 Cost Improvement Plan (Page 6)

4.1 The CIP plan for the year is £52.1m, (full year effect £62m).

4.2 Actual achievement of new CIP schemes in October was £5.2m (year to date £26.7m) of which £1.8m is central schemes. To date there is a favourable variance of £1.4m.All central schemes have now been allocated to CPGs and Corporate Services.

4.3 The CIP Delivery Board is closely monitoring the position and further plans are being developed to ensure delivery of the 2012/13 target. In addition, work is progressing on the schemes for 2013/14.

5 Statement of Financial Position (Balance Sheet -Page7)

5.1 The overall movement in balances when compared to the previous month is £2.2m.

5.2 The most significant movement on the balance sheet is an increase in cash of £17.5mrelatingmainly to the advance payment of SLA income(£4.7m) and R&D funding (£7.5m).

6 Capital Expenditure (Page 8)

6.1 Expenditure in month was £2.3m (£7.0m year to date) which is a favourable variance to the plan.

6.2 Expenditure is behind plan by £2.9m due to the delay in the approval of the RIS/PACS business case; backlog maintenance and IT both starting more slowly than planned.

7 Cash (Page 9)

7.1 The cash profile has been set out as per the plan to NHS London. The two key movements in the year relate to the advance payment of SLA income and funding received for new R+D projects. Cash is ahead of plan at month 7 due to payments to suppliers (including capital) and payroll payments being lower than the year to date plan.

8 Monitor metrics – Financial Risk Rating (Page 10)

8.1 The Trust's overall financial risk rating is a FRR of 3based on the results in October. All risk metrics were on plan for October. A score of 3 is mandatory for Foundation Trust status.

9 Conclusions & Recommendations

The Board is asked to note:

- The surplus of £2,163k for the month of October, the cumulative surplus of £5,120k, and the favourable variances, in month and cumulatively, of £499k and £3,322k respectively.
- The income position is supported by Project Diamond and Cerner income which has yet to be finalised with NHS London.
- Actual achievement of new CIP schemes in month 7 was £5.2m which is now above the average monthly run rate required of £4.4m to achieve the full year target of £52.1m.
- That further plans are being developed to ensure delivery of the 2012/13 CIP target.

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Prepared by Mark Collis, Deputy Director of Finance & Marcus Thorman, Director of Operational Finance

Imperial College Healthcare NHS
NHS Trust

Contents

Finance Performance Report for the month ending 31st October 2012

Page	Description	Risk		Report Status
		Month 7	Month 6	
1	Statement of Comprehensive Income (SOCI)	G	G	Attached
2	Income Report	A	A	Attached
3	Expenditure Report	G	G	Attached
4	Clinical Programme Groups Financial Performance	R	R	Attached
5	Corporate Services Financial Performance	G	G	Attached
6	Cost Improvement Plan	A	A	Attached
7	Statement of Financial Position (Balance Sheet)	G	G	Attached
8	Capital Expenditure Report	A	A	Attached
9	Cash Flow Report	G	G	Attached
10	Financial Risk Rating	G	G	Attached
11	SLA Activity & Income Performance	A	A	Attached
12	Risk Analysis	A	A	Attached

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PAGE 1 - STATEMENT OF COMPREHENSIVE INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income									
Clinical	65,248	64,783	(465)	437,802	436,771	(1,031)	748,559	746,909	(1,650)
Research & Development	4,380	4,498	118	30,660	30,559	(101)	52,561	52,561	0
Training & Education	5,301	5,275	(26)	37,109	36,677	(432)	63,616	62,366	(1,250)
Other	7,105	8,029	924	49,855	49,295	(560)	85,380	86,782	1,402
TOTAL INCOME	**82,034**	**82,585**	**551**	**555,426**	**553,302**	**(2,124)**	**950,116**	**948,618**	**(1,498)**
Expenditure									
Pay - In post	(39,757)	(39,433)	324	(280,134)	(277,087)	3,047	(476,744)	(473,661)	3,083
Pay - Bank & Agency	(4,143)	(3,733)	410	(26,529)	(24,444)	2,085	(45,487)	(42,392)	3,095
Drugs & Clinical Supplies	(18,635)	(16,735)	1,900	(125,822)	(116,736)	9,086	(213,774)	(200,927)	12,847
General Supplies	(3,658)	(3,645)	13	(25,608)	(24,872)	736	(43,900)	(44,537)	(637)
Other	(9,143)	(11,832)	(2,689)	(60,502)	(69,662)	(9,160)	(109,325)	(121,035)	(11,710)
TOTAL EXPENDITURE	**(75,336)**	**(75,379)**	**(43)**	**(518,595)**	**(512,800)**	**5,795**	**(889,230)**	**(882,553)**	**6,677**
EBITDA	**6,698**	**7,206**	**508**	**36,831**	**40,501**	**3,671**	**60,886**	**66,066**	**5,179**
Financing Costs	(5,034)	(5,042)	(8)	(35,033)	(35,382)	(349)	(60,386)	(60,651)	(265)
SURPLUS / (DEFICIT) before Impairment	**1,664**	**2,163**	**499**	**1,798**	**5,120**	**3,322**	**500**	**5,415**	**4,914**
Impairment of Assets	0	0	0	0	0	0	0	(4,701)	(4,701)
SURPLUS / (DEFICIT)	**1,664**	**2,163**	**499**	**1,798**	**5,120**	**3,322**	**500**	**714**	**0**

Surplus / (Deficit): The Trust delivered an Income and Expenditure surplus in month of £2,163k, a favourable variance of £499k against the plan. Cumulatively, at month 7, the Trust has delivered a surplus of £5,120k. The actual achievement of CIP schemes in month 7 was £5,161k, cumulative £26,671k. This is £1,442k above the required planned achievement of £25,229k in order to reach the full year target of £52,140k.
Income: Income includes projected funding from NHS London for Cerner & Project Diamond, however, final confirmation of funding is still awaited. Other income included the receipt of £1.5m from overage on disposal of the lease of Acton Hospital which is the main attributable factor to this month's surplus. The adverse variance in month for clinical income can be mainly associated with Private Patients income not achieving the revised increase in the planning target following the re-opening of the Lindo.

Expenditure: Total Pay expenditure is consistent with the previous month. Continued focus is required by Clinical Programme Groups to reduce this down to the budgeted levels. Non Pay is under-spent by £1,666k in month and is mainly attributable to drug expenditure being less than planned.

Forecast Outturn: This month's finance report includes the agreed forecast surplus of £5,415k with the NHS London. The forecast has increased by £1.5m due to additional non-recurring non-clinical income for overage on disposal of the lease of Acton Hospital. The forecast will be reviewed again at the end of the next financial quarter in December. We have included an estimate for impairment on assets of £4.7m, however, this loss is deemed to be below the line when reporting the Trust's financial performance.

Statement of Comprehensive Income (SOCI)	**Risk:**	**G**

PAGE 2 - INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income from Clinical Activities									
North West London Sector PCTs	43,541	43,541	0	293,719	293,719	0	500,000	500,000	0
Rest of London PCTs	5,970	5,927	(43)	40,175	40,297	121	68,420	68,420	0
Other PCTs	6,354	5,935	(420)	43,132	40,955	(2,177)	73,490	71,901	(1,589)
Specialist Commissioning	4,155	4,309	154	27,680	27,923	243	47,753	47,753	0
Other SLAs	549	(1,802)	(2,351)	3,428	1,440	(1,988)	6,843	6,843	0
Other NHS Organisations	831	3,581	2,750	5,821	11,321	5,500	9,514	13,056	3,542
Sub-Total NHS Income	**61,399**	**61,490**	**91**	**413,955**	**415,654**	**1,700**	**706,020**	**707,973**	**1,953**
Private Patients	3,399	2,902	(497)	20,697	17,773	(2,924)	37,139	33,029	(4,110)
Overseas Patients	150	151	1	1,050	1,052	2	1,800	1,803	3
NHS Injury Scheme	100	79	(21)	700	700	(0)	1,200	1,242	42
Non NHS Other	200	161	(39)	1,400	1,592	192	2,400	2,862	462
Total - Income from Clinical Activities	**65,248**	**64,783**	**(465)**	**437,802**	**436,771**	**(1,031)**	**748,559**	**746,909**	**(1,650)**
Other Operating Income									
Research & Development	4,380	4,498	118	30,660	30,559	(101)	52,561	52,561	0
Training & Education	5,301	5,275	(26)	37,109	36,677	(432)	63,616	62,366	(1,250)
Non patient care activities	2,833	2,508	(325)	19,831	19,244	(587)	33,996	33,471	(525)
Income Generation	600	2,022	1,422	4,200	4,109	(91)	7,200	5,673	(1,527)
Other Income	3,672	3,499	(173)	25,824	25,942	118	44,184	47,638	3,454
Total - Other Operating Income	**16,786**	**17,802**	**1,016**	**117,624**	**116,531**	**(1,093)**	**201,557**	**201,709**	**152**
TOTAL INCOME	**82,034**	**82,585**	**551**	**555,426**	**553,302**	**(2,124)**	**950,116**	**948,618**	**(1,498)**

Income from Clinical Activities: North West London (NWL) income reflects the block contract of £500m agreed with the NWL Commissioners. The underperformance for other PCTs is attributable to lower levels of activity in Critical Care, Bariatrics and Cardiology. Private Patient actual income has increased by £322k when compared to last month. Lindo income has steadily been increasing and this month's income of £888k is 91% of the new target. Other SLAs includes a re-mapping of income following the issue of the new Manual of Accounts.

Other Operating Income: Income Generation includes £1.5m for overage on disposal of the lease of Acton Hospital. Other Income includes funding from NHS London for Cerner & Project Diamond, however, final confirmation of funding is still awaited. Total Cerner funding has been reduced to £3m and Project Diamond increased to £8m in line with revised expectations following discussions with the DH and NHS London.

Statement of Comprehensive Income (SOCI)	**Risk:**	**A**

PAGE 3 - EXPENDITURE

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Pay - In Post									
Medical Staff	(12,715)	(12,708)	7	(91,071)	(88,826)	2,245	(153,907)	(152,236)	1,671
Nursing & Midwifery	(12,666)	(12,359)	307	(87,629)	(86,700)	929	(150,262)	(147,264)	2,998
Scientific, Therapeutic & Technical staff	(5,929)	(5,774)	155	(41,797)	(40,562)	1,235	(70,686)	(69,577)	1,109
Healthcare assistants and other support staff	(1,973)	(2,079)	(106)	(13,938)	(14,676)	(738)	(23,831)	(25,194)	(1,363)
Directors and Senior Managers	(2,470)	(2,563)	(93)	(17,352)	(18,033)	(681)	(29,697)	(30,422)	(725)
Administration and Estates	(4,004)	(3,951)	53	(28,347)	(28,290)	57	(48,361)	(48,968)	(607)
Sub-total - Pay In post	**(39,757)**	**(39,433)**	**324**	**(280,134)**	**(277,087)**	**3,047**	**(476,744)**	**(473,661)**	**3,083**
Pay - Bank/Agency									
Medical Staff	(273)	(609)	(336)	(2,318)	(3,870)	(1,552)	(3,617)	(6,521)	(2,904)
Nursing & Midwifery	(1,552)	(1,296)	256	(10,252)	(7,996)	2,256	(17,593)	(14,374)	3,219
Scientific, Therapeutic & Technical staff	(490)	(308)	182	(3,501)	(2,324)	1,177	(5,772)	(4,032)	1,740
Healthcare assistants and other support staff	(337)	(346)	(9)	(2,392)	(2,156)	236	(4,084)	(3,620)	464
Directors and Senior Managers	(442)	(405)	37	(3,082)	(2,612)	470	(5,292)	(4,412)	880
Administration and Estates	(1,049)	(769)	280	(4,984)	(5,486)	(502)	(9,129)	(9,433)	(304)
Sub-total - Pay Bank/Agency	**(4,143)**	**(3,733)**	**410**	**(26,529)**	**(24,444)**	**2,085**	**(45,487)**	**(42,392)**	**3,095**
Non Pay									
Drugs	(9,557)	(8,995)	562	(64,211)	(55,994)	8,217	(108,960)	(94,923)	14,037
Supplies and Services - Clinical	(9,078)	(7,740)	1,338	(61,611)	(60,742)	869	(104,814)	(106,004)	(1,190)
Supplies and Services - General	(3,658)	(3,645)	13	(25,608)	(24,872)	736	(43,900)	(44,537)	(637)
Consultancy Services	(1,042)	(925)	117	(7,292)	(7,344)	(52)	(12,500)	(12,561)	(61)
Establishment	(700)	(681)	19	(4,900)	(4,531)	369	(8,400)	(7,646)	754
Transport	(750)	(764)	(14)	(5,250)	(5,117)	133	(9,000)	(8,684)	316
Premises	(2,800)	(3,350)	(550)	(19,600)	(20,330)	(730)	(33,600)	(33,446)	154
Other	(3,851)	(6,113)	(2,262)	(23,460)	(32,339)	(8,879)	(45,825)	(58,698)	(12,873)
Sub-total - Non Pay	**(31,436)**	**(32,212)**	**(776)**	**(211,932)**	**(211,270)**	**662**	**(366,999)**	**(366,499)**	**500**
TOTAL EXPENDITURE	**(75,336)**	**(75,379)**	**(43)**	**(518,595)**	**(512,800)**	**5,795**	**(889,230)**	**(882,553)**	**6,677**
Financing Costs									
Interest Receivable	19	20	1	132	143	11	225	247	22
Interest Payable	(153)	(154)	(1)	(1,072)	(1,084)	(12)	(1,838)	(1,838)	0
Other Gains & Losses	0	0	0	0	(188)	(188)	0	(188)	(188)
Depreciation	(3,073)	(3,113)	(40)	(21,310)	(21,501)	(191)	(36,860)	(37,145)	(285)
Public Dividend Capital	(1,827)	(1,795)	32	(12,783)	(12,752)	31	(21,913)	(21,727)	186
TOTAL - FINANCING COSTS	**(5,034)**	**(5,042)**	**(8)**	**(35,033)**	**(35,382)**	**(349)**	**(60,386)**	**(60,651)**	**(265)**

Pay: Total pay expenditure is consistent with the previous month. However, improved controls are planned and HR and Finance are working on simplifying the weekly and monthly reporting to assist managers in reviewing the hours worked and paid.

Non Pay: The increase in month drug expenditure, when compared to previous months is due to increase spend on PbR exclusions, and the home delivery service. The adverse in month for Premises is associated with higher level of spend on IT hardware & software and building contracts. The adverse year to date variance on Other Non Pay relates to provisions for additional anticipated cost pressures and the re-mapping of pay recharges.

Financing costs: The costs are slightly above plan, but are based on actual costs. Other Gains & Losses relates decommissioned equipment being written off.

Statement of Comprehensive Income (SOCI)	**Risk:**	**G**

PAGE 4 - Clinical Programme Groups Financial Performance

	Risk Rating	In Month (Oct)			Year To Date (Cumulative)			FORECAST
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
CPG 1 - Medicine								
Income		521	540	19	4,499	4,709	210	
Pay		(6,990)	(7,017)	(27)	(50,513)	(49,623)	890	
Non Pay		(5,072)	(5,681)	(609)	(36,521)	(39,590)	(3,069)	
TOTAL	R	**(11,541)**	**(12,158)**	**(617)**	**(82,535)**	**(84,504)**	**(1,969)**	**(3,983)**
CPG 2 - Surgery and Cancer								
Income		102	92	(9)	711	624	(87)	
Pay		(3,674)	(3,892)	(219)	(26,543)	(27,298)	(754)	
Non Pay		(2,511)	(2,747)	(236)	(17,745)	(18,598)	(854)	
TOTAL	R	**(6,083)**	**(6,547)**	**(464)**	**(43,577)**	**(45,272)**	**(1,695)**	**(3,009)**
CPG 3 - Specialist Services 1								
Income		220	289	68	1,557	1,725	167	
Pay		(7,158)	(7,045)	113	(49,346)	(49,170)	176	
Non Pay		(4,961)	(5,231)	(269)	(35,038)	(35,235)	(197)	
TOTAL	G	**(11,899)**	**(11,987)**	**(88)**	**(82,827)**	**(82,681)**	**146**	**248**
CPG 4 - Cardiac & Renal								
Income		317	394	77	2,538	2,886	348	
Pay		(5,009)	(4,932)	77	(35,766)	(35,148)	618	
Non Pay		(5,715)	(5,910)	(196)	(40,607)	(41,634)	(1,027)	
TOTAL	A	**(10,408)**	**(10,449)**	**(41)**	**(73,835)**	**(73,896)**	**(60)**	**(181)**
CPG 5 - Women's and Children's								
Income		564	491	(73)	3,943	4,257	313	
Pay		(5,687)	(5,731)	(44)	(39,613)	(39,679)	(66)	
Non Pay		(1,872)	(1,954)	(82)	(12,929)	(13,860)	(931)	
TOTAL	R	**(6,995)**	**(7,194)**	**(199)**	**(48,598)**	**(49,282)**	**(684)**	**(1,402)**
CPG 6 - Clinical Investigative Sciences								
Income		1,407	1,319	(88)	13,708	13,252	(457)	
Pay		(7,815)	(7,764)	51	(56,019)	(54,770)	1,249	
Non Pay		(353)	(626)	(273)	(1,841)	(2,164)	(323)	
TOTAL	G	**(6,761)**	**(7,071)**	**(309)**	**(44,152)**	**(43,683)**	**469**	**71**
CPG 7 - Interventional Public Health								
Income		654	621	(33)	4,629	4,413	(215)	
Pay		(364)	(332)	32	(2,596)	(2,461)	136	
Non Pay		(292)	(302)	(9)	(2,074)	(2,169)	(95)	
TOTAL	R	**(2)**	**(12)**	**(10)**	**(42)**	**(216)**	**(174)**	**(328)**

Significant changes in forecast outturn are noted as:
-CPG1 (£505k) - PbR excluded drugs and R&D
-CPG2 (£218k) - PbR excluded drugs and delayed bed closures
-CPG6 (£705k) - Pathology recharges to other CPGs lower than previously forecast

Forecast outturns will be subject to detailed review to ensure that forecast CIP savings are fully reflect in improved financial performance.

Statement of Comprehensive Income (SOCI)	**Risk:**	R

PAGE 5 - Corporate Service Financial Performance

		In Month (Oct)			Year To Date (Cumulative)			FORECAST
	Risk Rating	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Corporate Governance								
Income		2	2	0	14	14	1	
Pay		(106)	(101)	4	(747)	(716)	31	
Non Pay		(28)	(27)	1	(195)	(182)	13	
TOTAL	G	**(131)**	**(126)**	**6**	**(928)**	**(884)**	**44**	**70**
Chief Executive Office								
Income		26	26	1	179	183	4	
Pay		(151)	(125)	26	(942)	(856)	86	
Non Pay		(82)	(80)	3	(837)	(854)	(16)	
TOTAL	G	**(207)**	**(178)**	**29**	**(1,600)**	**(1,526)**	**73**	**123**
Director Of Education								
Income		78	78	0	151	151	(0)	
Pay		(37)	(32)	5	(259)	(242)	17	
Non Pay		(155)	(154)	0	(446)	(446)	(0)	
TOTAL	G	**(114)**	**(108)**	**5**	**(554)**	**(537)**	**17**	**42**
Director Of Operations								
Income		153	168	15	1,142	1,180	39	
Pay		(866)	(815)	51	(6,222)	(5,778)	444	
Non Pay		(395)	(394)	1	(2,892)	(2,745)	147	
TOTAL	G	**(1,108)**	**(1,040)**	**67**	**(7,972)**	**(7,343)**	**629**	**964**
Estates Directorate								
Income		715	836	121	4,891	5,228	337	
Pay		(763)	(765)	(2)	(5,499)	(5,551)	(53)	
Non Pay		(1,189)	(1,499)	(310)	(7,776)	(8,421)	(645)	
TOTAL	A	**(1,237)**	**(1,428)**	**(191)**	**(8,384)**	**(8,745)**	**(361)**	**(941)**
Finance Directorate								
Income		13	11	(2)	172	193	21	
Pay		(630)	(576)	54	(4,174)	(3,794)	380	
Non Pay		(1,384)	(1,396)	(13)	(10,076)	(9,960)	116	
TOTAL	G	**(2,000)**	**(1,960)**	**40**	**(14,078)**	**(13,561)**	**517**	**603**
Human Resources								
Income		257	313	56	1,806	2,067	261	
Pay		(511)	(479)	32	(3,580)	(3,364)	216	
Non Pay		(257)	(280)	(23)	(1,719)	(1,824)	(105)	
TOTAL	G	**(511)**	**(446)**	**64**	**(3,493)**	**(3,121)**	**372**	**594**
Infection Control Directorate								
Income		0	0	0	22	22	0	
Pay		(147)	(142)	5	(1,119)	(990)	129	
Non Pay		(10)	(4)	6	(589)	(614)	(25)	
TOTAL	G	**(156)**	**(146)**	**11**	**(1,686)**	**(1,583)**	**103**	**135**
Information & Comms Technology								
Income		133	139	7	928	971	43	
Pay		(1,150)	(1,114)	36	(7,947)	(7,658)	289	
Non Pay		(907)	(900)	7	(6,519)	(6,544)	(25)	
TOTAL	G	**(1,924)**	**(1,875)**	**50**	**(13,539)**	**(13,231)**	**308**	**508**
Medical Director								
Income		2	5	3	118	171	52	
Pay		(207)	(175)	31	(1,550)	(1,340)	210	
Non Pay		(86)	(46)	40	(522)	(476)	46	
TOTAL	G	**(291)**	**(216)**	**75**	**(1,954)**	**(1,646)**	**308**	**527**
Nursing & Operations Directorate								
Income		6	6	0	6	6	0	
Pay		(215)	(205)	11	(1,469)	(1,345)	125	
Non Pay		(68)	(77)	(9)	(459)	(454)	5	
TOTAL	G	**(278)**	**(276)**	**2**	**(1,922)**	**(1,793)**	**130**	**234**
Press & Communications								
Income		2	(1)	(3)	12	9	(3)	
Pay		(81)	(83)	(2)	(548)	(567)	(19)	
Non Pay		(8)	(10)	(2)	(55)	(47)	8	
TOTAL	A	**(87)**	**(94)**	**(7)**	**(592)**	**(606)**	**(14)**	**(30)**
Private Patients								
Income		2,426	2,257	(169)	16,982	13,114	(3,868)	
Pay		(850)	(759)	92	(6,146)	(4,793)	1,353	
Non Pay		(522)	(477)	45	(3,652)	(2,513)	1,139	
TOTAL	R	**1,054**	**1,021**	**(33)**	**7,184**	**5,808**	**(1,376)**	**(1,537)**
TOTAL								
Income		3,813	3,841	28	26,423	23,310	(3,113)	
Pay		(5,714)	(5,371)	343	(40,203)	(36,996)	3,207	
Non Pay		(5,091)	(5,344)	(253)	(35,738)	(35,081)	656	
TOTAL		**(6,991)**	**(6,874)**	**118**	**(49,517)**	**(48,768)**	**750**	**1,292**

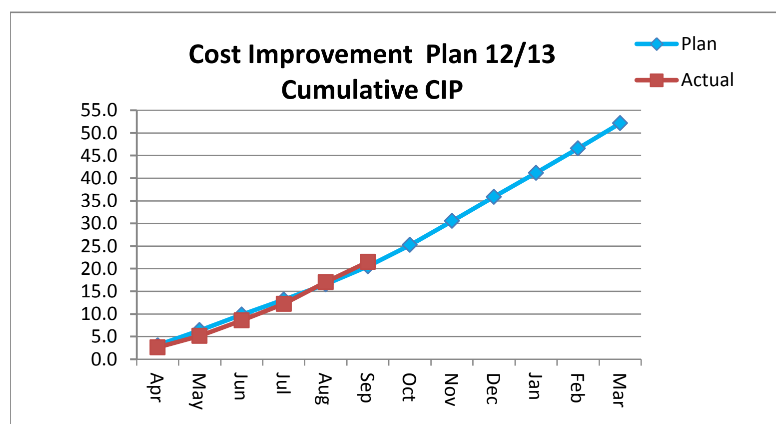
No change to the overall forecast for Corporate Services from last month.

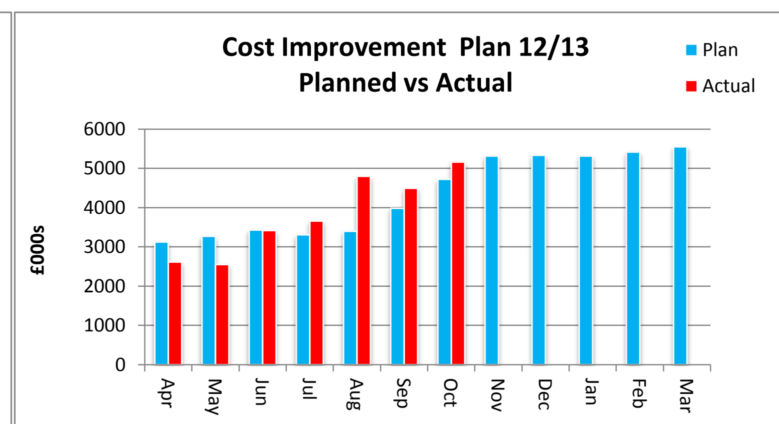
Forecast outturns will be subject to detailed review to ensure that forecast CIP savings are fully reflect in improved fina ncial performance.

Statement of Comprehensive Income (SOCI)	**Risk:**	**G**

PAGE 6 - COST IMPROVEMENT PLAN (CIP)

CIPS	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
CPG1 - Medicine	935	863	(72)	3,130	2,560	(570)	7,905	5,760	(2,145)
CPG2 - Surgery & Cancer	448	477	29	2,008	1,860	(148)	4,292	3,782	(510)
CPG3 - Specialist Services	695	1,042	347	4,497	3,381	(1,116)	7,990	6,493	(1,497)
CPG4 - Cardiology & Renal	553	670	117	4,320	4,387	67	7,318	8,223	905
CPG5 - Women's & Children	409	327	(82)	2,815	2,360	(455)	5,046	4,288	(758)
CPG6 - CIS	637	608	(29)	3,377	4,083	706	7,485	7,716	231
Corporate Services	1,065	1,126	61	5,610	6,053	443	11,065	12,178	1,113
Centrally Delivered schemes	(109)	0	109	(1,137)	1,787	2,924	0	4,302	4,302
TOTAL CIP	**4,633**	**5,113**	**480**	**24,620**	**26,471**	**1,851**	**51,101**	**52,742**	**1,641**
Income Generation	**Plan £000s**	**Actual £000s**	**Variance £000s**	**Plan £000s**	**Actual £000s**	**Variance £000s**	**Plan £000s**	**Actual £000s**	**Variance £000s**
CPG7 - Public Health	42	32	(10)	294	65	(229)	505	111	(394)
Private Patients	45	15	(30)	315	135	(180)	541	223	(318)
TOTAL Income Generation	**87**	**47**	**(40)**	**609**	**200**	**(409)**	**1,046**	**334**	**(712)**
TOTAL	**4,720**	**5,160**	**440**	**25,229**	**26,671**	**1,442**	**52,147**	**53,076**	**929**





CIP outturn for the year is projected at £53.0m - no change from last month. (The Full Year Effect £62m plan is forecast to be delivered in full).

Actual achievement of CIP schemes in October was £5,160 (YTD £26,672k) which is £437k ahead of plan for the month (YTD £1,442 ahead of plan)

The CIP Delivery Board is closely monitoring the position and further plans are being developed to ensure delivery of the 2012/13 target.

Statement of Comprehensive Income (SOCI)	Risk:	A

PAGE 7 - STATEMENT OF FINANCIAL POSITION

		Opening Balance £000s	Revised Opening Balance (Post audit) £000s	Current Month Balance £000s	Previous Month Balance £000s	Movement in month £000s	Forecast Balance £000s
Non Current Assets	Property, Plant & Equipment	744,023	744,023	729,586	730,378	(792)	727,230
	Intangible Assets	579	579	346	377	(31)	175
Current Assets	Inventories (Stock)	17,141	17,141	17,838	17,700	138	17,141
	Trade & Other Receivables (Debtors)	45,711	52,701	62,716	68,630	(5,914)	52,705
	Cash	22,974	22,974	59,067	41,613	17,454	27,985
Current Liabilities	Trade & Other Payables (Creditors)	(105,681)	(104,324)	(129,008)	(121,396)	(7,612)	(94,395)
	Borrowings	(3,764)	(3,764)	(3,764)	(3,764)	0	(4,274)
	Provisions	(4,542)	(12,891)	(17,101)	(16,023)	(1,078)	(11,900)
Non Current Liabilities	Borrowings	(45,046)	(45,046)	(43,164)	(43,164)	0	(42,558)
	TOTAL ASSETS EMPLOYED	**671,395**	**671,395**	**676,516**	**674,351**	**2,165**	**672,109**

Ratio/Indicators	Risk Rating		
	Current month	Previous Month	Forecast
Debtor Days	24	27	18
Trade Payable Days	53	51	41
Cash Liquidity Days	29	29	25

The decrease in trade debtors is predominantly due to:

-The release in Month 7 of £2.4m relating to a payment in advance for the ISS contract

- SLA payment in advance of £4.7m received from Kensington & Chelsea PCT

The increase in trade creditors is due to:

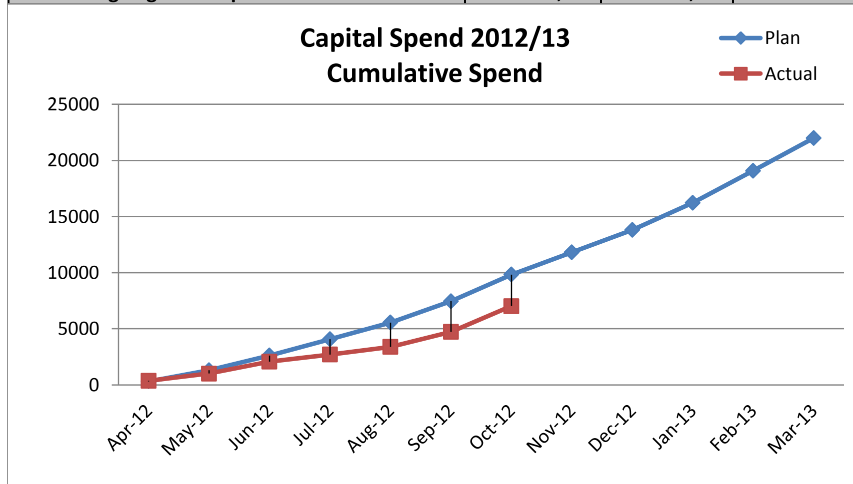
- Increase in PDC accrual of £1.8m
- Increase in R&D deferred income of £4.9m as result of income received for new projects
- Increase in deferred income for National Patient Safety of £0.76m

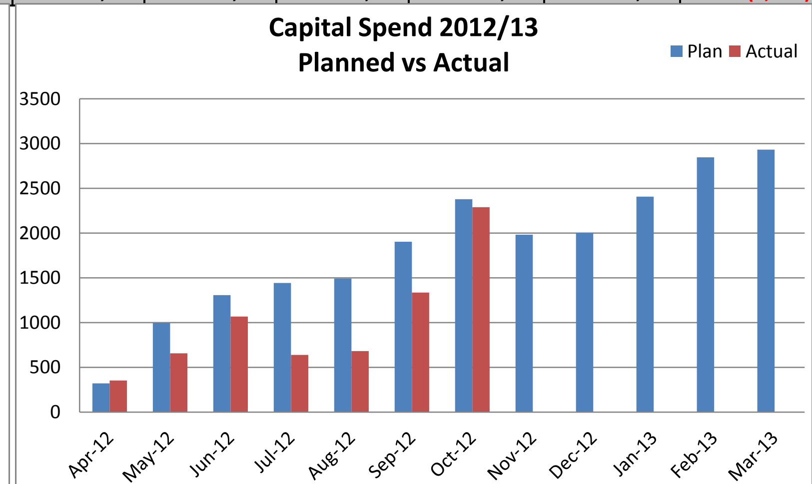
Provisions have increased mainly due to forecast redundancy payments (£0.55m).

Statement of Financial Position (SOFP)	Risk:	G

PAGE 8 - CAPITAL EXPENDITURE

By Scheme	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Lindo Wing Refurbishment	45	72	(27)	945	849	96	945	945	0
Surgical Innovation Centre	25	8	17	370	157	213	370	370	0
Clinical Chemistry Relocation	320	248	72	1,020	1,047	(27)	1,722	1,400	322
Paediatric Clin. Haem. Day Unit	405	438	(33)	1,245	1,189	56	1,680	1,680	0
Strategic RIS/PACS	0	0	0	450	0	450	450	200	250
St Mary's Electrical Infrastructure	300	86	214	800	172	628	1,295	1,636	(341)
Endoscopy Relocation	150	0	150	280	0	280	1,980	900	1,080
Relocate Cardiology Labs	15	261	(246)	75	363	(288)	322	1,400	(1,078)
Renal Dialysis Expansion	50	5	45	150	11	139	1,388	400	988
Medical Equipment	187	255	(68)	748	422	326	2,000	2,822	(822)
Backlog Maintenance	200	297	(97)	1,200	686	514	2,500	3,169	(669)
Aggregate - Estates	50	163	(113)	550	849	(299)	798	900	(102)
Aggregate - IT	600	254	346	1,900	963	937	4,550	6,820	(2,270)
Aggregate - IT Building Works	30	0	30	100	0	100	2,000	180	1,820
Energy Saving Schemes (Salix-funded)	0	201	(201)	0	312	(312)	0	2,042	(2,042)
Capital Expenditure	**2,377**	**2,290**	**87**	**9,833**	**7,018**	**2,815**	**22,000**	**24,864**	**(2,864)**
Capital Donations	**0**	**0**	**0**	**0**	**(87)**	**87**	**0**	**(794)**	**794**
Gov. Grant - Medical Equipment (ESC)	**0**	**0**	**0**	**0**	**(28)**	**28**	**0**	**(28)**	**28**
Total Charge against Capital Resource Limit	**2,377**	**2,290**	**87**	**9,833**	**6,903**	**2,930**	**22,000**	**24,042**	**(2,042)**

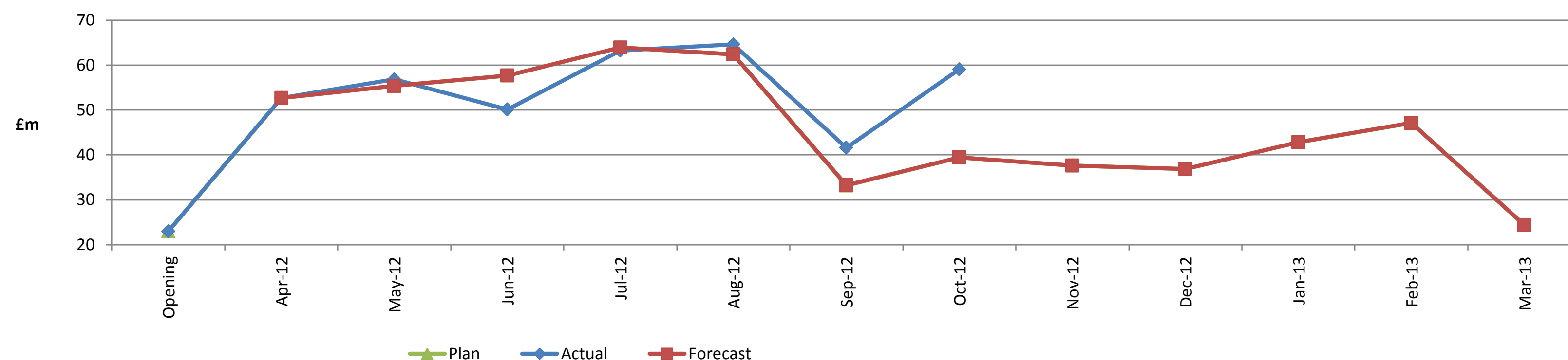




Expenditure remains behind plan due to slow starts to the IT and backlog maintenance programmes arising from time taken to plan projects at the start of the year.
The Clinical Chemistry relocation works are complete in Mint Wing at SMH and the department is moving across from the Medical School.
The dialysis expansion scheme at CHX is to be reviewed at CIG to determine if it is to be deferred to the next financial year.

Statement of Financial Position (SOFP)	Risk:	A

PAGE 9 - CASH



	Opening	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Plan	22,974	52,707	55,382	57,707	63,933	62,419	33,189	39,470	37,656	36,896	42,852	47,127	24,370
Actual	22,974	52,707	56,826	50,127	63,252	64,611	41,613	59,067					
Forecast		52,707	55,382	57,707	63,933	62,419	33,289	39,470	37,656	36,896	42,852	47,127	24,370

Aged Debtor Analysis

Category	Current	30 Days	60 Days	90 Days	<= 1 Year	>1 Year - <= 2 Years	>2 Years	Total Debt
NHS	£ 8,425,913	£ 4,089,191	£ 1,495,124	£ 3,203,184	£ 6,116,092	£ 80,783	£ 56,928	**£ 23,467,214**
Non-NHS	£ 1,685,096	£ 1,168,312	£ 128,599	£ 375,069	£ 1,027,854	£ 769,457	£ 319,857	**£ 5,474,244**
Overseas Visitors	£ 182,163	£ 131,266	£ 89,218	£ 186,201	£ 1,496,927	£ 832,629	£ 308,904	**£ 3,227,308**
Private Patients	£ 1,783,453	£ 1,245,258	£ 548,136	£ 248,248	£ 973,632	-£ 39,144	£ 119,976	**£ 4,879,559**
Total	**£ 12,076,625**	**£ 6,634,027**	**£ 2,261,077**	**£ 4,012,702**	**£ 9,614,505**	**£ 1,643,725**	**£ 805,664**	**£ 37,048,325**
% of Total Debt	**32.6%**	**17.9%**	**6.1%**	**10.8%**	**26.0%**	**4.4%**	**2.2%**	**100.0%**

Aged Creditor Analysis

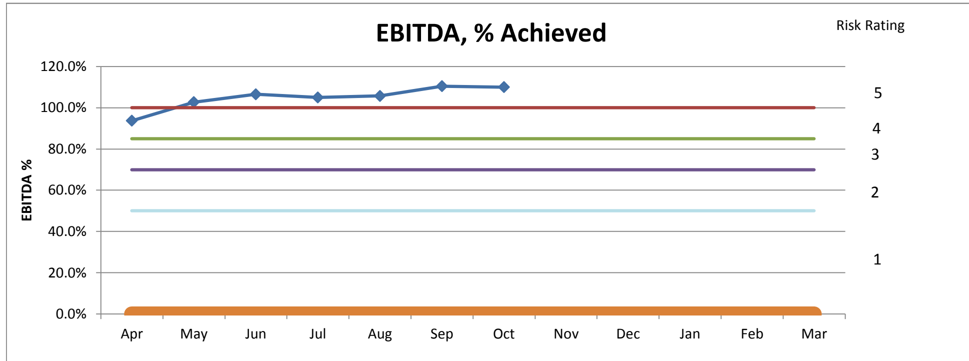
Category	Current	30 Days	60 Days	90 Days	<= 1 Year	>1 Year - <= 2 Years	>2 Years	Total Creditors
All AP Creditors	£ 4,005,873	£ 190,644	£ 96,607	£ 18,003	£ 236,666	£ 115,727	£ 53,911	**£ 4,717,430**
Total	**£ 4,005,873**	**£ 190,644**	**£ 96,607**	**£ 18,003**	**£ 236,666**	**£ 115,727**	**£ 53,911**	**£ 4,717,430**
% of Total Creditors	**84.9%**	**4.0%**	**2.0%**	**0.4%**	**5.0%**	**2.5%**	**1.1%**	**100.0%**

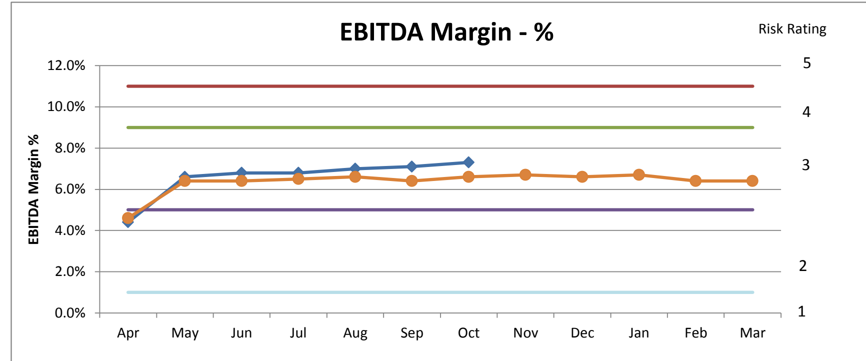
Actual cash is significantly above plan in October because payments to suppliers (including capital) and payroll payments were lower than the year to date plan. In addition an SLA payment of £4.7m was received in advance from Kensington & Chelsea PCT.

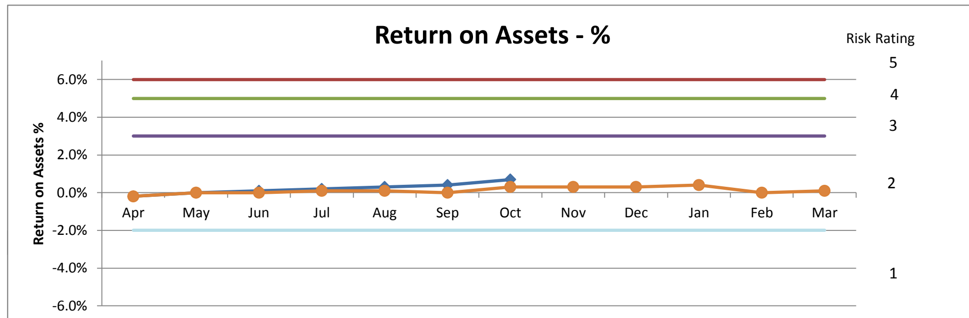
At the end of October, the balance of cash invested in the National Loan Fund scheme totalled £58m. This amount was invested for 7 days at an average rate of 0.32%. Total accumulated interest receivable at 31st October 2012 was £145k.

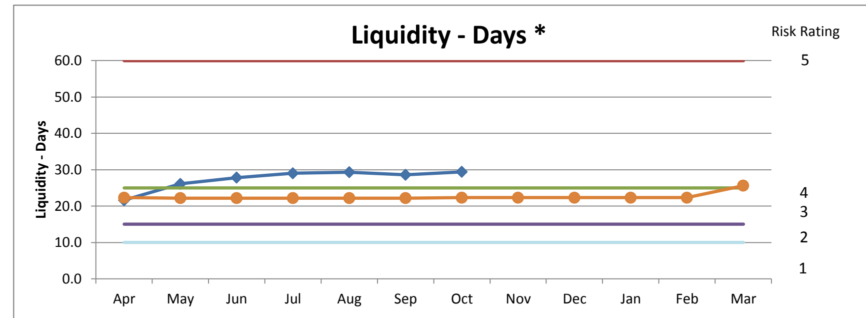
The NHS debtor balance for <= 1 year of £6m relates mainly to outstanding payment s for R&D market forces factor (MFF) which is awaiting confirmation from Department of Health but is not deemed to be at risk.

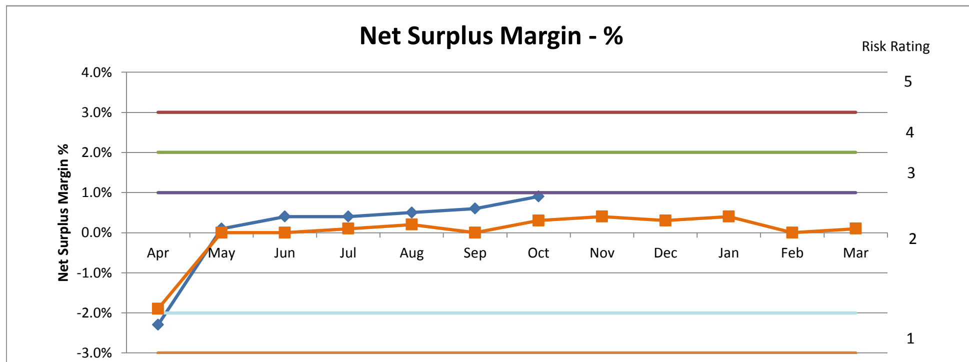
Statement of Financial Position (SOFP)	**Risk:**	**G**

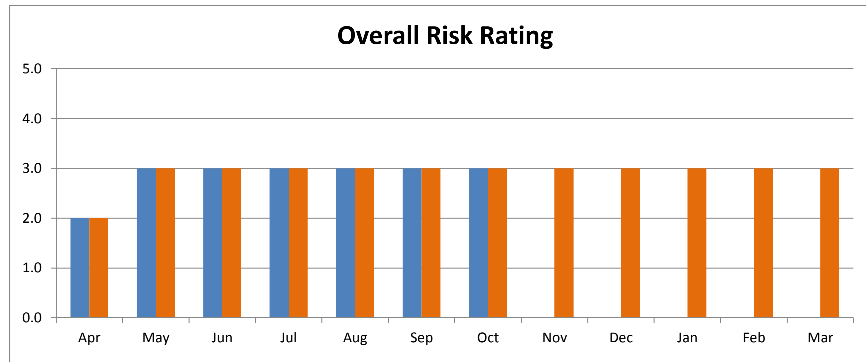












Each chart plots the current performance against each of the five Financial Risk Rating (FRR) metrics.

The Trust's overall FRR based on the results to the end of October is FRR3, as per plan. All risk metrics are on plan.

A score of 3 is mandatory for Foundation Trust status.

* This is a proxy rating assuming a 30 day working capital facility available only to Foundation Trusts.

Financial Risk Ratings	Risk:	G

PAGE 11 - SLA Activity & Income by POD (Estimate for October)

Point of Delivery	Year to Date (Activity) Plan	Year to Date (Activity) Actual	Year to Date (Activity) Variance	Year to Date (Income) Plan £000s	Year to Date (Income) Actual £000s	Year to Date (Income) Variance £000s	Forecast Outturn Plan £000s	Forecast Outturn Actual £000s	Forecast Outturn Variance £000s
Admitted Patient Care									
- Day Cases	39,536	37,815	(1,722)	32,689	31,790	(899)	55,593	54,762	(831)
- Regular Day Attenders	7,520	8,100	580	3,672	3,999	327	6,263	6,866	603
- Elective	12,870	12,242	(628)	37,519	36,879	(640)	63,495	62,940	(555)
- Non Elective	50,721	54,003	3,283	97,535	96,995	(540)	166,384	169,538	3,154
Accident & Emergency	112,849	115,767	2,917	12,642	12,948	306	21,566	22,115	549
Adult Critical Care	26,266	24,013	(2,253)	32,553	28,986	(3,567)	55,531	48,747	(6,784)
Outpatients - New	136,392	140,996	4,604	28,132	28,907	775	47,843	50,736	2,893
Outpatients - Follow-up	303,147	300,507	(2,641)	39,539	38,228	(1,311)	67,242	65,936	(1,306)
PbR Exclusions	73,657	390,999	317,343	34,818	35,240	422	197,487	198,085	598
Direct Access	1,293,066	1,284,422	(8,644)	9,076	9,442	366	17,407	17,958	551
Others	211,888	221,910	10,023	87,103	88,452	1,349	12,766	13,241	475
Commissioning Business Rules	(25,400)	(28,433)	(3,033)	(14,026)	(15,274)	(1,248)	(15,072)	(24,777)	(9,705)
NWL London Block Adj	0	0	0	5,147	7,741	2,594	1	8,772	8,771
TOTAL	**2,242,512**	**2,562,341**	**319,830**	**406,399**	**404,333**	**(2,066)**	**696,506**	**694,917**	**(1,589)**

Income by Sector	Year to Date (Income) Plan £000s	Year to Date (Income) Actual £000s	Year to Date (Income) Variance £000s	Forecast Outturn Plan £000s	Forecast Outturn Actual £000s	Forecast Outturn Variance £000s
North West - London	293,715	293,715	0	500,000	500,000	0
North Central - London	12,619	12,601	(18)	21,493	21,464	(29)
North East - London	4,439	4,433	(6)	7,558	7,548	(10)
South East - London	4,070	4,064	(6)	6,930	6,920	(10)
South West - London	17,770	17,746	(24)	30,263	30,221	(42)
East of England	17,354	17,543	189	29,557	29,349	(208)
South East Coast	6,207	6,271	64	10,567	10,564	(3)
Specialist Commissioning	28,482	28,724	242	49,119	49,738	619
SHA	1,716	1,607	(109)	2,927	2,741	(186)
Others	20,027	17,629	(2,398)	38,092	36,372	(1,720)
TOTAL	**406,399**	**404,333**	**(2,066)**	**696,506**	**694,917**	**(1,589)**

Income by NWL PCT's	Year to Date (Income) Plan £000s	Year to Date (Income) Actual £000s	Year to Date (Income) Variance £000s	Forecast Outturn Income Plan £000s	Forecast Outturn Income Actual £000s	Forecast Outturn Income Variance £000s
Hillingdon	12,857	12,182	(675)	21,897	20,806	(1,091)
Hammersmith & Fulham	48,750	50,495	1,745	83,028	86,244	3,216
Ealing	56,084	54,457	(1,627)	95,509	93,010	(2,499)
Hounslow	30,612	29,761	(851)	52,125	50,831	(1,294)
Brent	41,554	43,686	2,132	70,774	74,614	3,840
Harrow	11,361	11,387	26	19,350	19,448	98
Kensington & Chelsea	35,121	33,294	(1,827)	59,823	56,865	(2,958)
Westminster	52,229	50,712	(1,517)	88,714	86,622	(2,092)
Block Adj	5,147	7,741	2,594	8,780	11,560	2,780
TOTAL	**293,715**	**293,715**	**0**	**500,000**	**500,000**	**0**

The report is an analysis of NHS SLA Income from clinical activities excluding other NHS organisations.

The key variances are:

- Critical Care underperformance . The plan for 2012/13 was based on 2011/12 outturn which included a significant number of long stay patients that have not been treated in 2012/13.
- Day Case underperformance is associated with the following specialties Cardiology, General Surgery, Nephrology and Neurology and we are investigating the out of sector under performance.
- Non Elective underperformance is mainly due to reduced births in Obstetrics.
- Other Income & Contractual adjustment variance relates to the 70% emergency thresholds £3.8m, Outpatient follow-ups ratio £0.5m and NWL block contract/risk premium £7.7m. This assumes delivery to date of £4.7m additional indicative demand management metrics within the contract for NHS NWL.

NHS Service Level Agreement (SLA) Income by Point of Delivery (POD) **Risk: A**

Page 12 - Risk Analysis

DESCRIPTION OF RISKS	MITIGATION
Costs of overperformance against the block contract with NW London Commissioners. (noting premium costs associated with additional capacity and high cost drugs & devices).	Active management of demand and capacity by CPGs to ensure delivery of performance targets, minimise activity under block contract agreements and maximise activity under Payment by Results (ensuring this activity can be delivered with an appropriate contribution). Performance managed through CPGs and Performance Reviews with the Executive Team.
Underperformance against Payment by Results contracts resulting in a loss of contribution if fixed and semi-fixed costs are not reduced.	
Penalties for "Never Events" and breaches of performance targets.	
CPGs and Corporate Directorates do not deliver financial targets by shortfall in CIP delivery and/or management of costs and devolved income.	Performance managed through Performance Reviews with Executive Team, CIP Board & Delivery Board, fortnightly meetings with Turnaround Director and CPG Boards. Controls over recruitment of contracted staff, engagement of agency & bank staff and procurement.
Income for Cerner implementation is less than planned.	Review opportunities to reduce implementation cost without increasing risks of delivery of key milestones and benefits.
TOTAL	

Variance against Plan or Outturn

The key financial risks and mitigation actions are highlighted in the above table. The quantification of risks has yet to be determined and further work will be undertaken during the month to analysis and confirm the range of values of the individual risks.

* The information on this page reflects a number of issues which are uncertain in their timing and nature. Some, all or none of these may eventually crystallise. These issues will be reviewed and refined monthly, and as and when additional information becomes available.

Risk Analysis	**Risk:**	**A**

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER:12/11/28 – 11**

Report Title: Department of Health Single Operating Model

To be presented by: Mr. Bill Shields, Chief Financial Officer

Executive Summary:

As part of the Foundation Trust application process the Department of Health introduced the Single Operating Model (SOM) earlier this year. The SOM supports and assures trusts through their Foundation Trust (FT) applications by drawing on best practice to introduce one common set of tools, processes and guidance for FT development and application, which is more closely aligned with Monitor's authorisation approach. It will also support transition to management by the NHS Trust Development Authority and operational delivery and planning for 2013/14.

As part of the compliance with Part 2 of the SOM the Trust is required to submit self-certification templates to NHS London on a monthly basis in line with their timetable. The SOM model requires that self certification templates are approved by the Trust board before submission.

The rationale and purpose of the Oversight process is to focus on developing self awareness and self management of issues by Trust Boards. NHS Trusts are required to become self governing autonomous organisations when they commence an FT application and the Oversight approach develops the organisational capabilities that will be tested in detail as part of the assessment for FT status and what will be required once authorised.

The process sits alongside and complements the development and assurance of FT applications and is to be viewed as an ongoing process rather than a 'set piece' review like other elements of the FT pipeline, such as Historical Due Diligence (HDD) and the Board Governance Assurance Framework (BGAF).

The last submission, covering the month of September 2012, was made on 20th November 2012 using the templates provided by NHS London. The next submission, covering Trust performance in the month of October 2012, will be made on December 17th 2012 and is enclosed for discussion by the Board.

Following discussion the document will be signed on behalf of the Trust Board by the Trust Chairman and Trust Chief Executive Officer, or appointed deputies, before sign off of the TFA milestone section by NHS North West London submission to NHS London.

Legal Implications or Review Needed

a. Yes ☐
b. No ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report

a. For decision and approval ☐
b. For review/noting ✓

SELF-CERTIFICATION RETURNS
Organisation Name:
Imperial College Healthcare NHS Trust
Monitoring Period:
October 2012
NHS Trust Over-sight self certification template

Returns to som@london.nhs.uk by 17th December 2012 as per schedule

TFA Progress

Oct-12

Imperial College Healthcare NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Comments where milestones are not delivered or where a risk to delivery has been identified
1	Trust returns FY final accounts (deficit position)	Jun-12	Fully achieved in time	
2	Trust letter of support to NWL Cluster re public consultation	Jun-12	Fully achieved in time	
3	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-12	Fully achieved in time	
4	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-12	Not fully achieved	Finance - YTD position at M7 is a surplus of £5,120k against a planned surplus of £1,798k. CIP delivery was ahead of plan by £1,442k YTD. Cancer - Achieved 4 out of 9 targets in Month 6. Robust recovery programme in place to drive and monitor achievement of action plan. On track to achieve all 9 targets by end Q4 12/13. 18 weeks - Achieved non-admitted and incomplete pathway targets in Month 7. On track to also achieve admitted target by Nov 2012. Elective Access Programme Board monitors achievement of remedial action plan
5	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Dec-12	Will not be delivered on time	Cancer achievement trajectory set to hit all 9 targets by end Q4 12/13
6	JCPCT decision on NWL Shaping a healthier future consultation	Jan-13	On track to deliver	In the absence of any communication from NWL to the contrary, it is assumed that all SaHF Programme milestone remain on track for delivery. Achievement of this milestone is not within the influence of ICHT although the Trust remains an active participant in all levels of the SaHF Programme
7	Board Governance Assurance Framework commences	Feb-13	On track to deliver	
8	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Apr-13	On track to deliver	
9	Trust returns FY13 final accounts (financially balanced position)	Jun-13	On track to deliver	At M7 the Trust's YTD position was a surplus of £5,120k against a planned surplus of £1,798k. The improvement predominantly relates the cost reduction achieved across the Trust, but also to the inclusion of funding for Project Diamond. CIP delivery was ahead of plan by £1,442k YTD
10	NWL Shaping a healthier future OBCs complete (assuming no appeal)	Jul-13	On track to deliver	In the absence of any communication from NWL to the contrary, it is assumed that all SaHF Programme milestone remain on track for delivery. Achievement of this milestone is not within the influence of ICHT although the Trust remains an active participant in all levels of the SaHF Programme
11	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-13	On track to deliver	
12	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-13	On track to deliver	
13	NWL Shaping a healthier future FBC complete (assuming no appeal)	Dec-13	On track to deliver	In the absence of any communication from NWL to the contrary, it is assumed that all SaHF Programme milestone remain on track for delivery. Achievement of this milestone is not within the influence of ICHT although the Trust remains an active participant in all levels of the SaHF Programme
14	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Dec-13	On track to deliver	
15	Board sign off first draft of IBP and LTFM	Apr-14	On track to deliver	
16	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Apr-14	On track to deliver	

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:		Period:	

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	
Financial Risk Rating (Assign number as per SOM guidance)	
Contractual Position (RAG as per SOM guidance)	

*** Please type in R, A or G**

Governance Declarations

NHS Trusts must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.

The board is suggesting that at the current time there is **insufficient assurance available** to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.

Signed by :	Bill Shields	Print Name :	
on behalf of the Trust Board	Acting in capacity as:	Chief Financial Officer and Lead Director for Foundation Trust Application	
Signed by :	Mark Davies	Print Name :	
on behalf of the Trust Board	Acting in capacity as:	Chief Executive Officer	

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**Cancer waiting times**
The Issue :	**Underperformance against the national cancer waiting time target**
Action :	**Agreed remedial action plans with Commissioners**

Target/Standard:	**RTT**
The Issue :	**Underperformance in admitted RTT standard**
Action :	**Agreed recovery trajectory for admitted performance**

GOVERNANCE RISK RATINGS

Imperial College Healthcare NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information Referral information Treatment activity information	50% 50% 50%	1.0	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	N/a	N/a	No	No			No	The Trust's RTT performance for admitted patients Improved from last month in line with the improvement trajectory.
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	N/a	N/a	Yes	Yes			Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	N/a	N/a	Yes	Yes			Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes			Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery Anti cancer drug treatments Radiotherapy	94% 98% 94%	1.0	N/a	No	No	No			No	[Cancer data reported one month in arrears therefore October data represents pre-validated position, to be amended post-validation before final submission]. On track to achieve anti-drug treatments and radiotherapy targets as in recent months, but likely to breach surgery target. Trust has robust remedial action plan in place with trajectory to achieve all cancer targets by Q4.
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer From NHS Cancer Screening Service referral	85% 90%	1.0	N/a	No	No	No			No	[Cancer data reported one month in arrears therefore October data represents pre-validated position, to be amended post-validation before final submission]. Likely to breach screening target as referral volumes remain low therefore low tolerance for breaches. GP referrals target remains a challenge but Trust has robust remedial action plan in place with trajectory to achieve all cancer targets by Q4.
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	N/a	No	No	No			No	[Cancer data reported one month in arrears therefore October data represents pre-validated position, to be amended post-validation before final submission]. Likely to breach 31 day targets in Month 7 but Trust has robust remedial action plan in place with trajectory to achieve all cancer targets by Q4.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93% 93%	0.5	N/a	No	Yes	No			No	[Cancer data reported one month in arrears therefore October data represents pre-validated position, to be amended post-validation before final submission]. Likely to achieve urgent referrals target but likely to breach symptomatic breast target in Month 7 .Trust has robust remedial action plan in place with trajectory to achieve all cancer targets by Q4.
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	Yes	Yes			Yes	
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge Having formal review within 12 months	95% 95%	1.0	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
	3j	Category A call – emergency response within 8 minutes		75%	1.0	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a			Yes	Not applicable to this Trust
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes			Yes	Contractual ceiling - 110
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes			Yes	Contractual ceiling - 9
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No			No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No			No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No			No	
				TOTAL		**0.0**	**3.0**	**3.5**	**4.0**	**0.0**	**0.0**	**4.0**	

RAG RATING :

GREEN	**= Score of 1 or under**
AMBER/GREEN	**= Score between 1 and 1.9**
AMBER / RED	**= Score between 2 and 3.9**
RED	**= Score of 4 or above**

Overriding Rules - Nature and Duration of Override at SHA's Discretion

Ref	Rule	Details	Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	Comments
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective	Yes	No	No	No			No	
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.	Yes	No	No	No			No	
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	N/a	N/a	N/a	N/a			Yes	Due to reporting break, this will only become applicable in Q4
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	No	No	No	No			No	
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	N/a	N/a	N/a	N/a			Yes	Due to reporting break, this will only become applicable in Q4
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter	N/a	N/a	N/a	N/a			Yes	Not applicable for this Trust
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	N/a	N/a	N/a	N/a			Yes	Not applicable for this Trust
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.								
		Number of Overrides Triggered	***2.0***	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	***4.0***	

FINANCIAL RISK RATING

Imperial College Healthcare NHS Trust

Insert the Score (1-5) Achieved for each Criteria Per Month

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Comments where target not achieved
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	The I&E surplus will need to be 1% (£9.5m) for a FRR3 in this criteria
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	4	4	4	4	
Weighted Average		**100%**						**3.3**	**3.3**	**3.3**	**3.3**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

Max Rating	Rule	
3	Plan not submitted on time	No
3	Plan not submitted complete and correct	No
2	PDC dividend not paid in full	No
2	One Financial Criterion at "1"	
3	One Financial Criterion at "2"	
1	Two Financial Criteria at "1"	
2	Two Financial Criteria at "2"	

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

Imperial College Healthcare NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Historic Data #REF!	Historic Data #REF!	Historic Data #REF!	Current Data #REF!	Current Data #REF!	Current Data #REF!	Current Data #REF!	Comments where risks are triggered
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No			No	
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No			No	
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes			Yes	Payment due for R&D MFF awaiting confirmation from DH, income not deemed to be at risk
5	Creditors > 90 days past due account for more than 5% of total creditor balances		Yes	Yes	Yes			Yes	There are some invoices being disputed and separately a company has gone into administration whereby the Trust is awaiting for confirmation from the company adminisitrator
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No			No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No			No	
8	Quarter end cash balance <10 days of operating expenses	Yes	No	No	No			No	
9	Capital expenditure < 75% of plan for the year to date	No	No	Yes	Yes			Yes	Slow start of IT projects, however confirmed with the CIO that the total will be spent in year

CONTRACTUAL DATA

Imperial College Healthcare NHS Trust

Insert "Yes" / "No" Assessment for the Month

Criteria	Historic Data #REF!	Historic Data #REF!	Historic Data #REF!	Current Data #REF!	Current Data #REF!	Current Data #REF!	Current Data #REF!	Comments where reds are triggered
Are the prior year contracts* closed?			Yes	Yes			Yes	
Are all current year contracts* agreed and signed?			Yes	Yes			Yes	The London SCG SLA remains unsigned. The Trust and the SCG are working through the final parts of the contract following a response from the SCG on the comments submitted by the Trust. Out of London SLAs will form part of this SLA in 2012/13
Are both the NHS Trust and commissioner fulfilling the terms of the contract?			Yes	Yes			Yes	
Are there any disputes over the terms of the contract?			No	No			No	
Might the dispute require SHA intervention or arbitration?			No	N/a			No	
Are the parties already in arbitration?			No	N/a			No	
Have any performance notices been issued?			Yes	No			No	1) Management of Cancer Services, associated performance breaches and poor patient experience; 2) Application of the non PbR marginal rate
Have any penalties been applied?			No	No			No	

QUALITY

Imperial College Healthcare NHS Trust

Insert Performance in Month

	Criteria	Unit	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Comments on Performance in Month
1	SHMI - latest data	Ratio									76.0	76.0	76.0	70.0	
2	Venous Thromboembolism (VTE) Screening	%									91.08	90.93	91.3	92.03	
3a	Elective MRSA Screening	%													The Trust remains compliant with the DH population screening. Analysis at patient level for October identified that 87.9 per cent of patients were screened.
3b	Non Elective MRSA Screening	%													The Trust remains compliant with the DH population screening. Analysis at patient level for October identified that 87.9 per cent of patients were screened.
4	Single Sex Accommodation Breaches	Number									0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number									6	4	7	8	
6	"Never Events" in month	Number									0	0	0	1	
7	CQC Conditions or Warning Notices	Number									0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number									0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number											4		Data from M6 NHS Northwest London Acute Maternity Dashboard (reported 1 month in arrears)
10	Falls resulting in severe injury or death	Number									0	0	0	0	
11	Grade 3 or 4 pressure ulcers	Number									0	0	0	4	
12	100% compliance with WHO surgical checklist	Y/N													Spot audits are in place. The Trust is in the process of setting up monitoring strategies for managing this performance area in the future.
13	Formal complaints received	Number									88	72	66	76	
14	Agency as a % of Employee Benefit Expenditure	%										7.5	7.4	8.2	The Trust agency spend as a % of pay bill has reduced steadily since May 2012. The July position was not reported due to a planned reconciliation of agency spend accruals.
15	Sickness absence rate	%									3.4	3.4	3.5	3.8	Audits are in place. The Trust is in the process off setting up monitoring strategies for managing this performance area in the future.
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%													Audits are in place. The Trust is in the process off setting up monitoring strategies for managing this performance area in the future.

Board Statements

Imperial College Healthcare NHS Trust

October 2012

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes

	For FINANCE, that:	Response
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Yes
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes

	For GOVERNANCE, that:	Response
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO			
Chair			

Notes

Ref	Indicator	Details
Thresholds		The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries.
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.

Notes

Ref	Indicator	Details
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

Single Operating Model (SOM) - Board statements

Board Assurance process - Progress Tracker

For each statement, the Board is asked to confirm the following

	For CLINICAL QUALITY, that:	Tracker Evidence provided (Please list)	Assurance	Status (Response)	Actions	Lead
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	- Compliance with CQC Essential standards is reviewed continuously using numerous data sources and a formal request to update compliance status is made to standard leads. Quarterly reports provide an update on compliance and any improvement actions in progress and are reviewed by the Management Board. - CPG and Corporate leads have access to the Trust on-line management system which captures incidents, complaints ad claims data. Staff leads have been trained in how to access and produce reports in response to their needs. - Weekly complaints reports are shared with CPGS/corporates showing numbers, response rate against target, re-opened and oldest complaints. These triangulate complaints and PALs data. - Monthly Quality & safety scorecards provide data at Trust, site and CPG level and comprise comprehensive indicators with benchmarking against peers, historic trust performance or national average. - Quarterly patient safety and service quality reports: incidents, complaints, claims top themes and sub categories, changes in top themes over time, NICE compliance, CQC compliance updates and key themes and actions from arising from Trust programme of Leadership Walkarounds. - Quarterly clinical outcome reports contain mortality and 'basket of 56' procedures benchmarked against Dr Foster data, reviewed at he Clinical Standards Committee with reporting up to the Trust Board. Indicators that 'trigger as red' are reviewed and issues/actions reported back to the Board. - The Trust Quality Accounts were developed from workshops held with patients, public, staff and key stakeholders. They also include new draft DH targets. Performance monitoring is through the multi-stakeholder Quality Accounts Delivery Group and performance included in the quarterly patient safety and service quality reports. - Clinical audit programme comprising participation in national clinical audits, trust priority clinical audits and local audit programmes.	- CQC registration without conditions, CQC Quality and Risk Profile 'low compliance risk' with no red rated outcomes - HSMR 70, well below national average - NHSLA level 3 risk management standards for acute trust, Maternity achieved at level 3 in November 2012. - 100% participation in national clinical audits for 2011/12 and for those eligible for participation up to Q2 100% - 93% Complaint response rate against internal target of 15 working days for Q2. - Incident reporting rate against peer average has increased to 6.1% vs 6.6% per 100 admissions - Patient falls 3.47 per 1000 occupied bed das vs 5.6 against national average	Compliant		
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance	See above	See above	Compliant		
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Medical Services Directorate and HR maintain systems for checking registration. Regular reports are reviewed. In preparation for revalidation, 20% of doctors have been selected and confirmed as going through the Validation process from December	Registration checks were audited as part of the NHSLA assessment in September and standard were achieved.	Compliant	Review plans for achieving all revalidation requirements at the Management Board	

20%

	For FINANCE, that:	Evidence provided (Please list)	Assurance	Status (Response)	Actions	Lead
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	The Trust Board has signed off the medium term annual plan	Update forecasts in the finance report are presented to the Board every month. The LTFM is also updated annually	Compliant		
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Going Concern Assessment 2011/12 presented to the Board by CFO in May, this is annually reviewed.	Report to the Board as part of the Annual Accounts submission	Compliant		

	For GOVERNANCE, that:	Evidence provided (Please list)	Assurance	Status (Response)	Actions	Lead
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Director of HR is the responsible executive. The Board has previously reviewed its position against the NHS Constitution. Including reviews of procedural documents and induction materials	Included in Board inductions, Trust corporate induction includes key aspects of the NHS Constitution	Compliant	New NED lead to be confirmed	
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Internal audit programme developed from the Assurance framework, progress on completion of audits and actions reviewed at each meeting of the Audit and Risk Committee. Timescales for completion of actions. Escalation process re non-completion of actions. External audit present progress report to each meeting of the Audit and Risk Committee, including follow up of actions.	Minutes of the Audit and Risk Committee include numbers of actions completed to timescale.	Compliant		
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Local review of risk registers to develop top 10 risks which are reviewed by the Governance Committee, approval of risks for escalation to the Audit and Risk Committee and subsequently the Board level risk register. Training programme in risk assessment in place. Six monthly Board progress reports on new high scoring risks, changes in risk profile and progress related to mitigating actions.	NHSLA level 3 assessment included review of risk management processes, risk assessment and escalation of risks, internal audit review, scrutiny and challenge from the Governance Committee and ultimately the Audit and Risk Committee and the Board	Compliant		
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Evidence as above	Evidence as above	Compliant		
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	AGS reviewed by the Board, internal and external audit.	AGS opinion was compliant with all requirements	Compliant		
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	Performance report at CPG and Board level. Local performance review and escalation processes. Action plan from external reviews, cancer patient survey action plan developed with key stakeholders. Plan to achieve all cancer standards by Q4. Capacity and winter pressure plans.	Intensive Support Team signed off Trust plans, performance data, minutes of performance reviews. The executive summary of each performance report outlines improvement actions for each target which is under-performing	Non-compliant	Cancer action plan in place and regularly reviewed Winter pressure plan in place	
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	IG leads and community have compliance with IG toolkit as a regular agenda item to track progress	Currently rated level 1 due to not achieving training targets and in order to achieve Level 2 with the Pseudonymisation Standard (324) all other standards must be achieved at level 2. This meant that the Trust also was also scored Level 1 for the Pseudonymisation standard 324.	Non-compliant	Revised training programme, regular briefings at Management Board, new e-module implemented.	

13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of	Register of interests policy and hospitality policy, quarterly reports, Anti-bribary policy, staff training, Board induction, one NED vacancy	Annual audit of above, substantial assurance opinion, attendance records Board training	Compliant	Confirm recruitment plans for NED vacancy	
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Key Board appointments of Chief Operating Officer and Medical Director were made and a new NED appointed to chair the Quality & Safety Committee. Recruitment in progress for Director of HR. The annual operating plan process has been revised. The restructuring of CPG and operational structures will further assist the effective delivery of this process.	Trust performance and governance ratings	Compliant	To confirm the audit programme for checking qualifications check of all staff, Board to comment	
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Key Board appointments of Chief Operating Officer and Medical Director were made and a new NED appointed to chair the Quality & Safety Committee. Recruitment in progress for Director of HR. The annual operating plan process has been revised. The restructuring of CPG and operational structures will further assist the effective delivery of this process.	Trust performance and governance ratings	Compliant	Board to comment	

	Signed on behalf of the Trust:	
CEO		
Chair		

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 12**

Report Title: Implementation of recommendations from externals reviews relating to waiting list and pathway management.

To be presented by: Mr. Steve McManus, Chief Operating Officer.

Executive Summary:

This paper provides a progress report regarding the recommendations made via the external reviews undertaken over the last 12 months in relation to the Trust management of waiting lists. The key four reviews were:

1. The NHS Intensive Support Team reports: Initial review, RTT information systems review, Access/waiting list management in 2011 and Stock take report 2012.
2. Deloitte audit on Review of Compliance against National Waiting Time Standards 2012.
3. External Governance Review of the Breakdown in Reliability of Performance Data for Waiting Times: Terry Hanifin 2012.
4. Waiting List Clinical Review: Jane Fryer 2012.

Additionally, NHS London commissioned a clinical governance review into the level and capability of corporate governance within the Trust. The outcomes from this review are to be presented separately however many of the recommendations and actions contained within this paper are pertinent.

A significant number of the recommendations are complete as demonstrated by evidence contained in appendix one. All outstanding actions relating to cancer performance are contained within a specific paper regarding the Cancer Remedial Action Plan. The implementation of all remaining recommendations are being overseen via the Chief Operating Officer's Performance Team using the action plan in appendix two.

Although the majority of the recommendations have been implemented it is clear that a number of themes that were regularly referenced in most reports need to have sustainable systems and processes to ensure improvement is embedded. The remainder of this paper describes the progress on improvements with data quality and referral to treatment/waiting list management.

1. Data Quality

- Data quality is now aligned with the Trust's performance framework. From Month 7 CPG Performance Management scorecards will include data quality key performance indicators (from Cymbio) and the CPGs will be accountable to the Executive Team for their performance in this area. In addition, the Management Board will receive a monthly update on data quality going forward. Data Quality will also be one of the key 'temperature checks' of how the organisation is responding to the new Cerner Millennium system post go live in April 2013.

- Data quality key performance indicators specific to the elective access pathways are monitored through the Elective Access Waiting List meeting chaired by the Chief Operating Officer.
- An internal audit programme regarding data quality related to waiting list management has been agreed for quarter four in 2012/13 and will be part of future internal audit programmes. Final audit reports will be presented to the Audit Committee and Trust Board to ensure the veracity of waiting list management is tested at this level.

2. Referral to Treatment /Waiting list management

- The Trust Access Policy including cancer access and has been revised and ratified by the Management Board on the 29th October 2012.
- The underpinning standard operating procedures are being revised and ratified by the Elective Access Waiting List meeting chaired by the Chief Operating Officer.
- A comprehensive training plan is being worked up with the assistance of the NHS Intensive Support Team and the Head of Change Management, Cerner Millennium Programme. The intention is for the training to take a similar approach as the Trust ANTT training programme which is competency based incorporating the monitoring of the numbers of staff trained.
- A number of current data quality key performance indicators demonstrate adherence to the policy and a further set of key performance indicators are being developed that will enable monitoring of operational compliance of the policy.
- The indicators will be monitored through the Elective Access Waiting List meeting and as appropriate escalated to the CPG performance reviews.
- The weekly Elective Access Waiting List meeting and has senior representatives from the CPGs and is the key Trust forum where the referral to treatment and diagnostic patient tracking lists that were redesigned and signed off by the IST prior to the recommencement of reporting are monitored for patient tracking, data quality and performance.
- Waiting list management and performance indicators will be presented at the Trust Board Seminar by the Chief Operating Officer in December 2012.

3. Veracity of other key performance data

Accident and Emergency has been scrutinised in the past by an external audit, Review of Accident and Emergency Management of Breaches in May 2011 and external review on clinical governance and NHS London reviewed serious incident data quality and for further assurance the Board should consider internal audit or another mechanism.

In summary data quality, referral to treatment pathway and waiting list management are key areas identified in the reviews. The associated recommendations have clear ownership and actions as demonstrated within the attached appendices. However the recommendation below requires further discussion in order to ensure the opportunity for improvement is delivered.

The action plan is can be found under paper 22 in the supporting papers folder.

Key Issues for discussion:

Further consideration needs to be given by the executive and Trust Board regarding a specific recommendations made by the External Governance Review of the Breakdown in Reliability of Performance Data for Waiting Times: Terry Hanifin 2012 and whether the actions and systems

now in place are sufficient in relation to:

The Trust Board and Management Board should be more sceptical and proactive in anticipating and identifying major risks and insisting that action is taken and progress monitored. NEDs need to challenge constructively on important matters like waiting times, patient safety, clinical outcomes, etc. and the extent of progress in implementing action plans. The Board needs assurance (evidence) not just words of reassurance.

Legal Implications or Review Needed
No

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report

a. For Decision ☐
b. For information/noting

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 13**

Report Title: Full Business Case (FBC) to support the development of Endoscopy and Centralisation of Physiology Services.

To be presented by: Dr Julian Redhead, Clinical Programme Director, CPG1

Executive Summary :

1. **Overview**
The Full Business Case (FBC) outlines the proposal to redevelop Endoscopy and consolidate Physiology facilities on the St. Mary's Hospital Site (SMH) and seeks approval to invest £6.5 million over three years into a four procedure room unit (three endoscopy: one fluoroscopy). This change is essential to meet statutory & regulatory compliance; prevent the loss of accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG), which is essential for the service to continue; retain this unit's critical support function to other key clinical services on this site and enable this profitable service to deliver growth in line with national policy and local commissioning intentions. The preferred option has a favourable NPV of £6.4m over 30 years and £1.2m over 15 years, with a payback period of 11 years.

2. **Approvals to date**
At £6.5 million this FBC is over the Trust's delegated limit threshold of £3m and requires NHS London approval. Following Trust approval the outline business case (OBC) was approved by NHS London Capital Management Group on 3rd July 2012.

The FBC was presented and approved by Trust's Investment Committee on 15th October and Management Board on 22nd October 2012, with Chairs Actions taken 24th October 2012 to allow submission to NHS London in time for review at their December 2012 meeting.

3. **The Case for Change**

3.1. Patient care standards

The new facility will enable compliance with eliminating mixed sex accommodation (EMSA) requirements detailed in the 2012/13 NHS Operating Framework and Department of Health Standards. The current facility has been upgraded to maximise compliance with privacy and dignity but there is insufficient space to meet the new requirements. As a registered provider under the Health and Social Care Act, the Trust is committed to providing services that meet essential standards of quality and safety which are monitored by the Care Quality Commission (CQC). However previous Trust discussions with the Department of Health (DH) and commissioners have made it clear that no further derogations with regard to the issues of passing by or passing through in areas such as endoscopy will be accepted, therefore, transitional arrangements were agreed in 2011 and will be in place until the opening of the unit in early 2014.

3.2. Patient care facilities

The current unit provides sub-optimal care for acutely unwell patients. The majority of patient wards and acute services are based in the Queen Elizabeth the Queen Mother building

(QEQM), therefore patients who become acutely unwell and require emergency Endoscopy services have to be transferred to the unit in the Clarence wing.

The unit must also upgrade its current facilities as this is an essential part of maintaining JAG accreditation. During the accreditation visit in 2010 an assurance was given to JAG by the Trust Board that a new build would be undertaken. From 2012 this will be an annual as opposed to five yearly assessments. Failure to meet JAG accreditation standards could result in withdrawal of accreditation. A unit without accreditation is unlikely to maintain commissioner support and therefore patient flows, having a direct negative impact on Trust income in terms of gastroenterology (currently showing a strong 31% positive EBITDA) and threatening the income of the speciality services it supports (see factor 3). In addition, the Deanery is unlikely to support the unit as a viable training centre and therefore remove all the seven training grade doctors (Registrars) that it funds. As a result the unit will no longer be viable and the majority of patients will be referred to neighbouring hospitals.

3.3. Demand growth

Endoscopy at SMH is critical to the support of other clinical services including Gastrointestinal Cancer, Lung cancer, Bariatric Surgery and General Medicine. The Government has made a commitment to 'new action on cancer to save thousands more lives every year' and is expecting growth in lower GI endoscopy of circa 10% per annum for the next five years

4. Update from Outline Business Case (OBC)

4.1. Economic Evaluation

At OBC stage, the economic evaluation showed that Option 9 (to replace the current 3-room unit with a 4-room unit) was the preferred option. The relative benefits of the options were reviewed and confirmed as appropriate by the SMH Endoscopy Board on 12 September 2012. The table below shows the revised assessment, updated in the light of a reassessment of the financial costs and benefits since the OBC, and confirms that Option 9 is still the preferred option.

Evaluation Results	Option 11 (Do Minimum)	Option 8 (3-room endoscopy)	Option 9 (4-room endoscopy)	Option 6 (4-room with significant enhancements)
Equivalent Annual Cost £m	0.86	0.72	1.011	1.15
Benefits Score	39	68	99	105
EAC to Benefits ratio	0.0219	0.0105	0.0102	0.0109
Overall Ranking FBC stage	**4**	**2**	**1**	**3**
Overall Ranking at OBC	4	2	1	3

4.2. Commercial Case

Since the Outline Business Case was approved, the commercial case has followed the DoH preferred procurement route, known as P21+. Kier has been appointed as the 'Principal Supply Chain Partner' for the project and has been working with the Trust to produce a 'Guaranteed Maximum Price' which has been reflected in the FBC.

5. Financial Summary

5.1. The financial analysis shows that the preferred option can deliver a positive NPV for the Trust of £1.2million over a 15-year evaluation period and £6.4million over a 30-year period assuming activity growth in line with DoH expectations

5.2. The preferred option generates a positive EBITDA from Year 1 and this rises to £832k per annum from Year five. The preferred option generates a surplus on the income and expenditure account, after depreciation and capital charges, from Year 3 and this exceeds £400k from Year 6 onwards.

5.3. The preferred option has a payback period (undiscounted) of 11 years.

The full business case is available on request.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision √
b. For information/noting ☐

For ratification by the Trust Board following sign off under Chair's Actions on 24th October 2012.

In order to meet the submission timeline required by NHS London Chairman's Actions was requested and granted. A delay of review by the November Trust Board was not possible as this would have resulted in the approval being deferred until the New Year and an extension to the project timeline.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 14**

Report Title: Maternity Risk Management Strategy

To be presented by: Mr. Keith Edmonds, Clinical Programme Director, CPG5

Executive Summary:

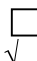
- The Maternity Risk Management Strategy has been written to fulfil the requirements of the Maternity Risk Management Standards as set by the NHS Litigation Authority.
- These standards aim to improve quality of care provided to mothers, babies and their families through early identification and analysis of potential and actual adverse events.
- Risk management is not primarily about avoiding or mitigating claims; rather, it is seen as a tool for improving the quality of care and thereby the experience of women and their families who access the maternity services.
- The strategy sets out the roles and responsibilities of key people within the maternity services together with the risk management structures that exist to ensure that significant risks are investigated, managed appropriately and escalated where required.
- It incorporates the requirement for risk assessments and the management of the maternity risk register.
- Training of staff will take place at induction and on mandatory training days.
- Information will be disseminated to staff through the maternity newsletter, "Risky Business" including lessons learned from incidents, complaints and claims.

The full policy is listed as paper 23 in the supporting documents folder.

Key Issues for discussion:

- There are two key points for discussion which are specific requirements for Trust Boards as set out in the standards. These have been incorporated into the strategy:
  1. that there is a process for escalating risk management issues from the maternity service to Trust Board level and;
  2. that there is a process by which the Trust Board lead executive (the Medical Director) communicates with and obtains assurance from the maternity service

Legal Implications or Review Needed

a. Yes 
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:
The Maternity Risk Management Strategy will be reviewed and monitored annually to ensure that it is

meeting its objectives and that lessons are being learned.

Purpose of Report

a. For Decision √

b. For information/noting ☐

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 15**

Report Title: Service Quality and Patient Safety Annual Report 2011/12

To be presented by: Professor Nick Cheshire, Medical Director

Executive Summary: The Service Quality and Patient Safety Annual Report for 2011/12 demonstrates the Trust's achievements in reducing harm and improving care and quality of services. It is a comprehensive document that outlines a commitment to providing safer, evidence based healthcare delivered by well-trained staff working within a culture that supports continuous learning and where possible links research to practice.

The full report analyses the Trust's performance in relation to reported incidents, Serious Incidents (SIs), complaints and claims. This executive summary is designed to provide an overview of key messages and outcomes in these areas.

Key messages from the report include:

- The Trust is registered 'without conditions' with the Care Quality Commission (CQC) for its 5 main physical sites (SMH, HH, CXH, WEH, and QCCH) and for its 7 renal dialysis satellite units. Three CQC inspections took place throughout the year. Two of these were reactive and one was a national review. The Trust was found to be compliant on all outcomes that were reviewed.

- The top three reported incident (clinical and non-clinical) categories are accident that may result in personal injury, medication and clinical assessment (investigations, images and lab tests). The top three themes of incidents across our peers are accident that may result in personal injury, treatment/procedure and medication.

- There has been a slight variation in the top 3 themes for complaints from 2010/11 to 2011/12. The top three themes for 2011/12 were clinical treatment (46.3%, 394), communication/information to patients (11.8%, 101) and outpatient appointments/delays (11.6%, 99). This compares to clinical treatment (46.11%, 332), staff attitude (13.33%, 96) and outpatient appointment/delays (15.83%, 114) in 2010/11. Notable changes are a reduction in complaints related to staff attitude and an increase in complaints related to communication/information to patients.

- The most common themes which formed the basis of claims were a failure to diagnose/delay in diagnosis, failed/delayed treatment and failure to recognise complication of treatment. This compares to failure to diagnose/delay in diagnosis and inappropriate treatment in 2010/11. Notable changes include a reduction in claims related to inappropriate treatment and an increase in claims related to failed/delayed treatment and failure to recognise complication of treatment.

- Six monthly reports by the NPSA show that the average incident reporting rate across our peers is 6.5 per 100 admissions. The Trust clinical incident reporting rate is 5.83 per 100

admissions. This compares to 5 in 2010/11. There was an increase in reporting rates throughout 2011/12 and the reporting rate for Q4 was 6.5.

- When compared to its peers the Trust reported a lower percentage of 'no harm' incidents (Trust, 62.5%, all Acute Teaching Organisations, 71.6%). It reported higher percentages of both 'minor' and 'moderate' incidents. Importantly, the Trust reported less 'major' and an equal amount of 'extreme' incidents which is considered to be an important indicator of safety of care.
- Year on year from 2010/11 to 2011/12 Trust figures show an increase in the percentage of 'no harm' incidents, a decrease in the percentage of 'minor' 'moderate' and major incidents. The percentage of 'extreme' incidents has remained the same over the last two years. However, when considered across the three year period (2009/10-2011/12) major incidents decreased by 54.54% and extreme incidents decreased by 21.05%.
- Incidents classified under accident that may result in personal injury represent 17.8% of the total reported incidents versus 23.3% of incidents reported by our peers. This category has seen a year on year increase of 1.60%.
- There was a lower number of falls per 1000 occupied bed days compared to the national average (of 5.6) for each month with no exceptions. The data ranged from 3.1 to 4.4 and averaged at 3.5. This is a small increase on the average of 3.2 in 2010/11.
- There were 1674 patient falls. There has been a decrease in the percentage of all reported incidents that are falls (12.94% compared to 15.06% in 2010/11 and 15.02% in 2009/10).
- The total number of patient falls that resulted in injury was 616 (36.7%) across the Trust. This is an increase on 2010/11 (531, 31.3%) and 2009/10 (405, 24.5%).
- 34% of reported patient falls were classified as being from a height, bed or chair. This is a reduction on the 2010/11 figure of 37.4%.
- The majority (62.98%) of falls from height, bed or chair resulted in no harm. 2 patient falls were classified as major and 1 was classified as extreme.
- Incidents classified under medication represent 14% of the total reported incidents versus 13.1% of incidents reported by our peers. Medication has seen a year on year increase of 18.72%. The sub-categories with the biggest increase were 'administration or supply of a medicine from a clinical area' and 'medication error during the prescription process'.

- Incidents classified under clinical assessment (investigations, images and lab tests) represent 12.5% of the total reported incidents versus 6.3% of incidents reported by our peers. Clinical assessment has seen a year on year increase of 121%. The significant increases in the sub-categories 'administration of assessment' and 'assessment other' are attributed to the reporting of cases where a VTE assessment had not been documented on the medication chart. 39.3% of incidents in this category were related to VTE.

- 53 incidents (49 resulting in harm) were reported involving an inadequate response to the change in a patient's status. This is an increase on 2010/11 when there were 25 reported incidents and 2009/10 when there were 33 cases.

- 35 incidents (11 resulting in harm) were reported relating to patients being wrongly identified. This is an increase on both 2010/11 and 2009/10 when there were 22 incidents. This represents an increase of 59%.

- This year there were 94 Serious Incidents (SIs) compared to 84 in the previous year. However, it is notable that an increase in reported Pressure Ulcers accounts for 13 SIs.
- The increase in surgical errors relates to the retained swab incidents which occurred during 2011/12 and significant improvement actions have been implemented.

- The number of outstanding actions at year end was 5 out of 325 which represents 1.5%. The response rate for completed investigation to NHS London deadline (n = 82) is 93%.

- There were 6 Never Event incidents in 2011/12. This compares to 3 Never Event Incidents in 2010/11. The increases were in the retained swab categories.

- NICE compliance is 81%. This represents an improvement in declared compliance from 75.7% at year end 2010/11.

- 100% of alerts have been closed to deadline. This represents a significant improvement on the Trust's position at year end 2010/11 (when there were 34 overdue alerts and 5 within timescale for completion).

- There were a total of 987 formal complaints, 851 were investigated formally and 136 were resolves by the Patient Advice & Liaison Service (PALS).

- There was an increase of 9.2% from 2010/11 (904) to 2011/12 (987). Complaints related to transport increased by 135% (from 15 to 36), CPG 5 complaints increased by 24% and CPG 3 complaints increased by 19%.

- 93% of all formal complaint responses were completed within timeframe for 2011/12. An increase from 92% in 2010/11.

- 28.7% of complaints were upheld. This is a small increase on 25.29% in 2010/11.

- There were 9 high risk grade complaints. This is a reduction on 10 in 2010/11.

- There were 185 new claims. This is an increase from 142 in 2010/11. The main areas of increase were A&E, maternity and neurology.

- The Trust settled 49 claims in 2011/12. This was a reduction on 55 settlements for 2010/11.

- The level of damages for claims settled was £6,194,503. This compares to £10,586,846 in 2010/11. There are currently six high value Obstetric and Maternity claims against the Trust where confirmation of settlement or closure is awaited. The total reserve for these ongoing claims is £32,000,000. Two claims settled in 2011/12 had a final damages figure of over £1,000,000.

- A significant number of improvements have been made as a result of incidents, complaints and claims. Examples of each are summarised throughout the report.

The full report can be found in the supporting documents folder as paper 24

Key Issues for discussion: N/A

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:

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3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision
b. For information/noting √

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 28th November 2012 **PAPER NUMBER: 12/11/28 – 16**

Title of Report: Summary of the Quality and Safety Committee meetings held on 5th November 2012 and 1st October 2012

To be presented by: Professor Nick Cheshire, Medical Director

Summary 5th November
2012 Action log of the previous meeting
The items on the action log were reviewed and the following items had been closed:

- Dr Mitchell introduced Professor Sir Anthony Newman Taylor, Non Executive-Director, who will Chair this Committee from 2013 onwards.
- Reed Agency issues were discussed as late cancellation of shifts remains a problem. The Reed Leadership Team had recently changed and Ms Morris is arranging a meeting with them and Bill Shields.

Control of Infection Pressure Ulcers Report
There had been 57 Trust-acquired pressure ulcers in September, including 1 grade 3 and 0 grade 4. In the year to date, there had been 214 Trust-acquired pressure ulcers in September, including 6 grade 3 and 0 grade 4. A Band 7 is to join the Tissue Viability Team and a bid for another is to be made, linked to CQUIN monies. Dr Redhead asked how feedback is provided to community providers on community-acquired pressure ulcers. Ms Savine stated these were escalated through the Governance Team and Ms Heywood added that grades 3 and 4 pressure ulcers often went via the Safeguarding Vulnerable Adults procedure.

Monthly (September 2012 and Q2) Quality & Safety Scorecards, **Q2 Risk, Patient Safety and Service Quality Report 2012/13 and Quality Accounts 2013 update – CPGs to report by exception**
Incident reporting rate is up in Q2. Fluctuation is observed in data on the severity of harm from reported incidents. There had been fewer SIs and no Never Events in Q2, though there had been a Never Event in October. The Trust is 100% compliant with Being Open. Falls remain below the national average and patient identification incidents have dropped after concerted work. Medication errors are above target and the need for a related report to this Committee remains on the Action Log. Work on Failure to Rescue has included junior doctor training and recent interview work with junior doctors has suggested that some are unaware of how to escalate, which mirrors reported issues regarding local induction. Immediate training action was completed with both junior doctors and Site Team members. A meeting to follow up this agenda is scheduled for 12th November. There had been a successful CQC visit to Western Eye Hospital, resulting in a declaration of full compliance. Future CQC visits to SMH and HH are anticipated shortly. Areas not currently meeting Quality Account targets were noted. Mr Edmonds asked whether the recent publicity surrounding Liverpool Care Pathway (LCP) required any local response. Ms Mottram suggested gathering local data. Mr Spearpoint stated that LCP data is available from the Patient Affairs Office.
ACTION:

- **Dr Mitchell to explore ways of quickly gathering audit data on Liverpool Care Pathway usage.**

For CPG5, Mr Edmonds noted the increase in medication errors. Mrs Newton stated there were no comments from CPG6. Dr Redhead, on behalf of CPG1, noted that outstanding SI actions are reviewed at Performance Review Meetings. For CPG4, Ms Truscott reported that most actions following SIs have been completed, adding that a grade 3 pressure ulcer is under investigation and a failure to rescue incident has recently been escalated to become an SI and actions have been taken. For CPG3, Ms Powls noted several grade 3 pressure ulcers and 2 failure to rescue incidents with significant harm being investigated. Valentine Ellis Ward is undertaking a programme of skills training for staff and out of hours care is being examined, particularly in relation to patient deterioration over weekends and links to pressure on Site Team cover availability. For CPG2, Ms Oke reported 1 failure to rescue incident under investigation, relating to junior doctor handover timings. The priority for CPG2 currently is to address a low incident reporting rate, caused by a drop in the reporting of non-clinical incidents.
ACTIONS:

- **Mrs Rodenhurst to review outstanding actions from serious incidents and note any recently closed items.**

Nursing & Midwifery Harm Free Care Report

The report included staffing incidents and NHS Safety Thermometer data, by ward. Comments were invited from CPGs. Dr Redhead reported that CPG1 had noted improvements. Some issues linked to staff re-distribution are now improving. For CPG2, Ms Oke noted leadership changes on Ward 6 North during the period of some incidents as well as an increase in reporting for required audits. For CPG3, Ms Powls acknowledged the issues relating to Ward 7 South. For CPG4, Ms Truscott reported that actions are being taken on the poor nursing outcomes reported. For CPG5, Mr Edmonds stated that Victor Bonney Ward is currently experiencing 20% staff vacancies and recruitment is under way. Stanley Clayton Ward has a small staff complement so percentages may not be the most suitable way of presenting data here, suggesting minimum staff levels for triggering action. For CPG6, Ms Heywood reported that the actions were being addressed by Mrs Dunn. Mr Edmonds suggested inviting the Lead Nurse of Private Patients to be a member of this Committee.

ACTION:

- **Mr Jones to invite Sue Boyle to attend this meeting on behalf of Private Patients.**

Clinical Standards Committee / Guidelines & Clinical Effectiveness Monitoring Group Annual Report

Clinical Standards Committee (CSC) covers both presentations of data from clinical effectiveness or benchmarking exercises and the Trust's obligations relating to clinical audit, NICE compliance and NCEPOD submissions and compliance. The recent NHSLA compliance declaration demonstrated that the Trust is meeting all requirements. Some challenges include generating clinical engagement and obtaining administrative support, particularly for the NCEPOD submissions, which are obligatory. As a result, quicker escalation to the Medical Director has been enacted and all recent NCEPOD cases have been submitted. NICE continues to be addressed and a programme of work to review outstanding actions from past clinical audit projects is being undertaken. The message to CPGs is to do fewer clinical audit projects in order to be better able to complete implementation and re-audit and to continue to promptly respond to NICE and NCEPOD requests. The continued support of the Medical Director to facilitate escalation will be key.

Professor Taylor asked how the Trust evaluates NICE compliance. Dr Fox explained the process in detail, emphasising the seeking of clinical responses from those leading in the respective clinical area. A quarterly report on NICE compliance goes to CSC and these data are summarised and included in the Risk, Patient Safety & Service Quality Quarterly Report and the Quality & Safety Scorecards. Ms Mottram asked whether the Trust is now compliant with failure to rescue NCEPOD recommendations and NICE CG50 on the Acutely Ill Patient. Ms Powls reported that this was not the case. Mr Jones reported that he is summarising outstanding failure to rescue NCEPOD recommendations for Ms Powls' attention. Ms Mottram asked whether there is an end deadline for the clinical guidelines review work. Dr Fox stated that the work was split into two phases. The first phase, of eliminating non-applicable guidelines, has been completed. Phase two is to revise existing guidelines and this will reside with CPGs. No clinical incidents have been linked to use of dated clinical guidelines. Ms Mottram suggested placing clinical guidelines for review on the Quality & Safety Scorecard and Dr Fox agreed. Ms Heywood noted that all Nursing & Midwifery clinical guidelines are now up to date. Dr Fox added that most clinical guidelines will need a brief review and an amended future review date. Dr Fox felt that the CSC will benefit from review with the new Medical Director. Ms Mottram noted that recent inspectors have been impressed with Trust work on NICE compliance, clinical audit and CAS alert implementation.

ACTIONS:

- **Mr Jones to summarise NCEPOD recommendations linked to failure to rescue and forward these to Ms Powls.**
- **Dr Fox to consider ways to generate quarterly clinical guidelines review data for the Quality & Safety Scorecard.**

Blood Transfusion Committee Annual Report

Recent changed to the small Blood Transfusion Team were reported and priorities were summarised. A plan is under consideration to change the governance arrangements for blood transfusion to create CPG-level 'Blood User Groups'. Inspections were summarised, with a critical non-compliance being identified in cold-chain management at CXH and HH during CPA inspection. As a result, kiosks are being considered for roll-out across all sites. Traceability was reported as 96% and above, though these figures routinely rise on further investigation. Blood transfusion training modules are now on Moodle and transfusion competency assessments for F1 doctors are now done before they start work. Work continues to meet the requirements of the 'Right Patient, Right Blood' NPSA alert. The Olympics response was successful and no emergency plan actioning was necessary. Fewer blood components are being used in comparison to earlier years. Usage data was presented, though better clinical-level data is needed to determine appropriateness of usage. A new policy and documentation on acute transfusion reactions have been launched. All national audits have been submitted to.

Flu Vaccination Programme

A report run today by Mr D'Arcy found that over 2000 doses had been administered in the first three weeks, more than double the achievement of last year. The report was noted.
ACTION:
- **Mr D'Arcy to present a further flu vaccination programme update at the next meeting.**

Resuscitation Services Annual Report
Level 3 NHSLA standard had been achieved for Resuscitation and DNAR. Participation in the National Cardiac Arrest Audit (NCAA) started on 1st January 2012. Data on resuscitation was presented, with prevention rates particularly notable. Work on unifying the service is nearing completion. Site differences were noted from the data, which was up to 31st December 2011. A discussion proceeded on the age of the data and some site comparisons which needed further explanation.
ACTION:
- **Dr Mitchell to discuss with Professor Cheshire and Mr Spearpoint the issues relating to data period and site comparisons for various categories of resuscitation data.**

Professional Registration Renewals Annual Report
Data on checks and verifications of professional registration showed 3 breaches amongst medical staff and 1 breach amongst non-medical staff. Robust systems and processes are in place to provide ongoing assurance on registration matters. All breaches had been satisfactorily investigated and all but two actions had been completed, with the remaining two in progress.

Minutes of sub-committees
The minutes of the Clinical Risk Committee of the 20th September 2012 and the Clinical Standards Committee of the 28th September 2012 were noted.

SUMMARY 1st October 2012

Action log of the previous meeting
The items on the action log were reviewed and the following items were closed:
- Dr Redhead agreed that in the absence of further comment on Dr James's CPG1 Dementia Policy, it can now proceed to being adopted as a Trust policy.
- Dr Redhead also confirmed that Dr Mitchell has commenced work on WHO checklist guidance.

Monthly Control of Infection Summary Report
There had been no MRSA BSI in August 2012, with a total of two in the year to date against an annual threshold of nine. For C Difficile, there had been six in August, 38 in the year to date against an annual threshold of 110.
ACTION:
- Infection Control Team to include a summary of ANTT in the November Report.

Pressure ulcers
There had been 56 Trust-acquired pressure ulcers in August of all grades, including one grade 3 ulcer but no grade 4 ulcers. There had been 214 in the year to date, including five at grade 3 or 4. Themes are emerging from related serious incidents which are being addressed. This constituted an improvement on 2011/12.

Antibiotic stewardship
Data from June shows an improvement in prescribing practice. Indicator 1 (prescribing within policy) and 2 (documented indication for prescription) are at around 90%, with Indicator 3 being at 64%, relating to stop/review date or duration being recorded. A sub-group of Antibiotic Review Group is managing this work.
ACTION:
- Infection Control Team to provide update on antibiotic stewardship Indicators 1 to 3 in each report to Q&SC.

- **Flu vaccination programme**

Last year saw the highest staff uptake, but still short of comparable trusts at 29% of head count. National average is 44%. The programme includes a communication strategy to support the imminent launch of the campaign. Joint effort of all staff is needed to improve uptake. It was agreed that the Committee would back this launch. This includes contracted staff and students.
ACTION:
- Mr Jones to place the flu vaccination programme on the agenda for November.

Monthly (August 2012) Quality & Safety Scorecards.
- CPGs to report by exception

Incident reporting rate is at 6.3%, below the national average of 6,5%. Variation between sites and CPGs was outlined. Serious incident actions due for completion are being addressed. There had been four serious incidents in August, a significant reduction on previous months. The Trust reported 100% of completed investigations to NHS London to deadline and was 100% compliant with its Being Open Policy. The Trust remains below national average for falls. Patient identification errors remain a concern and medication errors are above the internal target. August saw the highest monthly number of failure to rescue incidents this year. Those present agreed to launch the National Early Warning Score (NEWS) system. A discussion ensued on Trust leadership for failure to rescue. CPG3, via Dr Palazzo, shall lead on this work, including the launch of NEWS. The majority of reported failure to rescue incidents are at Charing Cross site. Action plans are to be reviewed at the next meeting. Complaints response rate remains above 90%, it had dropped in CPGs 2 and 3. Actions resulting from the scorecard were summarised. There were no CPG reports. Cross site transfer issues are being investigated. The. Transfer Policy has been reviewed and this issue is a pan-London quality priority. Further review will occur following completion of investigation of the serious incidents.
ACTIONS:

- Variation will be further reviewed as part of the next ‘Reporting Counts’ walkarounds and reported to the Committee in November.
- Local improvement actions will be included in the report to the Committee in November.
- CPGs to update on their outstanding actions from Serious Incidents.
- Medication Safety Group representative to present an overview of their work regarding near miss medication errors at the November committee.
- The Committee to be updated by Finance and Pharmacy leads regarding storage of fluids at the Hammersmith site.

Action Plan for IR(ME)R and ID Incidents
Data was summarised relating to 2011/12 incidents, with the majority related to patient identification. There had been a significant increase over time. The harm rating was ‘none’ or ‘minor’ in all but one case, which was rated ‘moderate’. Trends by site for identification incidents showed an increase across all sites. In CPG analysis, CPGs 2 and 3 showed an increase. Referral errors are also increasing. There were more IR(ME)R incidents noted at Charing Cross site, thought to be due to the Imaging case mix there. There had been no cases reported at Hammersmith site for two years. Imaging incidents relate mainly to Outpatients. Identification incident types were summarised. Mr Edmonds suggested using a ‘WHO Checklist’ type arrangement for Imaging. Ms Sigsworth agreed with this idea, in addition to the existing transfer form. Interventional Radiology uses a modified WHO Checklist already. Over 10% of junior doctors still are not trained nor have access to Pi and that a list of these staff has been requested.

ACTIONS:

- Mrs Dunn to take back to Imaging the suggestion that all specialties within Imaging use the modified WHO Checklist in future.
- Mrs Rodenhurst to send the list of junior doctors not trained or able to access Pi to Mr Jarrold when received.

Nursing & Midwifery Harm Free Care Report
The tool used was outlined and is evolving over time. The number of Nursing & Midwifery staffing incidents has been added. This tool is used at Establishment Review Meeting and CPG performance meetings. The Nursing & Midwifery Professional Practice Committee will also use the data to improve practice. The exception report by CPG is to be reviewed at this Committee and be noted by CPGs.

CPG1 Annual Report
Highlights emphasised included patient experience improvements and partnership working. Endoscopy had moved from Charing Cross and this had helped to deal with clinical safety concerns. The plan to rebuild Endoscopy at St Mary’s site is on target to complete during 2013/14. A reduction in falls was noted. The plans for 2012/13 were summarised, including measurement of the patient experience of acute areas. Other priorities include C Difficile prevention and antibiotic stewardship. Management and governance structures were changed and these are now reaping the intended benefits. Learning from complaints, incidents and particularly legal claims were emphasised. Changes had been made recently to the status of escalation beds in CPG1 but it remains an issue, with a check being kept on length of stay to minimise increases. Work is being undertaken with Mr McManus on escalation in the context of financial considerations. Ms Sigsworth asked which three achievements were felt to be the best. Ms Ballard suggested the 50% C Difficile reduction, the improvements in Outpatients experience using I Track data and the reduction in falls. Dr Redhead added the collaboration with local healthcare partners.

NSF Children Annual Report
An overview of achievements was given, including creation of a criteria-led discharge role, adoption of patient

experience tracker devices, improvements to catering, launch of pain management guidelines, implementation of a volunteer team and improvements in interface communications. Plans going forward include engaging users of disabled children's service, revision of the approach to Eliminating Mixed-Sex Accommodation (EMSA), development of a mental health pathway, consideration of the impact of the Trauma Unit and development of the website. The deadline for implementing the NSF is 2014. Staff at the Western Eye Hospital are addressing safeguarding issues.

CPG Staffing Clinical Incident Review Report
The issue of staffing-related clinical incidents was highlighted. The majority relate to Nursing & Midwifery and all but one were harm-rated as 'none' or 'minor'. The majority reside in CPGs 1, 2 and 5. In CPG1, 58% of incidents were in A&E and admission units. The weekend just past saw six such incidents across all sites, mostly at SMH and related to bank fill over the weekend. The relevant governance arrangements were detailed. CPG1 had held meetings regarding its recruitment plan and the CPG1 vacancy rate had reduced considerably. Some incidents relating to the need for a Lung Clinical Nurse Specialist were found to rest with CPG2. Concerns had been raised about Reed. A discussion on logistics in support of weekend cover ensued.
ACTION:

- Heads of Nursing to discuss concerns relating to Reed, escalating issues to Mr Griffin.

Tissue Guardian Annual Report
A brief overview of Tissue Bank, consent for extra tissue and Human Tissue Authority (HTA) inspection requirements was provided. An online system for data collection has been launched. The main issue remains consent. Patient information sheets had been agreed but these and the new consent forms are not yet widespread. Consent forms and patient information leaflets are now explicitly linked on Cedar. Problems with staffing due to funding delays had been partly alleviated with the appointment of a second technician in September. Funding for Tissue Bank was halved and though HTA compliance remains covered, there is little funding remaining after this cover is assured. Discussions are therefore now underway for new funding streams, with two years to address these.

New Interventional Procedures Committee Annual Report
The New Interventional Procedures Committee had seen an increase in procedures discussed and an improvement in attendance. A retrospective audit of procedures found no evidence of procedures not being brought to the Committee's attention. Turnaround times standards for decisions were being met. Although some submissions relate more to research, these have been successfully detected.

NHSLA report and feedback
The Final Report of the NHSLA Level 3 Assessment August 2012 was circulated and all those involved in passing this assessment were thanked for their participation. Dr Mitchell added that this was a major achievement. The process undertaken was summarised and detail given on the two standards not passed. One of these, Patient Information & Consent, had received mixed feedback from the NHSLA assessors and colleagues were reminded to document in clinical notes when patient information has been provided. Minor feedback had also been given by the NHSLA on a further five standards. Policy updates are under way. The Trust is implementing action plans from the compliance reviews; and the consistency of policy production is being addressed. The Maternity CNST assessment is in November.

Feedback on Consent Audit and Documentation Standards
A review of compliance with the consent policy showed good results. Quality of the documentation of 'best interests' decisions at St Mary's ICU using Consent Form 4 were noted and had been addressed since the review. Regarding Documentation Audit, a number of audits had taken place during 2012 and a further live records check was conducted by NHSLA assessors during the assessment. Documentation audit is now part of a rolling programme of Quality & Safety Walkarounds and a revised policy on Basic Records Keeping Standards had been implemented.

Minutes of sub-committees
The minutes of the Clinical Risk Committee of the 16th August 2012 and the Clinical Standards Committee of the 27th July 2012 were noted.

Policies and Documents for Ratification
The ratification was duly noted for Restraint Procedural Guidance and Resuscitation Policy. Subsequent review of Resuscitation Policy is under way. DNAR forms need addressing as there are currently two in use. Any decision on choice of DNAR form would need medical ratification.

Any other business
On the CQC visit in August, a report is due from CQC but no concerns had been raised at the visit. General CQC site visits to Hammersmith site and St Mary's site are due before the end of March 2013. Phase 2 of the

External Clinical Governance Review starts this week, with particular focus on CPGs 1, 3 and 5

Trust Board: 28th November 2012 **Paper number: 12/11/28 – 17**

Report Title: Summary of the Governance Committee Meetings held on 17th October 2012

To be presented by: Sir Thomas Legg, Non-Executive Director and Chair of the Governance Committee

Executive Summary:

Local Risk Assessment and Management of Risks
CPG 1, Nursing, Human Resources and Pharmacy all presented overviews of their risk management processes and top ten highest scoring risks. Risks and mitigations relating to the following were highlighted: failure to respond to acutely ill patient, patient falls, meeting CIP targets for CPG1 in addition they noted that capacity and failure to meet A&E targets, issues related to winter pressures and compliance with NHS London directives could be expected to escalate into the top ten upon regular review; CIP effecting staff levels, failure to deliver equality and diversity, patient experience data loss for Nursing; staff sickness issues, failure to improve workforce productivity, staff appraisals not being completed regularly and engaging staff for Human Resources; and failure to contain medicine budget expenditures, meeting CIP targets and maintaining acceptable staff levels, which will be followed up, for Pharmacy.

No risks as presented were escalated to the Board Level Risk Register.

Education Annual Report
The Trust was awarded Lead Provider status for postgraduate medical training in a further 9 specialties in addition to the provision of training in Core Medicine, Core Surgery and Core Psychiatry and a GP pilot for North West London Sector. Nursing and Midwifery have further developed their strategic aims of increasing staff with higher qualifications, which should translate into better patient care. The Trust improved e-learning capabilities, simulation infrastructure; initiated technology enhanced learning projects and raised significant new funds. Aims for next year included to enhance the opportunities of the AHSC and ensure education and training remain highlighted within any North West London reconfigurations. Governance of Education was discussed.

Mandatory Training Report and Training Schedules
It was reported that all relevant NHSLA standards for mandatory training were met at the recent NHSLA compliance assessment. Overall, mandatory training compliance is 76%, induction compliance for permanent staff is 58% and local Induction for permanent staff is 60%. The new e-learning platform Moodle has delivered some improved results. A targeted campaign will be launched again in October as all Trust staff are again required to complete Information Governance Training. From December onwards, the key Trust priority will be to ensure staff complete Cerner training in support of the 2013 implementation. Improvement plans continue and improvements in data capture are being undertaken. A link between mandatory training and the Education Directorate was discussed.

Reports Noted / Approved
A report on risk assessment of the CIP programme was considered. Reports from the Quality and Safety Committee and Patient Experience Committee were noted.

The Governance Committee approved the Health, Safety, Security and Fire Committee Terms of Reference.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
5. Achieve outstanding results in all our activities.

Purpose of Report

a. For Decision ☐
b. For information/noting √

Trust Board Meeting 28th November 2012

Supporting Documents

Paper 18 – Chief Executive Report Appendices

Paper 19 – Trust Approach to Risk Management in CIP

Paper 20 – Cancer Implementation Plan

Paper 21 – CQC Charing Cross Hospital Visit Report

Paper 22 – Update on Waiting List Actions

Paper 23 – Maternity Risk Management Strategy

Paper 24 – Patient Safety and Service Quality Annual Report

Appendix A – NHSLA Risk Management Standards for Acute Trusts letter to recognise level 3 compliance, Chief Executive

Litigation Authority

2nd Floor
151 Buckingham Palace Road
London
SW1W 9SZ
DX: 6611000 Victoria 91 SW

Tel. 020 7811 2700

31 October 2012

Our Ref: CD/ec/T670

Mr Mark Davies
Chief Executive
Imperial College Healthcare NHS Trust
St Mary's Hospital
Praed Street
London
W2 1NY

Dear Mark,

NHSLA Risk Management Standards for Acute Trusts
Level 3 Assessment: Thursday 30th and Friday 31st August 2012

As you may recall, shortly before this assessment took place we exchanged correspondence regarding your concerns about various aspects of the NHS LA standards and assessments. I hope my letter of 29 August 2012 adequately addressed your concerns.

Since joining the NHS LA, I have continued the practice started by my predecessor of writing personally to the Chief Executive of trusts that have achieved or retained Level 3 of our standards to congratulate them, because I feel that is important to recognise this considerable achievement and their commitment to managing risks and improving safety.

Thus, on behalf of the NHS LA and its team of independent risk management assessors, I would like to congratulate Imperial College Healthcare NHS Trust on retaining Level 3 compliance with the NHSLA Risk Management Standards for Acute Trusts. The Board and staff of the Trust can be justly proud of this achievement.

Yours sincerely

Catherine Dixon
Chief Executive

cc Anne Mottram, Director of Governance, Imperial College Healthcare NHS Trust
Andrea Holder, Senior Assessor - DNV Healthcare UK
Harriet Smith, Senior Assessor - DNV Healthcare UK

Appendix B – CNST Risk Management Standards for Maternity Services level 3 letter of confirmation

DET NORSKE VERITAS

DET NORSKE VERITAS

Highbank House
Exchange Street
Stockport
SK3 0ET

Support Team: 0161 477 3818
Direct line: +44(0) 1582 561 027
Email: Andrea.Holder@dnv.com
http\\www.dnv.com
Registered in England No.:1503799

Mr Mark Davies
Chief Executive Officer
Imperial Collage Healthcare NHS Trust
St Mary's Hospital
London
W2 1NY

13 November 2012

Our ref: T670

Dear Mr Davies

CNST Maternity Clinical Risk Management Standards 2012/13 - Level 3 Assessment

Please find enclosed the report following the assessment on Tuesday, 06 November and Wednesday, 07 November 2012, which confirms that the maternity service has been successful in achieving Level 3 of the CNST Maternity Clinical Risk Management Standards.

The scores awarded for each criterion are contained in the accompanying evidence template and report, and identify the areas of compliance and non-compliance. The report contains information on the maternity service's options for the next assessment.

Following a request under the Freedom of Information Act 2000, and in line with the ethos of providing more information for patients and public, the NHSLA will publish on its website the reports which are produced following an assessment. If the maternity service wishes to raise any concerns as to the wording and/or factual accuracy of the report, these should be notified to the assessor within 20 working days of receipt of the report. It will not be possible to make any additions to the report. Further information about assessments may be disclosed under the Freedom of Information Act 2000.

If you have any queries, or would like further information, please contact me via email or telephone as above.

Yours sincerely
for Det Norske Veritas Ltd

Andrea Holder
Senior Assessor - DNV Healthcare UK
cc Pippa Nightingale, Head of Midwifery, Imperial College Healthcare NHS Trust
Amanda Ayres, Senior Assessor, DNV Healthcare
Sue Calvert, Senior Assessor, DNV Healthcare
Kat Jenkin, Senior Assessor, DNV Healthcare

DNV Healthcare UK – working with the NHS Litigation Authority, Macmillan Cancer Support and CECOPS to help make healthcare healthier

www.nhsla.com
www.macmillan.org.uk
www.cecops.org.uk

Appendix C - NIDCAP Federation International letter

October 18, 2012

Mark Davies
Chief Executive
Imperial College Healthcare NHS Trust
Bays Building
St. Mary's Hospital
London W2 1NY

Main Office
Neurobehavioral Studies
Enders Building EN107
Children's Hospital Boston
320 Longwood Avenue
Boston, MA 02115
United States
617.355.8249
www.nidcap.org
nfidirector@nidcap.org

Membership Office
Suite 170-127
6300 Creedmoor Rd
Raleigh, NC 27612-6745
United States
nfimembership@nidcap.org

Dear Mr. Davies,

Although it has been two weeks since my return from England, I am still feeling the high level of enthusiam generated by our recent NIDCAP Federation International meeting held at the Sopwell House in St. Albans. Our hosting team led by Inga Warren (Director of the UK NIDCAP Centre at St. Mary's), supported by Pippa Jones, Chief Executive of the Winnicott Foundation, Beverly Hicks, OT and Cherry Bond (Winnicott Baby Unit) , created the perfect atmosphere for scientific exchange and professional development throughout our 23rd Annual NIDCAP Trainers meeting. It may interest you to know that our group of 110 professionals represented five continents, nineteen countries and nine different professional disciplines plus parent representatives of newborn intensive care.

Congratulations to you and the Imperial College Healthcare NHS Trust on this very successful international meeting. Inga and her colleagues are to be commended for their leadership in mentoring caregivers, changing hospitals and improving the lives of newborn and their families who experience intensive care. Our program evaluations applaud our hosts and rave about the support and facilitation enhancing our learning and scientific development. On behalf of our international organization I sincerely thank you for your support of our very successful meeting.

Sincerely,

gretchen Lawhon, PhD, RN, FAAN

gretchen Lawhon, PhD, RN, FAAN
President, NIDCAP Federation, International
Associate Professor of Pediatrics at Cooper Medical School of Rowan University
Clinical Nurse Scientist, Division of Neonatology
Director, Mid-Atlantic NIDCAP Center
Children's Regional Hospital, Cooper University Hospital
One Cooper Plaza, Suite 755, Dorrance Building
Camden, NJ 08103 U.S.A.

Cc: Inga Warren

Mentoring caregivers. Changing hospitals. Improving the future for newborns and their families.

Appendix D – JAG Accreditation letter of confirmation

JAG

Joint Advisory Group on GI Endoscopy

www.thejag.org.uk

20 November 2012

Mark Davies
CEO
Imperial College Healthcare NHS Trust
The Bays Building
St Mary's Hospital
Praed Street
London
W2 1NY

Dear Mark,

Re: JAG Accreditation – Hammersmith Hospital and Charing Cross Hospital

Following the JAG Accreditation visit to the endoscopy unit at Hammersmith Hospital and Charing Cross Hospitals on 18th and 19th July, I am pleased to confirm that the endoscopy unit at Hammersmith Hospital and Charing Cross Hospital have met all of the required JAG Accreditation standards.

We would like to congratulate you and your staff for the high standard of achievement.

Please find attached the final JAG visit reports, which show that the endoscopy units have been awarded full JAG Accreditation for one year.

From 2012 onwards, accreditation will be awarded annually following successful completion of the April GRS census and submission of the Annual Report Card. Thereafter there will be 5 yearly JAG Accreditation site visits.

Yours sincerely

Neil Haslam
Chair QA Units Working Group

cc: JAG Visit Assessment Team
Mrs Lynn Coleman - Assistant Director, NHS Cancer Screening Programmes

JAG Office
Accreditation Unit
Clinical Standards Department
Royal College of Physicians
11 St Andrews Place
Regent's Park
London
NW1 4LE

020 3075 1620
askjag@rcplondon.ac.uk

Page 1 of 1

Imperial College Healthcare NHS
NHS Trust

The Trust's approach to managing clinical risk within CIPs

Purpose

This is a paper for the Trust Board aimed at stimulating discussion and raising awareness of the recent reports from the National Quality Board (NQB), and in doing so assess ICHT's governance system and processes for managing its Cost Improvement Programme (CIP). This is of the highest importance for the Trust and is being considered within the context of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the "Francis Report") which is due to be published in the new year, as well as the changing landscape of the new health system.

The paper focusses on the NQB recent guide "*How to*: Quality Impact Assess Provider Cost Improvement Plans" which has been published to support all parts of the health system to minimise the impact of over ambitious or poorly governed CIPs and to ensure patient quality and safety is not put at risk. The approach set out in the guide is reflective of the guidance issued by Monitor to providers as described in the *Amendments to Applying for NHS Foundation Trust status – Guide for applicants (July 2010)* and *Delivering sustainable cost improvement programmes – January 2012*.

Summary

The NQB have recently published a set of guides to support health systems to assess, assure and intervene in the management of risk. The guides include:

1. ***How to: organise and run a rapid responsive review*** is the guide to help prepare for and organise a day-long systematic visit to a NHS organisation where quality indicators are beginning to cause concern. It is aimed at Commissioners / SHA. The paper sets out the triggers, which may result in an announced or unannounced Rapid Response Review by SHA or Commissioners. These triggers, which are not exhaustive, are set out in Appendix A;

2. ***How to: organise and run a risk summit*** will aid the supervisory and regulatory bodies in the effective communication and coordination between all stakeholders to respond in a coordinated way in the face of potential service failing in patient care during this transition year (see Appendix B);

3. ***How to: quality impact assess provider cost improvement plans*** will allow a trust board and the supervisory and regulatory bodies to make a quality impact assessment of proposed cost improvement plans with the focus on clinical input and the potential impact on patients and staff. This is aimed at Trust, Commissioner & SHA board. Its purpose is to ensure that the identification, management and impact of CIPs do not adversely affect quality or safety, nor create a situation whereby registration is put at risk.

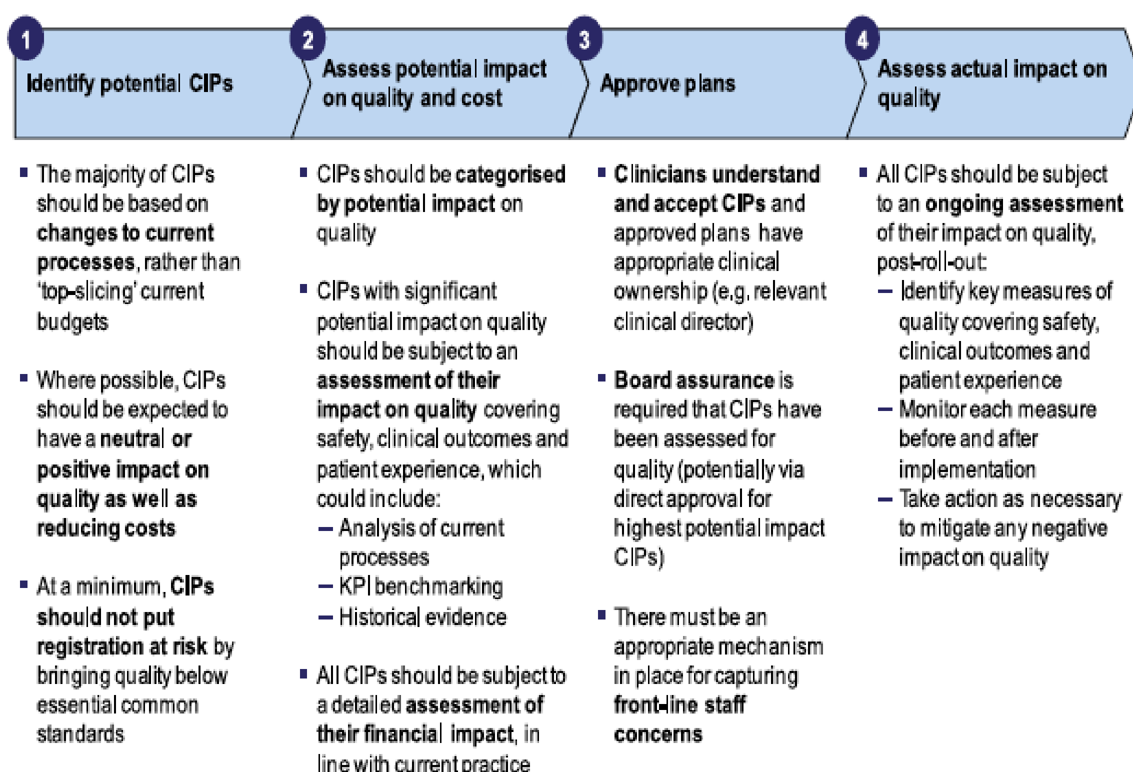
This paper focusses on the third guide.

Approach

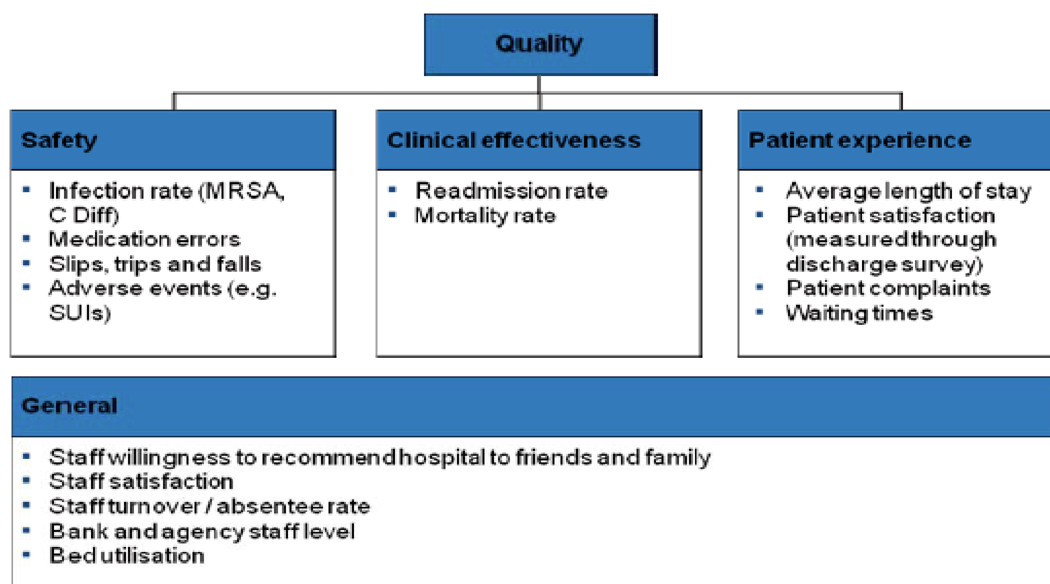
The third guide *"How to:* quality impact assess provider cost improvement plans" sets out the approach for the identification, management and assurance of the impact of CIPs to quality throughout an organisation. The document outlines a range of suggested approaches for the whole health system to adopt to ensure the impact of CIPs to quality or safety is fully understood and managed.

The guide sets out the following:

- ***Governance***
  The diagram below lays out the decision-making and assessment processes for the sign off and subsequent monitoring of CIP schemes:



- ***Defining quality***
  Suggests a range of quality metrics which should be used to track and monitor the impact of CIPs on quality and safety, and that these are being reported at a Board level:



The guide recommends that all CIP schemes are risk assessed and where quality is called into question that they are quality impact assessed.

- ***STAR Chambers***
  STAR Chamber should be established to monitor and assure that risks to quality and safety are being effectively managed. It specifically stresses the importance of the role of clinical staff and Medical/Nurse Directors:

  - The role of clinicians, particularly medical and nurse directors is central to making all this happen. By working systematically through the various stages set out in the guide, medical and nurse directors can add weight to any judgments made about the quality impact assessment of provider cost improvement plans.

  - Moreover, the 2012/13 Operating Framework makes clear the requirement for NHS trusts that all CIPs should be agreed by provider medical and nurse directors.

  - The chance that working documents will be accessed in the future or be subject to audit is fairly likely, particularly in the event of an adverse incident or negative organisational profile arising once commissioners and/or SHAs have assured themselves that specific CIPs were acceptable. For medical and nurse directors this will be particularly important given their board responsibilities for sign off of the quality impact assessments and the associated factors governing their respective professional registration with the General Medical Council and Nursing and Midwifery Council.

Self-assessment approach

By using the guide we have undertaken a preliminary self-assessment of ICHT's approach to managing its CIP.

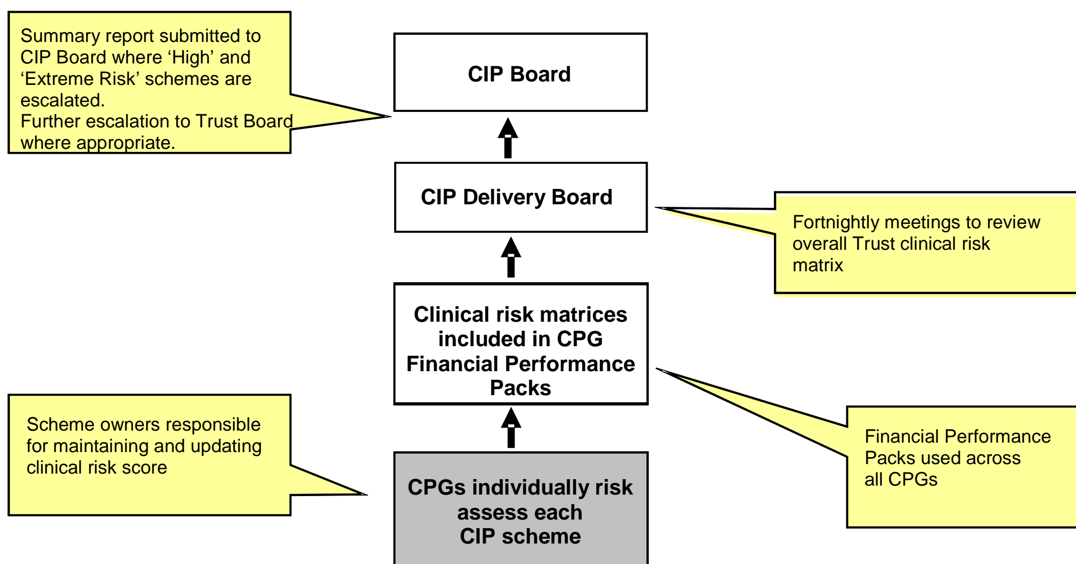
Governance (page 12 in the guide)

The self-assessment below compared the guide's Governance check list against ICHT's current approach:

Criterion	Current position/assessment
1. Has the chief executive agreed the governance arrangements and secured board endorsement?	Yes - the paper outlining the governance arrangements for the Trust's CIP (*CIP Management Arrangements, including Clinical Risk*) was presented and approved at both the Management Board (21 May 2012) and Trust Board (July 2012).
2. Are the medical and nurse directors engaged and leading the process?	Yes. The Medical and Nursing Directors are members of the Trust's CIP Board, which is the group established to monitor delivery of CIP and provide a means of holding the organisation to account for CIP delivery.
3. Is the board reporting regime clear and widely promoted i.e. is there transparency of process?	Yes - the paper outlining the governance arrangements for the Trust's CIP (*CIP Management Arrangements, including Clinical Risk* - presented at the 21 May 2012 Management Board meeting and July 2012 Trust Board meeting) specifically references the CIP reporting requirements and has been widely circulated throughout the trust, and other organisations such as the SHA. It specified that: - The CIP Board, with executive team membership, meets monthly, focusing on monitoring delivery and challenging those managerial and clinical leads that are not delivering to plan; - The CIP Delivery Board, chaired by the Head of Transformation, is a forum for leadership teams from all CPGs and corporate directorates to attend and discuss the delivery of CIP and tackle challenges being faced; - The Head of Transformation meets with the Head of Operations and Head of Finance of each CPG every fortnight to review progress and holds them to account for delivering their CIP; - There is a clearly defined process for CIP sign-off once the schemes have been fully scoped and worked up and entered into the central CIP database. This process ensures a clinical risk assessment is

	completed and considered for each CIP scheme. In addition, a clinical risk matrix is now included within each CPG's Financial Performance Pack which is discussed at a local level in the Trust at each CPG Board, as well as corporately at both the CIP Board and individual monthly CPG Performance Reviews.

As first detailed in *CIP Management Arrangements, including Clinical Risk*, the relationship of the CIP Board to how clinical risk is managed is set out below:



4. Are the arrangements for providing assurance to the board, commissioners and Monitor in the case of FTs, both about the delivery of the CIP and the on-going validity of the quality impact assessment clear and documented?	Yes, to some extent – we have established clear reporting and monitoring of CIP delivery through the CIP Board and CIP Delivery Board and monthly finance report to the Trust Board, which coincides with the monthly report on achievement of Performance and Quality Indicators. The SHA attended the August meeting of the CIP Board to gain assurance of ICHT's CIP governance processes. In the future a summary of the Trust's clinical risk matrix will be submitted to the Management Board and Trust Board.
5. Is the management team formally engaged and committed to matrix	The CIP Board's membership includes: Nursing Director, Medical Director, Chief Financial Officer,

working / information exchange?	Chief Operating Officer, Director of HR. The CIP Board reports back to the Trust Management Board, Chaired by the Chief Executive. The Trust's Management Board is also regularly updated on finance, CIPs and performance, including issues where performance and quality are potentially affected.
6. Are quality impact assessment reports generated and circulated regularly to stakeholders?	All CPGs have committed to completion of a risk assessment (including a Quality Impact Assessment (QIA)) of CIP schemes contained within their 12/13 plan. These are signed off and reviewed by each CPG's Clinical Director and Head of Nursing, often as a regular item on the agenda of their CPG Boards as required in *CIP Management Arrangements, including Clinical Risk.* Consequently 12/13 CIP schemes are routinely risk assessed and RAG rated by CPGs, and which is logged onto the central repository for CIP plans. There is currently limited visibility of CPGs' risk assessments outside of CPGs themselves. The CIP Board reviews the ratings of all CIP risk assessments of CIPs, focussing on those schemes that have rated as 'High' or 'Extreme Risk'.
7. Are all stakeholders such as HealthWatch, LINks, overview and scrutiny committees, social partnership forums briefed and engaged?	CPGs are required to hold ad hoc meetings with relevant stakeholders as appropriate to discuss the impact of CIPs (e.g. staff-side). Limited engagement to date with patient groups.
8. Are arrangements in place to ensure that quality is assessed as part of monthly performance reviews to ensure integration with finance, workforce and performance assessment?	All CPG leadership teams participate in a monthly Performance Review with the Executive team (see below for standard agenda), where the standard agenda includes the review of quality within the context of delivering financial, workforce, performance and strategic KPIs. It is important that the Trust ensures that it is compliant with the quality governance standards as set out in

	Monitor's *Quality Governance Framework (July 2010).* A clinical risk matrix is now included within each CPG's Financial Performance Pack which is discussed at a local level in the Trust at each CPG Board, as well as corporately at both the CIP Board and individual monthly CPG Performance Reviews (see below).

A standard agenda for monthly CPG Performance Review is set out below:

Quality
- *Clinical Outcomes*
- *Serious Incidents (i. Under Investigation, ii. Possible SIs under review)*
- *Infection Prevention & Control (MRSA, C.Diff, Hand Hygiene Compliance, ANTT Training rate)*
- *EMSA*
- *Patient Experience*
- *CQUIN*
- *Harm-free Care Report*

Financial Performance
- *Month position, forecast & Income & expenditure*
- *CIP*

Operational Performance
- *Elective Access*
- *Cancer waiting times*
- *Cancelled operations*

Workforce
- *Budget & Spend*
- *Workforce KPIs*
- *MPI*
- *Nursing Ward Establishments*

An example of the clinical risk matrix for CPGs is set out below (as of 18 October 2012):

	CPG1		CPG2		CPG3**	
	Number	£000s	Number	£000s	Number	£000s
Low [1-3 score after mitigation plan]	24	4,408	36	3,820	21	4,857
Moderate [4-8 score after mitigation plan]	7	1,251	1	480	5	667
High [8-12 score after mitigation plan]	0	0	0	0	3	119
Extreme Risk [12-25 score after mitigation plan]	0	0	0	0	0	0

	CPG4		CPG5		CPG6*	
	Number	£000s	Number	£000s	Number	£000s

Low [1-3 score after mitigation plan]	133	7,242	66	2,581	42	1,386
Moderate [4-8 score after mitigation plan]	0	0	10	1,685	42	2,819
High [8-12 score after mitigation plan]	0	0	0	0	38	3,493
Extreme Risk [12-25 score after mitigation plan]	0	0	0	0	2	75

**Please note that due to the large number of schemes rated as 'High' or above, CPG6 has been asked to review these CIP schemes to confirm whether the ratings are still valid and if so whether the schemes have been signed off for implementation. Following the review CPG6's Director and Head of Nursing will be attending the 29 November 2012 CIP Board to report back.*

In initial discussions with CPG6's acting Head of Operations it would appear that the risk ratings for the CIP schemes in question have not been revisited since being first assessed it is therefore envisaged that following the review many of the 'High' risk schemes will be downgraded.

***Of the other CPGs only CPG3 have any 'High' risk schemes. Of these three schemes, two had plans originally but which were then subsequently dropped (and so have a zero value). CPG3 have been asked to confirm the risk rating of their sole remaining 'High' scheme and if they confirm it still stands their Director and Head of Nursing will be asked to attend the CIP Board too.*

9. Have "cross-over reviews" been designed into the governance process to help assess the cumulative impact of CIPs and to keep a search for any unintended consequences or known risks which are not being adequately mitigated?	Yes, informally. The CIP Delivery Board, chaired by the Head of Transformation, is a forum for leadership teams from all CPGs and corporate directorates to attend and discuss the delivery of CIPs, to highlight cross directorate issues and risks, and to tackle challenges being faced. Currently there is no formal mechanism for "cross-over reviews".
10. Is there a robust facility for front line staff to confidentially report concerns about CIP schemes and their potential negative impact on quality, patient experience or safety or indeed on staff?	The Trust has made clear its expectation around whistleblowing in its *Raising Concerns Policy and Procedure (Whistleblowing) An Organisation-wide Policy and Procedural Document (2011).* It states as follows: *Staff have a contractual duty to report concerns to the Trust about malpractice, patient safety, financial impropriety or any other serious risk they consider to be in the public interest. Staff are also encouraged to suggest CIP approaches which are then assessed for impact.* In terms of managing risk associated to CIP schemes the Trust is very clear that this is the responsibility of individual CPGs and Corporate

	Directorates.
	
	As set out in *CIP Management Arrangements, including Clinical Risk,* CPGs are responsible for the identification, assessment and management of all risk in their areas, and Directors within their Corporate Directorates. CPGs and Corporate Directorates are required through their CPG Boards, to consider a range of aspects when risk assessing their CIP schemes. This requires having access to data and information to adequately risk assess the impact of the proposed scheme on delivery of the required standard of safety and quality in clinical environments and on wider organisational performance.
	
	CPGs & Corporate Directorates will therefore:
	
	• Complete the approved Quality Impact Assessment (QIA) form which will be signed off by the CPG Board, namely the Clinical Programme Director and CPG Head of Nursing.
	• Once developed, CPGs will ensure that the completed and signed off QIA form is hyperlinked or referenced within the respective scheme's Risk Assessment section within the central CIP database as evidence for each CIP scheme.
	• Ensure that all CIP schemes are logged in the appropriate database and record:
	   o Date of assessment;
	   o Risk Assessment rating (Likelihood and Consequence score);
	   o Actions to mitigate the risk and the resulting residual score, which will then be reviewed at CPG / Corporate Directorate level.
	• Ensure that all CIP schemes which are risk assessed as "High" or "Extreme Risk" (i.e. a rating of '8' and above) have mitigating

	actions to reduce risk.
	• Monitor all live CIP schemes at their CPG Quality Governance Boards / Corporate Directorate meetings.
	
	CIP Board will therefore:
	
	• Receive regular reports on:
	  o Number of schemes with QIA complete, from live CIP schemes;
	  o Number of schemes risk assessed for patient safety category;
	  o Number of schemes with "High" or "Extreme Risk" ratings.
	• Act as necessary where any patient safety risk is deemed unacceptable.
	• Consider other aspects of risk which are required to make informed decisions and be assured that risk is being mitigated and adequately managed at scheme level.
	
	The CIP Board is required to assure itself that CPGs are addressing the risk assessment of all CIPs appropriately - particularly risks to patient safety which are not being adequately mitigated, or where the scheme presents a constant risk to the safeguarding of quality and patient safety. The CIP Board may make decisions regards risk to deliverability of CIP schemes where it feels that there is significant risk to patient safety.
	
	The CIP Board will be responsible to update the Management Board of risks, including patient safety risks of schemes.
	
	The CIP Board will continue to review, led by the Medical Director with the Director of Nursing with input from the Director of Corporate Affairs and Governance, the processes around CIP risk assessments to ensure they comply with Trust policy

	and are adequate to support safe delivery of the CIP work programme.

Star Chamber (page 19 in the guide)

The guide recommends STAR Chambers be established to monitor and assure that risks to quality and safety are being effectively managed. While ICHT does not currently have an exact STAR Chamber model in operation, it does operate a variant model at a local level (through CPG Boards) and at a corporate level (through the CIP Board).

The self-assessment below compared the scope a STAR Chamber as recommended in the guide, against ICHT's current approach:

Criterion	Current assessment
1. Track record of delivery of savings plans – specifically in terms of the proportion of the plans for previous years delivered	ICHT has demonstrated recent delivery of CIP savings. During 2011/12, the trust delivered £45m savings but this included an in-year downward revision to the CIP target. In 2012/13 CIP planning and delivery has been more robust with year-to-date delivery on track to deliver more than £52m of savings.
2. The relative scale of the CIP in terms of cash value, CIP as a % of turnover (as an indicator of the challenge presented by the scale of the CIP required) and the level of unidentified CIP as an indicator of the level of planning already undertaken	Granular reporting of CIP performance is now included as part of the financial performance reports for each CPG.
3. The extent of change to the organisation's footprint arising from the level of Transforming Community Services (TCS) transaction value	N/A.
4. Triangulation of available data to ascertain whether the reported numbers align (between the FIMS plan, any other plan documents, and detailed CIPs as submitted to the provider board)	Granular reporting of CIP performance is now included as part of the financial performance reports for each CPG. Stronger links to effective workforce planning and reporting under development.
5. Whether activity, workforce and savings plans are aligned – do the assumptions correlate?	Granular reporting of CIP performance is now included as part of the financial performance reports for each CPG.
6. Do CIP plans, as presented to the board, contain sufficient granularity?	Yes but will need take into consideration any issues highlighted in these self assessments.
7. i) Has each CIP scheme been risk assessed and RAG rated? ii) Has the risk assessment been	(i) Yes – there is a clearly defined process for sign-off by the CPG leadership team once the CIP schemes have been fully scoped and

	reviewed for impact on staff, impact on quality of services, ability to deliver, ensuring that all 3 areas have been separately assessed?	worked up. This process ensures both a clinical risk assessment and RAG rating is completed and considered for each CIP scheme, which is entered into the central CIP database. (ii) Yes - the paper providing the guidance on how to complete risk assessments for CIP is contained in *CIP Management Arrangements, including Clinical Risk* recommends a Quality Impact Assessment template is used, which outlines the questions that should be considered during the assessment for each CIP scheme. This considers questions in relation to Clinical Quality, Effectiveness and Patient Safety; Patient Experience; and Staffing. In addition the guidance outlines that a RAG rating is applied to each CIP scheme using pre-defined criteria where: • schemes which are delivering 100% of the target will be rated GREEN • schemes which are delivering 95% - 100% will be rated AMBER • schemes which are delivering less than 95% of the target will be rated RED Enhanced scrutiny of CPGs risk assessments is required to ensure compliance with Trust policy (see 'Recommendation' at the end of this paper).
8.	Evidence of comprehensive risk assessment process on the quality impact assessment completed for schemes with a potential impact on quality. This should include assessment of schemes in terms of patient experience, safety and clinical outcomes	Yes – could provide evidence of CPG Board minutes where CIP schemes signed-off; examples of completed Quality Impact Assessments; reports from CIP database showing the RAG and risk assessment outcomes. CPGs gave assurance to the CIP Delivery Board (24/07/12) that their CPG Boards have documented decision to approve their CIPs.
9.	Have organisations used the Monitor Quality Assessment Framework to quality assure their CIPs?	Partially – incorporated in the approaches above, subsequent assessment maybe necessary.
10.	Evidence that unintended consequences have been assessed and mitigating	Yes – the detail captured in the CIP database for identified risks

actions clearly expressed for the risks identified	associated with CIPs by schemes owners, and approved at their respective CPG/Directorate boards, covers the likely consequence of any risks and the planned mitigation actions.
11. Have the trust medical and nurse directors explicitly and formally signed off the CIP? (For the SHA have the commissioner medical and nurse directors fulfilled their joint responsibilities and signed off the plans/quality impact assessment?)	Yes – the 12/13 CIP plan was signed off at the CIP Board, Trust Board and by the SHA.
12. Has the provider board formally approved the detail and risk assessment of the CIP?	Board paper received in July 2012.
13. Is there sufficient level of transparency with regard to public, staff and patient engagement?	As required. All CIP schemes relating to service reconfiguration and changes to staff terms and conditions are subject to the requisite public and staff consultation. The patient experience objectives set out in the ICHT Patient Experience Strategy (2012 – 2014) demonstrate the Trust's commitment to this objectives: i) We want to provide all our patients with a good & excellent patient experience when they come into contact with our services using a patient experience charter to drive improvement; ii) We want patients to choose our services not only based on our clinical outcomes, but also based on excellent patient experience; iii) We want to rank with other peer Trusts – in particular the Shelford Group on patient experience results to enhance our reputation to attract the very best staff and expand opportunities for commercial and third sector partnerships; iv) We want to improve staff experience to enhance patient experience. This will be delivered within the Staff Survey Action Plan.

Recommendations

The Trust Board is asked to note and comment on the Trust's current CIP approach to managing risks to patient quality and safety.

It is important to recognise however, that the Trust must continue to ensure its approach is fit for purpose – especially in light of the forthcoming publication of the Francis Report as well as the changing landscape of the new health system in which SHAs and PCTs/commissioners will be replaced by the NHS Commissioning Board, NHS Trust Development Authority and Clinical Commissioning Groups (see the NQB's *Quality in the new health system – Maintaining and improving quality from April 2013* http://www.dh.gov.uk/health/2012/08/quality-new/).

The Trust Board is therefore also asked to approve the following:

1. CPG & Corporate Directorates should be able to demonstrate decisions taken on the approval and risk assessment of their CIPs. It is suggested that an audit of CPGs' approaches to managing CIP clinical risk (to include board minutes and CPG QIAs) be undertaken through the CIP Delivery Board and then presented at the CIP Board.

2. CPG and Corporate Directorates' clinical risk matrices to be regularly reviewed at the CIP Delivery Board.

3. CIP Board to receive a monthly summary of the Trust's overall CIP clinical risk matrix, including details of all CIP schemes rated as "High" or "Extreme Risk".

4. A summary of the Trust's overall CIP clinical risk matrix should be presented at future Management Board and Trust Board meetings.

5. Following publication of the Francis Report a further paper be brought to Trust Board with any necessary recommendations for how ICHT's CIP clinical risk governance processes should be revised.

References

Imperial College Healthcare NHS Trust, *CIP Management Arrangements, including Clinical Risk (May 2012)*

Imperial College Healthcare NHS Trust, *Risk Management Strategy including Risk Management Processes 2012-13 (August 2012)*

Monitor, *Quality Governance Framework (July 2010),* http://www.monitor-nhsft.gov.uk/sites/default/files/Quality%20Governance%20Framework%20July%202010.pdf

Monitor, *Amendments to Applying for NHS Foundation Trust status – Guide for applicants (July 2010),* http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-applicants/amendments-applying-nhs-foundation-trust-s

Monitor, *Delivering sustainable cost improvement programmes (January 2012),* http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/AC-monitor-CIPS-20120118.aspx

National Quality Board, *How to: organise and run a rapid responsive review: 2012/2013 (June 2012), http://www.dh.gov.uk/health/files/2012/07/How-to-Organise-and-Run-a-Rapid-Responsive-Review.pdf*

National Quality Board, *How to: organise and run a risk summit:2012/2013 (June 2012*), http://www.dh.gov.uk/health/files/2012/07/How-to-Organise-and-Run-a-Risk-Summit.pdf

National Quality Board, *How to: quality impact assess provider cost improvement (June 2012)*
http://www.dh.gov.uk/health/files/2012/07/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

National Quality Board, *Review of early warning systems in the NHS (24 February 2010)*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125234

National Quality Board, *Quality in the new health system – Maintaining and improving quality from April 2013 (August 2012)*
http://www.dh.gov.uk/health/2012/08/quality-new/

Appendix A: Triggers which may result in an announced or unannounced Rapid Response Review by SHA or Commissioners

- Alarms or concerns arising from the examination of qualitative and quantitative data. For example, raised mortality rates, deteriorating infection profiles or concerning patient harm reports.
- Alternatively a worrying set of workforce metrics or credible soft intelligence which is not readily accounted for by the provider
- When a concern about quality has been identified and acknowledged by provider and commissioner yet the mitigating actions to improve the situation are showing little signs of having an impact and patients continue to be at risk
- Repeated failure to deliver agreed improvement plans
- Trend data indicates potential or actual patient safety issues. For example, little or no improvement in performance and an unconvincing submission of evidence by the provider such that there is a breakdown in confidence that the provider has sufficient grip on the situation
- Credible and material whistle blower feedback
- Complaints about services provided for patients which suggest problems are not isolated and perhaps are more systemic
- Heroic cost improvement plans (CIPs) which are focused on cost reduction through major workforce or service reductions. This might include a poor outcome to the quality impact assessment
- Evident or suspected poor leadership and/ or governance, particularly clinical governance
- Dramatic media exposure / covert reporting. For example of a type used to report on events at Winterbourne
- Escalation of the number and type of minor concerns that begin to raise more fundamental questions of governance or competence of the provider to deliver a safe service
- Highly critical independent service review reports which identify repetitive serious failures
- Serious concerns raised by CQC, Monitor or professional bodies

Source How to: Organise and Run a Rapid Responsive Review, National Quality Board (2012)

Appendix B: Triggers that may require a Risk Summit

- Care Quality Commission issues a warning notice(s), applies material conditions on a provider or serves notice to withdraw registration
- Serious failings in the provision of care such that patients are at imminent or immediate risk. For example;
    - Quality, patient safety / experience metrics causing alarm
    - Clinical services poorly performing, missing targets and the serious incidents / never event profile suggests / confirms there to be an unsafe or failing service
    - Serious and sustained safety breaches indicative of a more systemic quality failure within a single provider or across a health and social care system
    - Death of a patient(s) which is unexpected and avoidable and which raises specific alarms about clinical practice
    - Significant safeguarding breaches and breakdown in systems which compromise the protection of vulnerable adults and children (statutory and other formal processes apply)
  - Soft intelligence, which when triangulated against the quantitative data, including trend analysis, clearly identifies a serious problem
  - Patients / carers speak out at a level beyond that which would be expected to be addressed by the provider and local commissioners
  - Monitor raises serious concerns about the governance and/or leadership of an FT
  - One or more of the professional regulators raises concerns about the appropriateness of trainees / students remaining on clinical placements in a provider and are considering / intend withdrawing them
  - An independent report, such as a Royal College report, raises serious concerns about patient safety which cannot be managed locally through routine service improvement
  - Validated staff / staff side concerns which make clear that patients are at risk
  - Repeated and sustained failure to deliver agreed remedial action plans such that little or no progress is made and patients are exposed to sustained and increasing levels of risk
  - Significant and damaging loss of public confidence in a provider / alarming media profiles
  - When clinical staffing levels / clinical leadership is inadequate to support safe service delivery
  - Major public health failing
  - Breakdown in confidence in the senior leadership of the provider, including clinical leadership such that clinical services are compromised placing patients and staff at risk
  - An unusual or novel situation which is judged to require action beyond routine intervention
  - A significant commissioning failure which leave patients / services at risk
  - Significant shortfalls in patient safety identified through education and training reviews / trainee feedback

Source How to: organise and run a risk summit, National Quality Board (2012)

Cancer Implementation Plan - Appendix 1
22nd October 2012

Authors: Dr Catherine Urch - Trust Lead Cancer Clinican
Sarah Gigg - Trust Lead Cancer Nurse
Cathy Wybrow - Trust Lead Cancer Manager

1. **Pathway Management**
2. **Tumour Site Specific Pathway**
3. **Data Quality and Completeness**
4. **Governance and Reporting Structure**

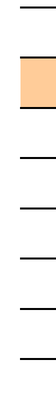
<u>Patient Experience</u>

5. **Performance Diagnostics**
6. **Performance Monitoring**
7. **Communication and Engagement with Key Stakeholders across the Trust (all hospital sites and CPGs)**
8. **Patient Information and Support**
9. **Patient Inclusion**
10. **Education and Training**
11. **Pathway Intervention**
12. **Governance**

<u>Governance Arrangements for implementing this plan</u>
- Report weekly to the Elective Access Waiting List Group
- Report biweekly to the Cancer Operational Group
- Report weekly to the Patient Experience Steering Group
- Report monthly to the Trust Cancer Board
- Report monthly to the Trust Board

Executive ownership by the Chief Operating Officer and Director of Nursing. Clinical services will be held to accountable for particular actions and will report to the above forums.

	Imperial College Healthcare NHS NHS Trust	ICHT DELIVERY	DELIVERY BY END OF JANUARY 2013 (WEEK ENDING)																		FUTURE DATE	ON TRACK
			OCTOBER					NOVEMBER				DECEMBER					JANUARY					
			7	14	21	22	28	4	11	18	25	2	9	16	23	30	6	13	20	27		
1	**PATHWAY MANAGEMENT**																					
1.1	Observe all MDT meetings pan Trust	TLCC																				DEL
1.2	Develop MDT best practice pack to include MDT SOP, Escalation Policy, ECAD SOP	TLCC																				DEL
1.3	Set up tumour specific MDT PLT meetings to run weekly	TLCC																				DEL
1.4	Undertake a review of all MDT Staff to ensure clarity around Roles and Responsibilties	TLCC																				22 & 23rd Nov
1.5	Provide MDT training for all leads.	TLCC																				DEL
1.6	Set up research project to review MDT changes.	TLCC																				TBC
1.7	Develop revised Cancer Access Policy	TLCM																				DEL
1.8	Launch revised Cancer Access Policy alongside Trust Elective Access Policy.	TLCM																				On Track
1.9	Ensure there are appropriate information reports to support proactive management of patients on their pathway so as to avoid preventable breaches by including escalation points on PTL.	TLCM																				On Track
1.10	Develop local tumour specific pathways which identify key event milestones and escalation points	TLCM																				On Track
1.11	Ensure all Outcome Clinic Slips clearly identifies Urgent Suspected Patient Pathway	TLCM																				DEL
1.12	Ensure all Urgent Suspected Cancers referred to Diagnostics are clearly identified	TLCM																				DEL
1.13	Ensure all Urgent Suspected Cancers referrals to Endoscopy are identifyable.	TLCM																				DEL
1.14	Ensure all 2 week wait referrals are entered onto Execlicare within 48 hrs of recepit	TLCM																				DEL
1.15	Set up Email communication with MDT C from clinic to advise if patitent pathway closed	TLCM																				On Track
1.16	Audit Email comms with GPs to advise when patients discussed at MDT and outcome.	TLCM																				On Track
1.17	Initiate Somerset template to communicate to GPs OPD and MDT outcome	TLCM																				On Track



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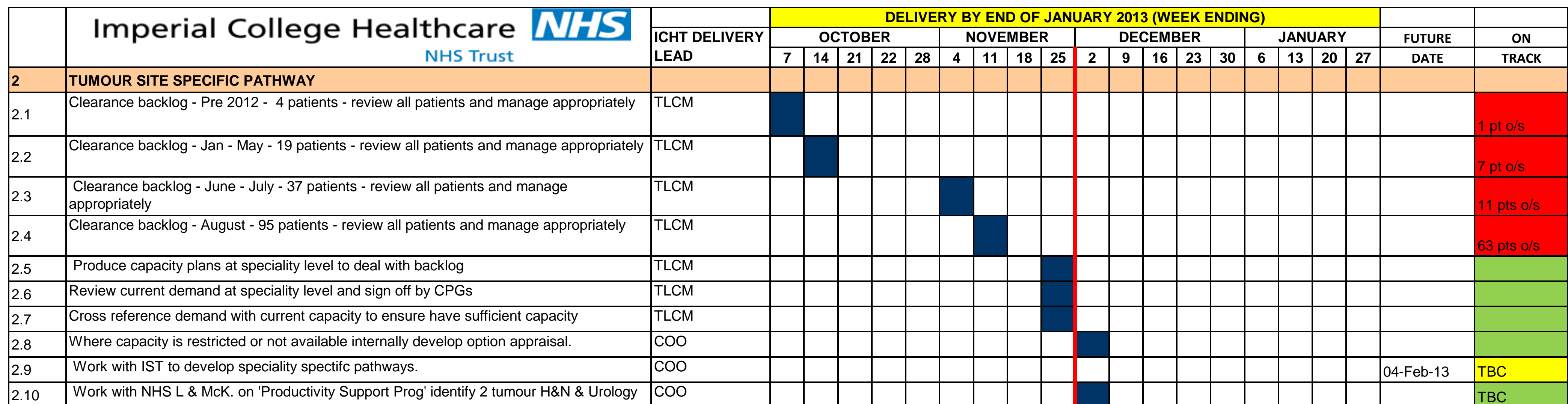

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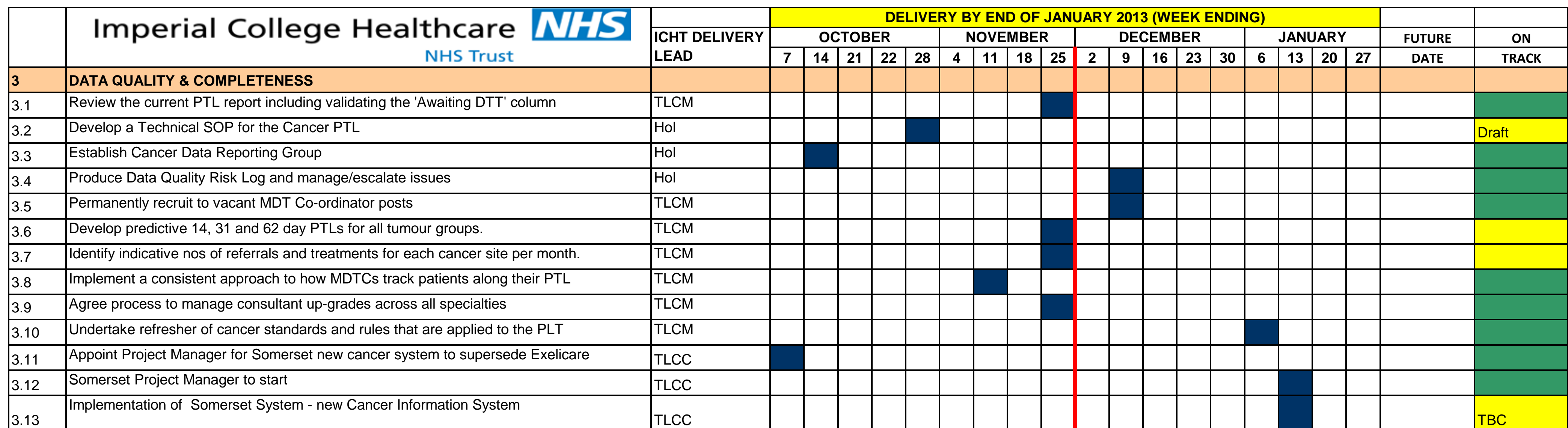
2	**TUMOUR SITE SPECIFIC PATHWAY**																					
2.1	Clearance backlog - Pre 2012 - 4 patients - review all patients and manage appropriately	TLCM																				1 pt o/s
2.2	Clearance backlog - Jan - May - 19 patients - review all patients and manage appropriately	TLCM																				7 pt o/s
2.3	Clearance backlog - June - July - 37 patients - review all patients and manage appropriately	TLCM																				11 pts o/s
2.4	Clearance backlog - August - 95 patients - review all patients and manage appropriately	TLCM																				63 pts o/s
2.5	Produce capacity plans at speciality level to deal with backlog	TLCM																				
2.6	Review current demand at speciality level and sign off by CPGs	TLCM																				
2.7	Cross reference demand with current capacity to ensure have sufficient capacity	TLCM																				
2.8	Where capacity is restricted or not available internally develop option appraisal.	COO																				
2.9	Work with IST to develop speciality spectifc pathways.	COO																			04-Feb-13	TBC
2.10	Work with NHS L & McK. on 'Productivity Support Prog' identify 2 tumour H&N & Urology	COO																				TBC



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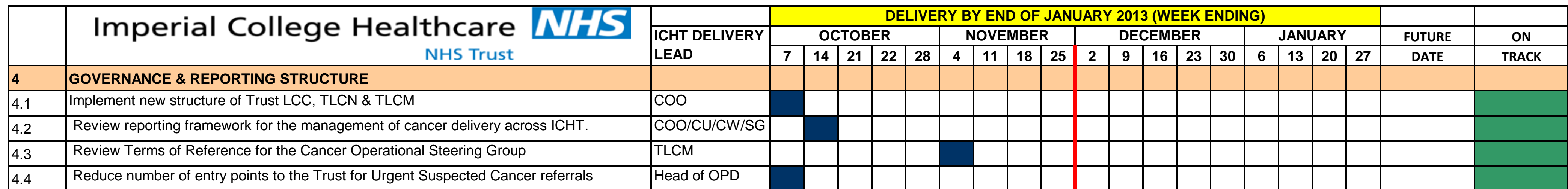
3	**DATA QUALITY & COMPLETENESS**																					
3.1	Review the current PTL report including validating the 'Awaiting DTT' column	TLCM																				
3.2	Develop a Technical SOP for the Cancer PTL	HoI																				Draft
3.3	Establish Cancer Data Reporting Group	HoI																				
3.4	Produce Data Quality Risk Log and manage/escalate issues	HoI																				
3.5	Permanently recruit to vacant MDT Co-ordinator posts	TLCM																				
3.6	Develop predictive 14, 31 and 62 day PTLs for all tumour groups.	TLCM																				
3.7	Identify indicative nos of referrals and treatments for each cancer site per month.	TLCM																				
3.8	Implement a consistent approach to how MDTCs track patients along their PTL	TLCM																				
3.9	Agree process to manage consultant up-grades across all specialties	TLCM																				
3.10	Undertake refresher of cancer standards and rules that are applied to the PLT	TLCM																				
3.11	Appoint Project Manager for Somerset new cancer system to supersede Exelicare	TLCC																				
3.12	Somerset Project Manager to start	TLCC																				
3.13	Implementation of Somerset System - new Cancer Information System	TLCC																				TBC



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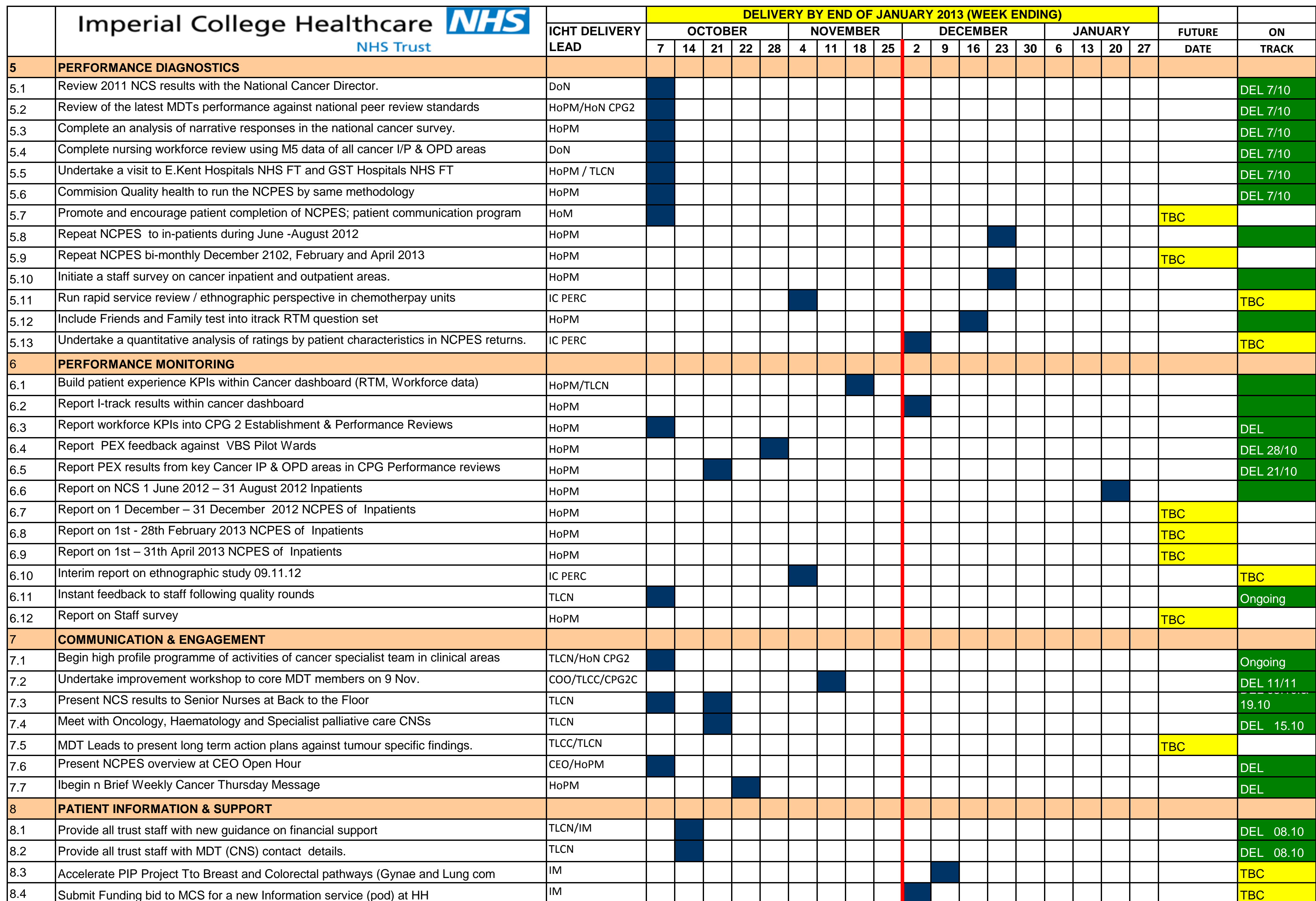
4	**GOVERNANCE & REPORTING STRUCTURE**																							
4.1	Implement new structure of Trust LCC, TLCN & TLCM	COO																						
4.2	Review reporting framework for the management of cancer delivery across ICHT.	COO/CU/CW/SG																						
4.3	Review Terms of Reference for the Cancer Operational Steering Group	TLCM																						
4.4	Reduce number of entry points to the Trust for Urgent Suspected Cancer referrals	Head of OPD																						



Imperial College Healthcare NHS Trust

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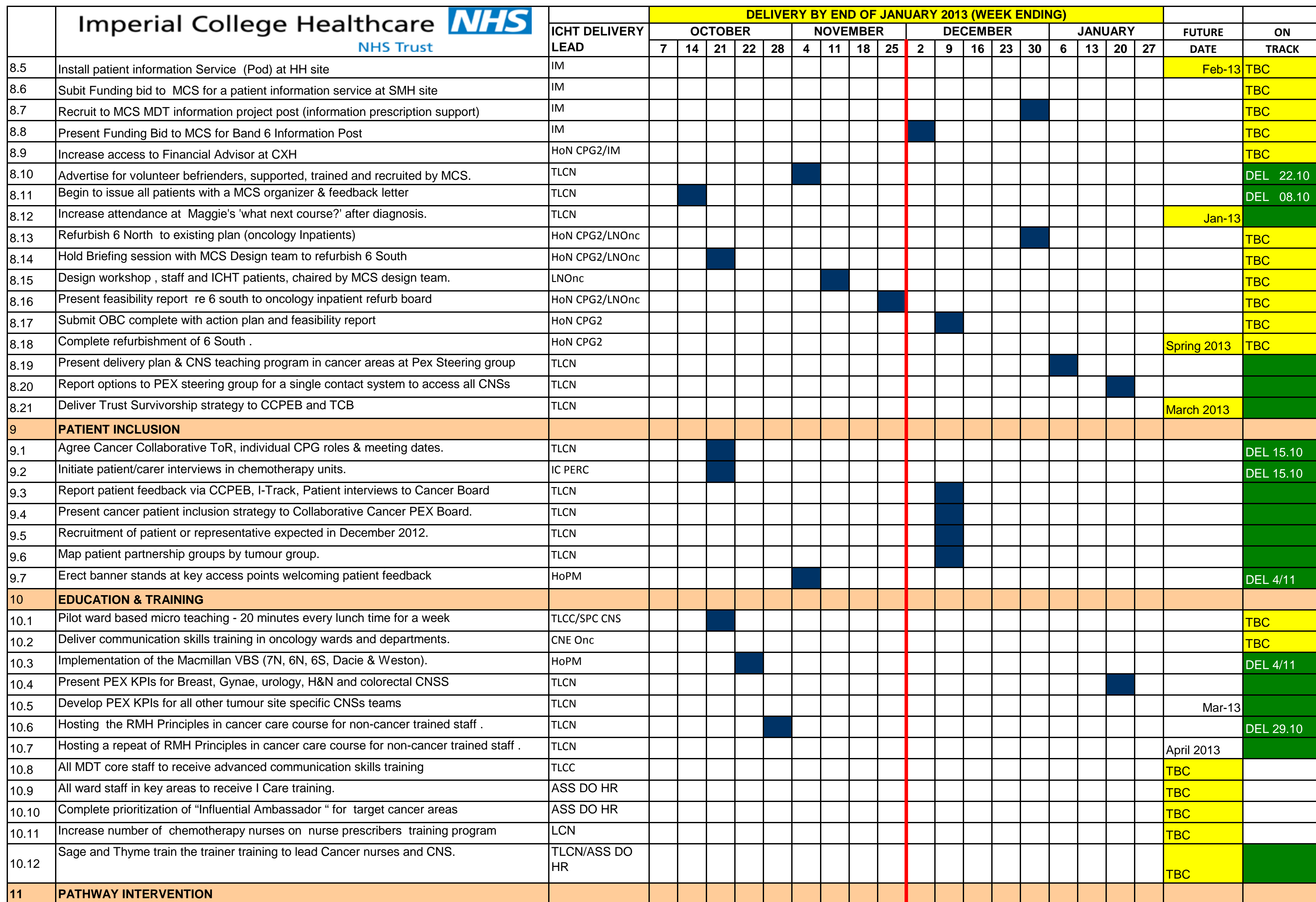
5	**PERFORMANCE DIAGNOSTICS**																					
5.1	Review 2011 NCS results with the National Cancer Director.	DoN	■																			DEL 7/10
5.2	Review of the latest MDTs performance against national peer review standards	HoPM/HoN CPG2	■																			DEL 7/10
5.3	Complete an analysis of narrative responses in the national cancer survey.	HoPM	■																			DEL 7/10
5.4	Complete nursing workforce review using M5 data of all cancer I/P & OPD areas	DoN	■																			DEL 7/10
5.5	Undertake a visit to E.Kent Hospitals NHS FT and GST Hospitals NHS FT	HoPM / TLCN	■																			DEL 7/10
5.6	Commision Quality health to run the NCPES by same methodology	HoPM	■																			DEL 7/10
5.7	Promote and encourage patient completion of NCPES; patient communication program	HoM	■																		TBC	
5.8	Repeat NCPES to in-patients during June -August 2012	HoPM													■							
5.9	Repeat NCPES bi-monthly December 2102, February and April 2013	HoPM																			TBC	
5.10	Initiate a staff survey on cancer inpatient and outpatient areas.	HoPM													■							
5.11	Run rapid service review / ethnographic perspective in chemotherpay units	IC PERC						■														TBC
5.12	Include Friends and Family test into itrack RTM question set	HoPM												■								
5.13	Undertake a quantitative analysis of ratings by patient characteristics in NCPES returns.	IC PERC										■										TBC
6	**PERFORMANCE MONITORING**																					
6.1	Build patient experience KPIs within Cancer dashboard (RTM, Workforce data)	HoPM/TLCN								■												
6.2	Report I-track results within cancer dashboard	HoPM										■										
6.3	Report workforce KPIs into CPG 2 Establishment & Performance Reviews	HoPM	■																			DEL
6.4	Report PEX feedback against VBS Pilot Wards	HoPM					■															DEL 28/10
6.5	Report PEX results from key Cancer IP & OPD areas in CPG Performance reviews	HoPM			■																	DEL 21/10
6.6	Report on NCS 1 June 2012 – 31 August 2012 Inpatients	HoPM																	■			
6.7	Report on 1 December – 31 December 2012 NCPES of Inpatients	HoPM																			TBC	
6.8	Report on 1st - 28th February 2013 NCPES of Inpatients	HoPM																			TBC	
6.9	Report on 1st – 31th April 2013 NCPES of Inpatients	HoPM																			TBC	
6.10	Interim report on ethnographic study 09.11.12	IC PERC						■														TBC
6.11	Instant feedback to staff following quality rounds	TLCN	■																			Ongoing
6.12	Report on Staff survey	HoPM																			TBC	
7	**COMMUNICATION & ENGAGEMENT**																					
7.1	Begin high profile programme of activities of cancer specialist team in clinical areas	TLCN/HoN CPG2	■																			Ongoing
7.2	Undertake improvement workshop to core MDT members on 9 Nov.	COO/TLCC/CPG2C							■													DEL 11/11
7.3	Present NCS results to Senior Nurses at Back to the Floor	TLCN	■		■																	19.10
7.4	Meet with Oncology, Haematology and Specialist palliative care CNSs	TLCN			■																	DEL 15.10
7.5	MDT Leads to present long term action plans against tumour specific findings.	TLCC/TLCN																			TBC	
7.6	Present NCPES overview at CEO Open Hour	CEO/HoPM	■																			DEL
7.7	Ibegin n Brief Weekly Cancer Thursday Message	HoPM				■																DEL
8	**PATIENT INFORMATION & SUPPORT**																					
8.1	Provide all trust staff with new guidance on financial support	TLCN/IM		■																		DEL 08.10
8.2	Provide all trust staff with MDT (CNS) contact details.	TLCN		■																		DEL 08.10
8.3	Accelerate PIP Project Tto Breast and Colorectal pathways (Gynae and Lung com	IM											■									TBC
8.4	Submit Funding bid to MCS for a new Information service (pod) at HH	IM										■										TBC



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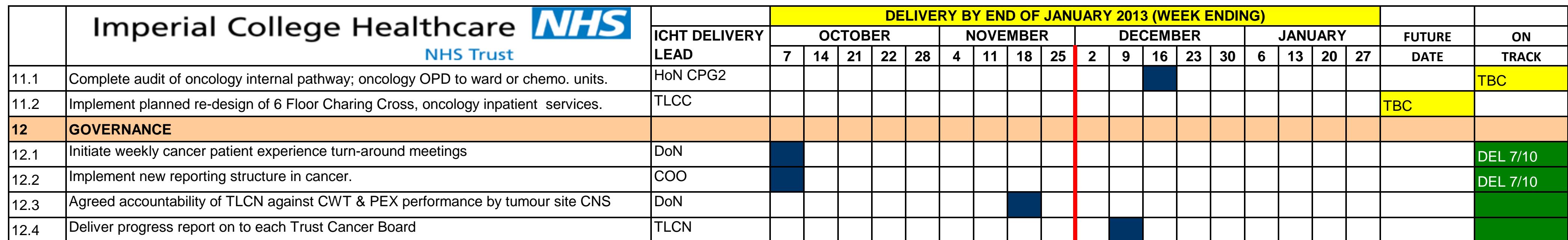
8.5	Install patient information Service (Pod) at HH site	IM																			Feb-13	TBC
8.6	Subit Funding bid to MCS for a patient information service at SMH site	IM																				TBC
8.7	Recruit to MCS MDT information project post (information prescription support)	IM														■						TBC
8.8	Present Funding Bid to MCS for Band 6 Information Post	IM										■										TBC
8.9	Increase access to Financial Advisor at CXH	HoN CPG2/IM																				TBC
8.10	Advertise for volunteer befrienders, supported, trained and recruited by MCS.	TLCN						■														DEL 22.10
8.11	Begin to issue all patients with a MCS organizer & feedback letter	TLCN		■																		DEL 08.10
8.12	Increase attendance at Maggie's 'what next course?' after diagnosis.	TLCN																			Jan-13	
8.13	Refurbish 6 North to existing plan (oncology Inpatients)	HoN CPG2/LNOnc														■						TBC
8.14	Hold Briefing session with MCS Design team to refurbish 6 South	HoN CPG2/LNOnc			■																	TBC
8.15	Design workshop , staff and ICHT patients, chaired by MCS design team.	LNOnc							■													TBC
8.16	Present feasibility report re 6 south to oncology inpatient refurb board	HoN CPG2/LNOnc									■											TBC
8.17	Submit OBC complete with action plan and feasibility report	HoN CPG2											■									TBC
8.18	Complete refurbishment of 6 South .	HoN CPG2																			Spring 2013	TBC
8.19	Present delivery plan & CNS teaching program in cancer areas at Pex Steering group	TLCN															■					
8.20	Report options to PEX steering group for a single contact system to access all CNSs	TLCN																	■			
8.21	Deliver Trust Survivorship strategy to CCPEB and TCB	TLCN																			March 2013	
9	**PATIENT INCLUSION**																					
9.1	Agree Cancer Collaborative ToR, individual CPG roles & meeting dates.	TLCN			■																	DEL 15.10
9.2	Initiate patient/carer interviews in chemotherapy units.	IC PERC			■																	DEL 15.10
9.3	Report patient feedback via CCPEB, I-Track, Patient interviews to Cancer Board	TLCN											■									
9.4	Present cancer patient inclusion strategy to Collaborative Cancer PEX Board.	TLCN											■									
9.5	Recruitment of patient or representative expected in December 2012.	TLCN											■									
9.6	Map patient partnership groups by tumour group.	TLCN											■									
9.7	Erect banner stands at key access points welcoming patient feedback	HoPM						■														DEL 4/11
10	**EDUCATION & TRAINING**																					
10.1	Pilot ward based micro teaching - 20 minutes every lunch time for a week	TLCC/SPC CNS			■																	TBC
10.2	Deliver communication skills training in oncology wards and departments.	CNE Onc																				TBC
10.3	Implementation of the Macmillan VBS (7N, 6N, 6S, Dacie & Weston).	HoPM				■																DEL 4/11
10.4	Present PEX KPIs for Breast, Gynae, urology, H&N and colorectal CNSS	TLCN																	■			
10.5	Develop PEX KPIs for all other tumour site specific CNSs teams	TLCN																			Mar-13	
10.6	Hosting the RMH Principles in cancer care course for non-cancer trained staff .	TLCN					■															DEL 29.10
10.7	Hosting a repeat of RMH Principles in cancer care course for non-cancer trained staff .	TLCN																			April 2013	
10.8	All MDT core staff to receive advanced communication skills training	TLCC																			TBC	
10.9	All ward staff in key areas to receive I Care training.	ASS DO HR																			TBC	
10.10	Complete prioritization of "Influential Ambassador " for target cancer areas	ASS DO HR																			TBC	
10.11	Increase number of chemotherapy nurses on nurse prescribers training program	LCN																			TBC	
10.12	Sage and Thyme train the trainer training to lead Cancer nurses and CNS.	TLCN/ASS DO HR																			TBC	
11	**PATHWAY INTERVENTION**																					



	Imperial College Healthcare NHS NHS Trust	ICHT DELIVERY LEAD	DELIVERY BY END OF JANUARY 2013 (WEEK ENDING)																		FUTURE DATE	ON TRACK
			OCTOBER					NOVEMBER				DECEMBER					JANUARY					
			7	14	21	22	28	4	11	18	25	2	9	16	23	30	6	13	20	27		
11.1	Complete audit of oncology internal pathway; oncology OPD to ward or chemo. units.	HoN CPG2																				TBC
11.2	Implement planned re-design of 6 Floor Charing Cross, oncology inpatient services.	TLCC																			TBC	
12	**GOVERNANCE**																					
12.1	Initiate weekly cancer patient experience turn-around meetings	DoN																				DEL 7/10
12.2	Implement new reporting structure in cancer.	COO																				DEL 7/10
12.3	Agreed accountability of TLCN against CWT & PEX performance by tumour site CNS	DoN																				
12.4	Deliver progress report on to each Trust Cancer Board	TLCN																				

Task Lead Key	
DoN	Director of Nursing
CPG 2 CD	Clinical Director, CPG 2
HoN CPG 2	Head of Nursing, CPG 2
HoN CPG 6	Head of Nursing, CPG 6
HoM	Head of Marketing
HoPM	Head of Programme Management, Nursing Directorate
IC PERC	Imperial College Patient Experience Research Centre
COO	Chief Operations Officer
LCN	Lead Chemotherapy Nurse
IM	Information Manager
LNOnc	Lead nurse oncology
CNE Onc	Clincial Nurse Educator, Oncology
TLCC	Dr Catherine Urch, Trust Lead Cancer Clinician
TLCM	Cathy Wybrow, Trust Lead Cancer Manager
TLCN	Sarah Gigg, Trust Lead Cancer Nurse
GG	Gareth Gwynn, Specialty Manager for Cancer
ASS DO HR	Assistant Director of HR

Care Quality Commission

Review of compliance

Imperial College Healthcare NHS Trust Charing Cross Hospital	
Region:	London
Location address:	Fulham Palace Road Hammersmith London W6 8RF
Type of service:	Acute services with overnight beds Doctors treatment service Urgent care services
Date of Publication:	October 2012
Overview of the service:	Charing Cross Hospital is part of Imperial College Healthcare NHS Trust and provides a full range of adult clinical specialties. It is also a key site for the teaching of medical students from Imperial College London. The Kennedy Institute of Rheumatology and the West London Neuroscience Centre are

	located at this site. The hospital has approximately 580 beds.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Charing Cross Hospital was meeting all the essential standards of quality and safety inspected.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 29 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People told us what it was like to be a patient in Charing Cross Hospital. They described how they were treated by staff and their involvement in making choices about their care. They also told us about the quality and choice of food and drink available. This was because this inspection was part of a themed inspection programme to assess whether older people in hospitals were treated with dignity and respect and whether their nutritional needs were met.

We visited five wards during our visit and observed lunchtime on three wards. The wards were chosen as the majority of the patients were older people.

The inspection team was led by a Care Quality Commission (CQC) inspector joined by two other CQC compliance inspectors, a practising professional and an Expert by Experience, who has personal experience of using or caring for someone who uses this type of service.

We spoke with more than 20 people and their relatives. They were generally positive about the hospital regarding the information they received about their care and treatment, ward environment, choice of menu, facilities and their surroundings. They were very positive about their experience of staff. One person said they "couldn't ask for more" and another described Charing Cross Hospital as a "magnificent organisation" and had the highest praise for the hospital.

We saw positive feedback from relatives about the care given to their family members, for example the relative being "treated with great respect and treated seriously" and being made welcome when visiting.

What we found about the standards we reviewed and how well Charing Cross Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 05: Food and drink should meet people's individual dietary needs

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Patients we spoke with were generally positive about the information regarding the ward environment, choice of menu, facilities and their surroundings. Patients had mobile phones and were able to use them and charge them.

Patients knew why they were in hospital, what their treatment plans were and when they could expect to leave hospital. Patients' relatives were satisfied with the way doctors discussed treatment with their relatives. Relatives who had raised concerns with nursing staff had been able to discuss and resolve their concerns.

Patients were able to be independent but told us that they could call on staff to assist them if they needed help. Patients told us that they had been treated with dignity and respect at all times and by all levels of staff. Patients who had been on several wards were equally positive about their experiences on the different wards. One person said she "couldn't be happier". Some patients reported that they observed the way others were treated and could not find anything negative to report.

Other evidence
Is people's privacy and dignity respected?
Patients were cared for in single sex bays or in single rooms on all the wards we visited.

There were female and male only bathrooms. We saw that patients could have the curtains closed around the bed when they wished or when they were receiving care and treatments. We saw staff knocking on room doors before entering. There were quiet rooms available for private conversations when needed. There were lockable cupboards for patients to keep their possessions.

Patients were given appropriate information and support regarding their care or treatment. Staff greeted patients when they approached their bedsides. We observed that nurses, doctors and other staff were attentive to their patients and were courteous, calm and respectful in their manner. They spoke loudly enough to be heard, but as quietly as possible to avoid being overheard. Staff explained what they were going to do before starting a treatment, for example before taking blood.

We saw staff assisting patients to walk. They encouraged them to walk at their own pace and provided support. Patients were free to move around the wards, walking frames were within reach of patients. Patients were also encouraged to be independent if they could, in caring for themselves and in eating and drinking. Staff described how they would encourage this.

Call bells were answered as soon as possible. We saw that call bells were within reach of patients. On one ward we saw that there were buzzers for patients to use in the day room where there were no call bells. This enabled patients to call for staff when needed.

Hourly nursing rounds took place on the wards. These rounds involved the nurse in charge of a group of patients visiting each patient and checking if they needed anything such as pain relief or drinks.

Patients were offered handwipes and napkins to protect their clothes prior to eating. On one ward we saw that patients were wearing their day clothes and not nightwear. This was to enable better assessment of patients' independence and in preparation for going home. The wards generally had a good stock of the new "dignity" gowns, which did not open at the back, as well as men's and women's pyjamas for patients to use.

People's diversity, values and human rights were respected. Staff were aware of dignity and cultural issues and dignity and privacy was part of core nursing training. People's choices and preferences and their care needs were discussed on initial assessment when they arrived on the ward and reviewed by staff at staff shift handover meetings. There were facilities available to meet the needs of patients of different faiths.

We saw information on the wards on a range of subjects and this included complaints and PALS (Patient Advice and Liaison Service) information.

Are people involved in making decisions about their care?
Nursing staff told us that they assessed patients on admission and during care rounds to ask preferences and to check they were meeting their needs. Other healthcare professionals, such as doctors, physiotherapists, occupational therapists and dietitians, saw and reviewed their patients regularly. Records were updated following discussions so that other staff could use the most up to date records. Multi-disciplinary staff meetings involved patients or their relatives.

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
Patients were satisfied with the hospital food in general and told us they had enough to eat and drink and that food was served at the appropriate temperature. They chose what they were going to eat for the day each day and said there was enough choice to meet their needs. Meals were described as tasty and we saw that they were eaten with little wastage. One person told us "the food is very nice and I don't need any help". Another said "the presentation of food is good, and also a suitable tasty choice".

One person said that she had been very unwell and had been coaxed to eat little amounts and now had her appetite back.

Other evidence
Are people given a choice of suitable food and drink to meet nutritional needs?
Patients were provided with a choice of suitable and nutritious food and drink. We observed lunchtime on three wards. A choice of meal was provided and this included choice of portion size, salad or a light choice. The menu identified which meals were healthy choices and had photographs of the meals to assist choice. Patients were assisted by staff to make choices if this was needed.

Snacks and snack boxes for patients who missed their meals were available on every ward between mealtimes. Ward catering staff confirmed that they would keep and then heat patients' meals if they were out of the ward at a mealtime. Extra nutritional supplements and special meals, such as gluten free or for diabetic patients, were available for patients and these were prescribed by dietitians. Staff on one ward gave patients a lunch box and milk to take with them when they were discharged.

Hot drinks were served during the day. We saw jugs of water at bedsides, within reach of patients.

Some patients needed specialist support with nutrition, for example using intravenous or nasogastric feeds. This was planned and reviewed by the medical team, dietitians and pharmacists daily in their multi-disciplinary teams.

Are people's religious or cultural backgrounds respected?
Patients' food and drink met their religious or cultural needs. Patients were offered a varied menu for all meals and this included Halal, Kosher and other cultural requirements. The menus detailed which foods were suitable for a vegetarian or vegan.

Are people supported to eat and drink sufficient amounts to meet their needs?
Patients were supported to be able to eat and drink sufficient amounts to meet their needs. The wards we visited had protected mealtimes and no other patient activity was allowed in that time. Staff understood the importance of adequate nutrition and fluids as part of their patients' treatment.

At lunchtime the meals were organised in the ward kitchens and then taken to the ward bays, the ward dining room or individual rooms according to patients' choices. Meals were served by the catering staff and the mealtime was coordinated by designated members of staff. Meals were served in stages so that assistance could be given to patients and the meals were served hot. The catering team had a list of who needed help or a special diet. This was developed from each patient's nutrition assessment completed and scored on the ward. Relatives and volunteers were also involved in assisting patients.

Patients had their nutritional needs assessed within 24 hours of admission and reviewed a week later. Care plans were created and updated in the light of these assessed needs. We saw that if needs changed, for example if patients were not eating as well as had been originally assessed, then a new assessment and care plan would be undertaken. Specialist advice and support was obtained, for example from speech and language therapists if patients had swallowing difficulties, if patients were observed to require this.

Patients requiring support or at risk of malnutrition received a red tray. Catering staff were instructed not to take away a red tray without a nurse's permission. This allowed the staff to record what had been eaten and drunk. We saw that patients with a red tray received support to eat and drink. Staff explained to patients that their food and drink was being monitored. We observed staff being gentle and kind when assisting frail patients. Patients were also encouraged to be independent if they could.

Our judgement
The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Patients did not raise any issues about their safety with us. Some patients told us that they would raise any concerns with the ward staff and would be comfortable doing this.

Other evidence
Are steps taken to prevent abuse?
There were safeguarding policies and procedures in place. Staff told us that they had received safeguarding training and were aware of the procedure for reporting concerns. They knew about the different types of abuse and were able to explain the processes for following up any potential safeguarding issues.

Safeguarding was discussed at staff handovers and at multi-disciplinary meetings. Staff followed a flow chart for risk assessing vulnerable people.

The trust had representation on local authority safeguarding adults boards and there was a trust safeguarding board which reported to the main trust board. The trust safeguarding board met monthly and was the formal means by which the trust reviewed safeguarding concerns and received updates on progress of concerns.

The provider responded appropriately to any allegation of abuse. Senior staff confirmed that this would involve local authority partners and generally received good feedback on the progress of alerts made by hospital staff.

Do people know how to raise concerns?

All staff had safeguarding training with appropriate levels of training for the different occupational groups. This was initially covered for all staff at the corporate induction. We were given examples of staff raising concerns when they suspected that patients were at risk of abuse. Staff spoken with told us they would be comfortable raising and documenting concerns in the best interests of their patients. Staff were encouraged to raise safeguarding alerts in the first instance and these would be reviewed and downgraded if the concern later proved to be unfounded. We saw the hospital monthly reports which were reviewed by senior nurses. The trust had a whistleblowing policy.

Are Deprivation of Liberty Safeguards used appropriately?
Staff we spoke with were familiar with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Some patients had been assessed for DoLS. Multi-disciplinary meetings were used, which involved patients' relatives, to assist staff in deciding what was best for each patient. The hospital worked in partnership with the local authorities when DoLS referrals were made.

Our judgement
The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Patients were positive about their experience of staff at Charing Cross Hospital. One person told us "they take as much time as is necessary".

Other evidence
Are there sufficient numbers of staff?
There were sufficient skilled and experienced staff to assist all those patients that required help with their meal on the three wards where we observed lunchtime. All nursing staff assisted with serving and supporting patients to eat and drink at lunchtime.

There were sufficient qualified, skilled and experienced staff to meet the requirements of patients with regard to privacy, dignity and independence. Call bells were answered promptly and we saw that patients were supported with their care needs. Hourly nursing rounds were used to ensure that patients had their needs assessed and met routinely.

Senior nursing staff set the nursing staff numbers on the wards. Senior staff told us that staffing tools were used that calculated the care needs and dependency levels of patients on the ward. The numbers were reviewed annually or if the ward configuration changed. Nursing staff numbers had recently been reviewed. Agency and bank staff were regularly used to fill gaps in staffing as well as to provide extra care for individual patients.

Senior nursing managers routinely worked on the wards each Friday and used part of that time to ensure that staffing levels were appropriate in practice.

Do staff have the appropriate skills, knowledge and experience?
All nurses received training in completing the nutrition assessments. Staff were trained to complete the patients' records and charts. There was also ad hoc in house training on specialist nutrition and a nutrition link nurse on the wards and a trust specialist nutrition nurse who offered support and advice. Catering staff had training in organising meal times and the importance of ensuring that patients were given the correct meals.

We were told that there were sufficient dietitians to provide dietetic advice and support for those patients and staff that required this. The speech and language therapy team was available for specialist support for patients with swallowing difficulties. Staff knew how to complete nutrition assessments and how to access specialist support.

Our judgement
The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
Patients were aware that they had medical records, but in general not concerned about their storage. One person said "'I don't need them. If I needed them I'd ask". Patients knew that staff completed their charts and records of food and drink.

Other evidence
Are accurate records of appropriate information kept?
Patients' records were accurate and fit for purpose. Patients had nutrition assessment scores and care plans completed. There were mechanisms in place for checking that these had been completed and reviewed when required. Senior staff had a process for reviewing record keeping to ensure that records were accurate and appropriate for each patient. Patients had doctors', nurses' and other health professionals' records recorded in the handwritten medical notes. Records clearly distinguished which professional had written in them.

We saw that patients had fluid and food recording charts near the bedside and that these were completed. Generally weights had been recorded on admission and weekly unless patients were too unwell to be weighed.

Overall we saw that care plans recorded the care and treatment provided.

Are records stored securely?

Records were kept securely and could be located promptly when needed. We saw that paper medical records were stored on the ward but held securely in a lockable trolley. Staff had access to these records. There were paper records near the bedside for staff to complete as they cared for patients.

Our judgement
The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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Appendix one

Update against all recommendations from IST reports, Deloitte report and External Governance Review and Waiting List Clinical Review reports as at 20 November 2012

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
Initial IST Feedback Report					
1. Leadership and management					
1.1	Identify trust executive to lead and manage operational performance of CPGs or make explicit CPD responsibilities in relation to management of access targets.	Chief Operating Officer		Chief Operating Officer in post since September 2012 who is the executive responsible for operational performance.	Complete
1.2	Consider convening a "Planned Care Board" to unify primary and secondary care approaches.	Chief Operating Officer		Monthly Elective Access programme Board with commissioner membership chaired by the Chief Operating Officer in place.	Complete
1.3	That clear and unambiguous guidance is given to the Clinical Programme Group Directors and Heads of Operations in terms of responsibilities for delivery of operational performance and standards in line with a revised operational performance structure.	Chief Operating Officer		Minutes from Elective Access Waiting List Group, Cancer Delivery Group and CPG Performance Reviews.	Complete
1.4	Realign operational performance structures to embed consistency across CPGs and provide assurance to executive team.	Chief Operating Officer		Each CPG has replicated the Trust structure to manage 18 weeks with weekly or fortnightly HoOs (or GM as deputy) chaired Elective Access meetings.	Complete
2. Reporting and governance					
2.1	Waiting list management and operational performance meetings should be chaired by executive lead with senior CPG representatives consistently in attendance until any new management framework is embedded.	Chief Operating Officer		Weekly Elective Access Waiting List Group chaired by Chief Operating officer with senior representatives from CPGs and Outpatients, Admissions, Information in place since September 2012.	Complete
2.2	Waiting list/operational performance meeting should be standardised at a Trust level providing a focused agenda and action orientated approach across all specialities.	Chief Operating Officer		Weekly Elective Access Waiting List Group meeting is action focused and covers all CPGs.	Complete
2.3	Review of access policy and training on implementation particularly in the OP setting to ensure patients are added and removed from the waiting list appropriately, focusing on the front end as a priority. This would involve refresher training for all reception and clerical staff.	Chief Operating Officer	Training plan being developed on the implementation of the Trust Access Policy. Super user training programme delivered April - May 2012	Revised Trust Access Policy signed off by Management Board 29/10/12.	In progress: monitored via action plan
2.4	Assessment of incomplete pathways and on future validation and management processes to focus on key areas and streamline workload.	Chief Operating Officer		Incomplete pathways validated with the development of the newly constructive PTL in June 2012. Minimum level of pathway validation as a 'business as usual' process to ensure an acceptable level of data quality agreed by CPGs and monitored via the Weekly Waiting List meeting. Weekly reports for focused validation in place such as additions and removals, historic TCIs.	Complete
2.5	More robust and live waiting list meeting with appropriate level of seniority of staff attending to include an enhanced dashboard/pivot to focus on key areas of delivery and support the action orientated approach evidencing progress on a weekly basis.	Chief Operating Officer		Weekly Elective Access Waiting List meeting receives newly constructed suite of reports, including RTT PTL, with appropriate pivots to enable RTT management including for example patients waiting over 52 weeks.	Complete
2.6	Develop a prospective 18 week report, ensure Elective Access Group has action orientated approach, and ensure appropriate level of seniority of staff in attendance.	Chief Operating Officer		The Elective Access Weekly Waiting List Group receives and reviews a newly constructed prospective booking report.	Complete
2.7	Create an enhanced dashboard to focus on key areas of delivery and support action oriented approach by evidencing weekly progress.	Head of Information		Information team have developed a suite of elective access reports that have been in place since July 2012	Complete
3. Access and Choice					
3.1	Review of all outpatient referral points into the system and a debate and agreement as to whether this is best managed centrally or devolved to CPGs ensuring a consistent approach.	Chief Operating Officer	Review currently being undertaken of routine and urgent referrals to determine what other services should be centrally managed, if any for completion in December 2012.	All cancer referrals centrally managed from July 2012.	In progress: monitored via action plan.
3.2	Agreement on how this will be cascaded into primary care and how this will be managed to ensure compliance.	Chief Operating Officer	To be completed following review.		In progress: monitored via action plan.
4. Specialty level performance/management					
4.1	Review existing demand and capacity work focusing on all pressured specialties in order to evidence true capacity gaps and produce robust clearance and sustainability plans based on accurate activity and capacity data.	Chief Operating Officer	Demand and Capacity modelling software needs embedding in the Trust enabling plans for sustainability.	Performance team has supported backlog recovery modelling in pressured specialities and led the procurement of demand & capacity modelling software, which will ensure this becomes part of the routine analysis going forward.	In progress: monitored via action plan
4.2	Streamline central waiting list office and performance information into a unified CPG weekly report from a central mailbox aligned with the weekly performance meeting.	Head of Information		Internal due diligence review of waiting list office has been undertaken. This reviewed the reports used by the WL office. Agreement that the IPWL is the basis for bookings and they are done chronologically, or in line with backlog clearance plans in specialties with backlog. Intensive validation of this report, and addition of 'Adjusted 18 week breach date' to this report has made this feasible.	Complete
4.3	Examine and implement a consistent approach to outpatient and inpatient booking processes, either in a devolved or centralised structure.	Head of GP Liaison & OPD and IST Lead.	Outpatient booking processes review to be scheduled.	Internal due diligence review of inpatient waiting list office has been undertaken. This has developed Trust-wide principles inpatient booking to be applied across all booking areas. This is under implementation.	In progress: monitored via action plan
4.4	Development of an operational dashboard incorporating all reports into one place.	Head of Information		Elective Access Dashboard with drill down into RTT PTL has been developed in QlikView.	Complete
5. Waiting List Management					
5.1	Review outpatient and inpatient waiting list management processes as a separate work stream.	IST lead, Head of GP Liaison & OPD		Outpatient and inpatient waiting list management processes were a separate workstream during the Elective Access Programme.	Complete
5.2	Review processes for tertiary referral management for cancer pathways as part of the cancer diagnostic work.	Chief Operating Officer		This was brought to the attention of the new Cancer Management team to carry forward.	Complete
6. Information					
6.1	Centralised distribution address set up for all information being sent to operational managers.	Head of Information		Implemented summer 2011	Complete

Imperial College Healthcare NHS Trust

Appendix one

Update against all recommendations from IST reports, Deloitte report and External Governance Review and Waiting List Clinical Review reports as at 20 November 2012

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
6.2	Formal review undertaken by the IST information team to examine data quality for elective RTT (and cancer) information and this be reported back separately.	IST		Report received from IST Jan 2012	Complete
6.3	Focused attention by CPGs is given to cleaning and sustaining the waiting lists and 18 week/cancer PTLs.	Chief Operating Officer	A review of resources required to deliver validation standards is being undertaken by Chief Operating Officer and the Chief Information Officer.	Minimum level of pathway validation as a 'business as usual' process to ensure an acceptable level of data quality agreed by CPGs and monitored via the Weekly Waiting List meeting. Weekly reports for focused validation in place such as additions and removals, historic TCIs.	In progress: monitored via action plan
6.4	Operational managers and information agree as to a set of data required at CPG level and this is then driven and delivered through one Trust dashboard.	Head of Information	Same as Recommendation 4.4	Elective Access Dashboard with drill down into RTT PTL has been developed in QlikView.	Complete
7. Cancer					
7.1	A detailed review undertaken by key pressured cancer pathways	Chief Operating Officer		Information team has supported modelling in pressured tumour sites and performance Team has led the procurement of demand & capacity modelling software, which will ensure this becomes part of the routine analysis going forward.	In progress monitored by Cancer Remedial Action plan.
7.2	The Trust examines securing a cancer management system that can link to the current PAS.	Chief Operating Officer		Sommerset cancer management system that can be linked with Trust PAS procured.	Complete
8. Diagnostics					
8.1	Rapid development of a diagnostic management tool (waiting list) so that this can become part of the overall waiting lit management process.	Chief Operating Officer		2 diagnostic PTLs (for diagnostic tests recorded on PAS and those recorded on Radiology Information System) in place since June 2012.	Complete
8.2	Clarification of accountability for both operational management of these waits and reporting.	Chief Operating Officer		Elective Access Waiting List Group monitors diagnostic PTL. This group includes the accountable operational managers.	Complete
IST Cancer diagnostic of Imperial College Healthcare NHS Trust					
9. Key recommendations for Trust priority and focus					
9.1	Making an urgent decision on whether to continue with the development of Excelicare or to purchase an off the shelf fully functioning cancer waiting times database.	Chief Operating Officer	* Status report regarding deficiencies with current cancer information system presented to Cancer Pathways Steering Group - agreed to replace. Ability to manage two week wait referrals to be specified within the requirements of the new system. * Specification for new fit for purpose Cancer Information System is currently being written. * System to be purchased, timescales dependant on competitive tendering process.	Sommerset cancer management system that can be linked with Trust PAS procured.	Complete
9.2	Implementing PTL reports for 14 days and 31 day patients and improvements to the 62 day PTL report.	Chief Operating Officer	*Predictive report being produced for sign off by IST end 30/11/12. * 14, 31 and 62 day tumour site specific PTLs (including breach reporting and trend analysis by tumour site) are being finalised ready for circulation first week of January 2012.	14, 31 and 62 day PTLs signed off by the IST circulated weekly to all CPGs since August 2012.	Complete
9.3	Reviewing the reporting framework for the management of cancer delivery across the whole organisation and also specifically cancer waiting times.	Chief Operating Officer		Newly established Lead Cancer Team in place since September 2012.	Complete
9.4.1	a) ensuring that there is an appropriate senior manager identified as the executive lead for cancer within the organisation and also identification of the cancer lead clinician.	Chief Operating Officer		Chief Operating Officer designated as Executive Lead for cancer and lead clinician for Cancer established in September 2012.	Complete
9.4.2	b) ensuring that the right structure of meetings is in place to discuss cancer as a service and cancer performance against key indicators.	Chief Operating Officer		Weekly Cancer Delivery Group in place and chaired by Chief Operating Officer since September 2012.	Complete
9.4.3	c) ensuring that there are appropriate information reports to support proactive management of patients on their pathway so as to avoid preventable breaches.	Chief Operating Officer	First prospective report has been produced and is being finalised 12/12/12 before circulation to CPGs. IST support needed and meeting has been organised with technical support.	* 14, 31 and 62 day PTLs now circulated weekly to all CPGs.	In progress monitored by Cancer Remedial Action plan.
9.4	Giving focus to the issue of clinical engagement and ownership of the cancer waiting time standards within the organisation.	Chief Operating Officer	MTD clinical review weekly PTL review meeting with CNS, Clinical Lead, MDTC and operational manager.	MTD meetings and weekly PTL meetings with CNS, Clinical Lead and Operational Manager include focus on the cancer waiting times.	Complete
9.6	Development local tumour specific pathways which identify key event milestones and escalation points, including the cross organisational elements of the pathway.	Chief Operating Officer	Development in progress with IST		In progress monitored by Cancer Remedial Action plan.
9.7	Reviewing the cancer management team structure to ensure that the lines of accountability and control are strengthened to support the organisation to deliver compliant cancer services.	Chief Operating Officer		Newly established Lead Cancer Team in place since September 2012.	In progress monitored by Cancer Remedial Action plan.
10. Leadership and management					
10.1	Trust to review the organisational structure for cancer within the organisation, across all CPGs and to give clear responsibilities for how and by whom cancer performance should be managed.	Chief Operating Officer		Lead cancer team reporting directly to the accountable Executive Officer the Chief Operating Officer.	Complete
10.2	Trust to review key cancer personnel and identify appropriate lead manager and clinician for cancer for the organisation.	Chief Operating Officer		Lead cancer team reporting directly to the accountable Executive Officer the Chief Operating Officer.	Complete
10.3	Trust to review the current cancer team structure and consider whether re-alignment would provide greater accountability for cancer waiting times management and allow better focus on priority action areas.	Chief Operating Officer		Lead cancer team reporting directly to the accountable Executive, the Chief Operating Officer	Complete
10.4	Trust to review the job role of the Multi Disciplinary Team Co-ordinators (MDTCs) to ensure these posts are value for money at their current band.	Chief Operating Officer		MDTC structure review complete 1/10/12	Complete
10.5	Trust to agree a timeline for permanent recruitment to the vacant posts.	Chief Operating Officer		Timeline agreed for recruitment process	Complete
11. Reporting and governance					

Appendix one

Update against all recommendations from IST reports, Deloitte report and External Governance Review and Waiting List Clinical Review reports as at 20 November 2012

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
11.1	Trust to review current Cancer Delivery Group forum and consider need for enhancement to this or further forums that may be required to bring key staff groups together to discuss cancer at the appropriate level within the organisation.	Chief Operating Officer		Lead cancer team reporting directly to the accountable Executive the Chief Operating Officer who chairs the cancer delivery group from October 2012.	Complete
11.2	Trust to review the role of the clinical leads in the cancer waiting times performance management framework within the organisation to develop greater clinical ownership.	Chief Operating Officer		Clinical leads are accountable for the MDT Education session completed by International Researcher on Patient Safety and MDT November 2012. Draft MDT SOP to be signed off in November.	In progress monitored by Cancer Remedial Action plan.
11.3	Trust to review attendance at external meetings to ensure appropriate representation following restructure.	Chief Operating Officer		Senior clinical team engaged with external stakeholders. CPD lead for CPG 2 on London Cancer Alliance Board.	Complete
11.4	Trust to urgently review the benefits of progressing with development of Excelicare versus purchasing an off the shelf cancer waiting times database and tracking system.	Chief Operating Officer		Sommerset cancer management system that can be linked with Trust PAS procured.	Complete
11.5	Trust to review the role and priorities of the Cancer Data and Performance Manager and other cancer team members to address the issues highlighted above including development of 14 day and 31 day PTL.	Chief Operating Officer		* 14, 31 and 62 day PTLs now circulated weekly to all CPGs. * 14, 31 and 62 day tumour site specific PTLs (including breach reporting and trend analysis by tumour site) are being finalised ready for circulation first week of January 2012. * First predictive report has been produced and is being finalised before circulation to CPGs. IST support needed and meeting has been organised with technical support.	Complete
11.6	Trust to implement a consistent approach to how MDTCs track patients along their PTL.	Chief Operating Officer		* MDTC using 31 and 62 day PTLs. * Patients discussed each week at Cancer Delivery Group meeting. * Procedure for removal of patients from PTL consistently applied. All from 15/10/12.	Complete
11.7	Trust to undertake a review of the cervical screening pathway to ensure that patients are not being omitted from tracking in error.	Chief Operating Officer		Data and Performance Manager met with team and all cervical patients are now appearing on the PTL since January 2012.	Complete
11.8	Once received from the Trust, the IST to review the cancer access policy.	IST Lead		Cancer access policy integrated into the Trust Access Policy signed off by the IST and Management Board	Complete
12. Access and choice					
12.1	Trust to review the operational processes employed across all the hospital sites to manage two week wait referrals and register them on ICHIS and Excelicare; including appropriateness of information analysts to carry out specific data entry roles; reducing amount of hand-offs in process reducing the reliance on paper process, etc.	Chief Operating Officer		All cancer referrals centrally managed from July 2012. All referrals entered onto ICHIS and excelicare by same person at the same time.	Complete
13. Capacity and demand					
13.1	IST to share demand and capacity modelling tool with the organisation.	IST Lead		Model in use	Complete
RTT Information Systems Review - October 2011					
14. How information is generated					
14.1	It is recommended that the planned move to all reporting from the Data Warehouse be progressed and existing reports discontinued as soon as is practical.	Head of Information		New Elective Access Suite of reports was built in data warehouse. Legacy databases/reports have been decommissioned.	Complete
14.2	The Trust look carefully at the use of pseudo-pathways and, where the RTT status could be derived within data processing from other operational information (e.g. referral source, clinic type), carefully consider whether they are helpful and what the effect on data quality may be.	Head of Information		Design specification for RTT PTL agreed by working group of CPG and Information representatives.	Complete
14.3	Where pseudo-pathways are used, a regular process of data quality exception reporting be put in place to audit their appropriate use.	Head of Information		Pseudo pathway PTL in development	In progress: monitored via action plan
14.4	Explore options around the combination of RTT status and other PAS information in order to provide assurance around the quality of RTT pathway data.	Head of Information		Data Quality Assurance checks undertaken as part of month-end validation process	Complete
14.5	Assess the merits of each Outpatient PTL exclusion in turn in terms of practicality versus the danger of excluding patients still waiting an appointment and, where appropriate, commence data quality reporting to identify anomalies.	Head of Information		Design specification for OP Waiting List agreed by working group of CPG and Information representatives. Rules for hospital and patient cancellations agreed and built.	Complete
14.6	Analyse any discrepancies between the two first outpatient data sources and move to the use of a single data source for all referral/outpatient activity to be used for both statutory and internal reporting.	Head of Information		New Elective Access Suite of reports was built in data warehouse. Legacy databases/reports have been decommissioned.	Complete
14.7	Look critically at the diagnostic reporting process in order to get assurance on the issues highlighted.	Head of Information	*An urgent review of the reporting of DM01 diagnostics has been undertaken. A detailed risk matrix and action plan have been completed with key actions including: * Work is ongoing to include Radiology activity in the diagnostic PTL. * Work is planned to audit recent diagnostic waiting times to ensure reporting is accurate.	The diagnostic PTL has been reviewed and developed to ensure all activity recorded on ICHIS is accurately reported on, including validating and expanding clinic code and key word search terms, and seeking assurance from CPGs regarding their pathway and data entry processes. The PTL has been signed off by the IST.	Complete
14.8	Renew focus on resolving the issue of free-text procedure information on the elective waiting list.	Chief Operating Officer	Under considering with respect to Cerner go-live timetable.		In progress: monitored via action plan
14.9	Where at all possible, any validation of/correction to waiting times data be made at source on ICHIS.	Chief Operating Officer		CPGs validate/correct waiting times data on ICHIS.	Complete
14.10	Assess the level of risk attached to not monitoring patients who are marked as "added to waiting list" until they are actually added to the waiting list.	Head of Information		This cohort of patients is monitored via Admitted RTT PTL. In addition, Cymbio Data Quality Key performance indicator: patients added to the elective waiting list > 2 days after decision to admit date will be reported from M7 in the CPG performance reports and monitored at the CPG performance reviews.	Complete
14.11	Embark upon an audit of recent diagnostic waiting times.	Head of Information		An internal audit programme has been agreed for quarter 4 in 2013 and future years and on waiting lists, including diagnostics, to provide assurance on operational performance data quality	In progress: monitored via action plan

Update against all recommendations from IST reports, Deloitte report and External Governance Review and Waiting List Clinical Review reports as at 20 November 2012

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
14.12	It is recommended that the Trust take into account only one pause in making RTT calculations.	Head of GP Liaison & OPD		Included in design specification for RTT Reporting agreed by working group of CPG and Information representatives.	Complete
14.13	Review the use of reasonable notice.	Head of GP Liaison & OPD	For consideration for the access policy, followed by appropriate SOP, training and reporting.	Reasonable notice is identified in the Trust Access Policy for outpatient appointment, diagnostics and inpatient referrals.	Complete
14.14	Cease the use of waiting list suspensions.	Head of GP Liaison & OPD	For consideration for the access policy, followed by appropriate SOP, training and reporting.	Trust no longer operates waiting list suspensions.	Complete
14.15	Complete work around the use of business rules and cease the use of the "6 month" business rule in the first instance.	Head of Information		Design specification for RTT PTL agreed by working group of CPG and Information representatives. Use of '6 month' rule discontinued in Feb 2012	Complete
15. How information is used					
15.1	See urgent assurance that the large numbers of patients on the outpatient PTL on separate cancellation list are not 'real' waiting patients.	Chief Operating Officer	Further validation of OP Waiting List required. Clinically approved scenarios for automated validation being developed.		In progress: monitored via action plan
15.2	Cease the practice of reporting patients in separate 'cancellation' list.	Head of Information	* This is being addressed as part of the OPWL review and a small working group has been convened to address the issue.	Design specification for OP WL agreed by working group of CPG and Information representatives. Hospital and Patient cancellations included.	Complete
15.3	It is recommended that the target date on the first outpatient report should reflect specialty-level target waiting times and that the RTT treatment date be added for information.	Head of Information	in progress and on track for completion		In progress: monitored via action plan
15.4	The Information team should work closely with CPG and specialty managers, as well as the operational staff (in Central Booking for example) to produce a single view of the first outpatient waiting list, consistent with RTT rules at an appropriate level of granularity for each user level.	Head of Information	* The source of the OPWL has been reviewed and it has now been moved onto the Data Warehouse. * Comparison work is underway with the reports produced by the info team to ensure all patients are being correctly captured and reported accurately. Once this and further validation is complete the OPWL will become the single data source on first outpatient referrals and appointments. * The format of the OPWL is being reviewed by the Reporting Group to ensure it is fit for all levels of internal operational use and external statutory reporting.	Design specification for OP WL agreed by working group of CPG and Information representatives.	Complete
15.5	Audit the process for booking follow-up patients to gain assurance that patients are not missing out on follow-up deadlines or on any follow-up.	Chief Operating Officer/Head of Information	This is being discussed as to how best to take it forward with regards to the operational and reporting aspects. * Next steps - to be confirmed	An internal audit programme has been agreed for quarter 4 in 2013 and future years and on waiting lists, including follow up appointments, to provide assurance on operational performance in this area	In progress: monitored via action plan
15.6	Put in place a follow-up PTL report to be used and monitored operationally.	Chief Operating Officer/Head of Information		Being developed in QlikView as an addition to the existing elective access suite of reports	In progress: monitored via action plan
15.7	Move to create an RTT diagnostic PTL.	Head of Information		2 diagnostic PTLs (for diagnostic tests recorded on PAS and those recorded on Radiology Information System) in place since June 2012. Minor enhancement required to include RTT treatment date on diagnostic PTL	Complete
15.8	Produce a single RTT admitted PTL.	Head of Information		Implemented as part of new elective access suite of reports in April 2012	Complete
15.9	The Information team work closely with CPG and specialty managers, as well as operational staff, to produce a single view of the admitted waiting list, consistent with RTT rules, at an appropriate level of granularity for each user level.	Head of Information		Implemented as part of new elective access suite of reports in April 2012	Complete
15.10	Introduce a degree of structure around RTT validation to enable the data collections around breach reporting.	Head of Information/Deputy Head of Information		Weekly reports for focused validation in place such as additions and removals, historic TCIs.	Complete
15.11	Commence reporting both the completeness of RTT validation and aggregated route cause analysis of 18 week breaches to facilitate better understanding of areas of concern and focus for service improvement.	Chief Operating Officer/Head of Information	Elective Access Waiting List Group to agree whether to implement systematic RCA for breaches.	Minimum level of pathway validation as a 'business as usual' process to ensure an acceptable level of data quality agreed by CPGs and monitored via the Elective Access Waiting List Group.	In progress: monitored via action plan
15.12	The Information team work closely with the Performance team to refresh the monthly scorecards to make specialty level information available on the full range of RTT measures and other benchmarks.	Head of Performance/ Head of Information	An elective access dashboard showing CPG performance at specialty level against milestone and RTT targets has been developed and is now included in the monthly scorecards.	CPG performance reports- scorecards contain RTT performance following lifting reporting break in July 2012.	Complete
Access/Waiting List Management - IST Report					
16. Inpatient waiting list management - Charing Cross Hospital					
16.1	That a unified approach to the booking of patients is considered across these two sites with common procedures/processes to ensure appropriate dating of all patients in line with good practice.	Head of GP Liaison & OPD	Cross site and service structure to be put in place.		In progress: monitored via action plan
16.2	Training is considered for teams booking outside the recognised booking offices in the short term.	Head of GP Liaison & OPD and IST Lead	* Local training material has been developed. * 18 week and Access Policy and procedures training commenced for admin staff - receptionists, booking clerks, managers etc. Training run collaborative by IST and Trust staff.	List of those trained.	Complete
16.3	A review of data links and out coming procedures to ensure all pathways are linked appropriately at the patient's entry into and throughout the pathway.	Head of GP Liaison & OPD and IST Lead	* Programme of training staff on 18 week rules and Trust Access Policy has commenced Further training to be implemented Standard Operating Procedures to be finalised.		In progress: monitored via action plan
16.4	A review is undertaken of patients booked into slots outside the Trust's access policy guidelines and the planned training reflects and supports patients only being booked into the window identified within the access policy.	Head of GP Liaison & OPD	Standard Operating Procedures to support staff to manage within 18 weeks with appropriate escalation processes. This will be incorporated into Elective Access training	Trust Access policy signed off.	In progress: monitored via action plan
16.5	All patients with long waits should be validated and dealt with through the Trust performance framework with clear plans identified for each.	Chief Operating Officer	* Reporting facilitation of this managed via Information Reporting Group's waiting list and 18 week reports * Management of patients with long waits will be conducted through Waiting List Group.	Monitor of long waits occurs by the Performance team and the weekly Waiting List Group meeting and the CPG performance reviews.	Complete

Appendix one

Update against all recommendations from IST reports, Deloitte report and External Governance Review and Waiting List Clinical Review reports as at 20 November 2012

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
16.6	Detailed demand and capacity analysis should be undertaken in high risk specialties as a minimum to identify backlog clearance plans and sustainability plans for 11/12.	Chief Operating Officer		Performance team has supported backlog recovery modelling in pressured specialities and led the procurement of demand & capacity modelling software, which will ensure this becomes part of the routine analysis going forward.	In progress: monitored via action plan
16.7	A review of all patients booked for IP admission following follow up appointment be reviewed to ensure correct clock start date has been applied and assurance be sought that all future booking reflect the RTT date from original referral.	Head of GP Liaison & OPD	Managed through Elective Access Waiting List Group, Intensive validation of inpatient waiting list has occurred, this identified problem areas for CPGs to address, all staff are undertaking 18 week refresher and access policy training which will also help to address.	An internal audit programme has been agreed for quarter 4 in 2013 and future years and on waiting lists, including admissions following a follow up appointment, to provide assurance on operational performance in this area	In progress: monitored via action plan
16.8	All staff are trained within the booking office to apply the full range of RTT rules within ICHIS.	Head of GP Liaison & OPD and IST Lead	Training plan being developed with the assistance of the Intensive Support Team (IST) and Cerner and will include clinicians.	Trust Access policy signed off. SOPs to support staff to manage within 18 weeks with appropriate escalation processes	In progress: monitored via action plan
16.9	A process is developed to ensure real time data input into ICHIS from clinical data support systems and an assurance framework is in place to manage data transfer.	Head of Information	* Managed through Information Reporting and Waiting List Groups. CPGs are now using much enhanced waiting list reports that allow them to quickly identify any changes in waiting list volumes on a day to day basis. The Cymbio data quality tool also allows managers to monitor data entry onto ICHIS. Any omissions from reporting to ICHIS will therefore be picked up.	100 Data Quality KPIs for monitoring data quality of elective access pathways are in place, including KPIs for monitoring timeliness of data entry	Complete
16.10	Unified processes are agreed across these 2 sites for the management of waiting lists/booking of patients and standard operating procedures are developed to ensure equity and correct chronological dating of patients is in place.	Head of GP Liaison & OPD	* A revised Access Policy has been signed off by the Trust Board. * 23 Standard Operating Procedures (SOPs) associated with the Access Policy are being developed and are to be uploaded onto the Trust's intranet. * Priorities for further SOPs to be identified following initial period of training.	4 out of the 23 SOPs have been signed off by the Elective Access Waiting List Group.	In progress: monitored via action plan
16.11	A standard process is agreed for the booking of patients onto the waiting list for HH patients including completion and transfer of TCI cards from one site to another (with an assurance framework to test this in place).	Head of GP Liaison & OPD	* SOPs have been developed to address adding patients to the waiting list and booking a TCI. Need to confirm process for assurance framework around transfer of TCI cards cross-site.	4 out of the 23 SOPs have been signed off by the Elective Access Waiting List Group.	In progress: monitored via action plan
17. Inpatient waiting list management - St Mary's Hospital					
17.1	The Trust discuss and agrees a unified approach to waiting list management that looks at either a centralised or decentralised structure.	Chief Operating Officer	Review currently being undertaken of routine and urgent referrals to determine what other services should be centrally managed, if any.		In progress: monitored via action plan
17.2	That clear administrative pathways are identified for the management of TCI/DTA cards and patients updated status on ICHIS for all staff.	Head of GP Liaison & OPD	SOPs to support staff to manage within 18 weeks with appropriate escalation processes		In progress: monitored via action plan
17.3	That booking and operational staff are involved in the PTL management at operational level to ensure appropriate booking of patients and management of backlog clearance in a pro active way.	Head of GP Liaison & OPD	* Managed through Waiting List Group - CPGs have each set up local working arrangements with booking staff to involve them in PTL management- in some areas Service Managers are meeting with waiting list office on a weekly basis, in other CPGs waiting list office are attending CPG elective access meetings. This new process is still bedding in.		Complete
17.4	That issues identified through the CXH recommendations are also applied to the SMH site, particularly surrounding demand and capacity management, standardised operating procedures and administrative processes for patient management.	Head of GP Liaison & OPD		The recommendations are applied throughout the Trust.	Complete
18. Outpatients					
18.1	The new Access Policy should be formally launched at all levels of the organization.	Head of GP Liaison & OPD		Signed off at Management Board -29/10/12.	Complete
18.2	Standard operating procedures should be developed and support this launch in conjunction with the IT and operational teams to ensure all processes are clear to staff.	Head of GP Liaison & OPD	23 Standard Operating Procedures (SOPs) associated with the Access Policy are being developed and are to be uploaded onto the Trust's intranet.	4 out of the 23 SOPs have been signed off by the Elective Access Waiting List Group.	In progress: monitored via action plan
18.3	A significant training programme for key staff should be developed and delivered across the whole organization. The recent list of registered users that has been developed could form the basis of prioritising user training.	Head of GP Liaison & OPD	* 18 week training is underway and will be part of mandatory training to gain ICHIS password. * Clinicians and nurses to be included in training and e-learning is also being developed for clinical staff.	Training programme signed off. Implementation plan agreed	Nov 2012 January 2013
19. Validation					
19.1	An review is undertaken in respect of the process for updating ICHIS information for all tertiary patients received in the Trust. This needs to address in particular the population of ICHIS with appropriate RTT information in a timely and accurate way.	Head of GP Liaison & OPD	One out of the 23 SOPs will be an interprovider SOP.		In progress: monitored via action plan
19.2	Validation processes for management of RTT clock stops are reviewed to ensure all patients have appropriate clock stops applied to their pathway.	Chief Operating Officer/Head of Information		Minimum level of pathway validation as a 'business as usual' process to ensure an acceptable level of data quality agreed by CPGs and monitored via the Weekly Waiting List meeting. Weekly reports for focused validation in place such as additions and removals, historic TCIs.	Complete
19.3	That the trust should clearly clarify outpatient roles and responsibilities for validation with all staff.	Head of GP Liaison & OPD	23 Standard Operating Procedures (SOPs) associated with the Access Policy are being developed and are to be uploaded onto the Trust's intranet.	Trust Access Policy signed off by Management Board on 31/10/12	In progress: monitored via action plan
19.4	That an outpatient reporting suite be developed to support operational management decision making.	Head of GP Liaison & OPD		Design specification for OP WL agreed by working group of CPG and Information representatives. Launched as part of new elective access reporting suite.	Complete
19.5	That daily reports should be available to highlight un cashed up clinics so that appropriate action can be taken in a timely manner.	Head of Information	Managed through creation of 18 week data quality suite of indicators via Reporting Group.	100 Data Quality KPIs for monitoring data quality of elective access pathways are in place, including KPIs for monitoring uncashed up clinics	Complete
20. Entry points (the following actions involve significant structural change to how OP services are provided, and further work is underway to scope time-frames for this)					

Appendix one

Update against all recommendations from IST reports, Deloitte report and External Governance Review and Waiting List Clinical Review reports as at 20 November 2012

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
20.1	The Transforming Out Patient Group needs to agree timelines for the implementation of the centralisation of all OP referral points into the trust (if agreed corporately) to ensure standardised processes in the management of OP referrals.	Chief Operating Officer	Review currently being undertaken of routine and urgent referrals to determine what other services should be centrally managed, if any	Complete for Urgent Suspected Cancer referrals.	In progress: monitored via action plan
20.2	That communication be sent to all Consultant staff informing them of agreed process and need for referrals to be managed through one source.	Chief Operating Officer	Dependant on 5.1		In progress: monitored via action plan
20.3	That referrals received through any entry points other than OP centre be managed pro actively to contact referrer directly and inform them of correct procedure.	Chief Operating Officer	Dependant on 5.1		In progress: monitored via action plan
20.4	This issue is raised through the cross economy group being implemented to ensure a clear directive/message is sent to referring GP's of correct process/procedure.	Chief Operating Officer	Dependant on outcome of 5.1 for further work	Completed for Cancer with commissioner input.	In progress: monitored via action plan

Stock take of readiness to report elective access performance at Imperial Healthcare NHS Trust May 2012					
21.	**Cancer**				
21.1	Consider establishing a single point for receipt of urgent 2 week wait referrals (or a single point on each site)	Chief Operating Officer		A single point of receipt of urgent suspected cancer has been established by one team within the Central Booking office and has been in operation since July 2012.	Complete
21.2	Provide each speciality/CPG with information on expected numbers of cancer referrals and treatments, so that any shortfalls in the numbers of patients can be investigated and if necessary corrected in real time.	Chief Operating Officer		Numbers of 2 week wait referrals for urgent suspected cancer broken down by tumour group and CPG are monitored weekly by the cancer team speciality manager and presented fortnightly at the Waiting List Meeting since August 2012.	Complete
21.3	Policy and procedures that underpin cancer performance reporting is sign off and disseminated through the Trust.	Chief Operating Officer	In process. Further update in December 2012.		In progress: monitored via action plan
22. Diagnostic					
22.1	Dedicate more resource to resolving the outstanding data production concerns, such that full reporting of all diagnostic waiting times can recommence in August.	Head of Information		Newly constructed diagnostic PTL developed and in place signed off by the IST enabling full reporting of diagnostic waits from August 2012.	Complete
23. Referral to Treatment					
23.1	All CPGs identify clear plans for engaging clinical staff in the management of elective pathways.	Chief Operating Officer		Clinical staff attend CPG waiting list groups, CPG Board meetings and CPG Performance Review meetings.	Complete
23.2	Redesign the clinic outcome forms are redesigned by a clinically led group.	Head of GP Liaison & OPD		Revised clinic outcome form signed off by IST and has been in practice since July 2012.	Complete
23.3	Secure early agreement of the revised policy, and completing an appropriate training programme, aimed at all different levels of staff, including clinicians.	Chief Operating Officer	Training plan being developed with the assistance of the Intensive Support Team (IST) and Cerner and will include clinicians.	Trust Access Policy signed off by Management Board 31/10/12.	In progress: monitored via action plan.
23.4	The super-users are mapped to individual services and specialities so that every person that has responsibility for any RTT data entry is aware of how to get day to day advice and support.	Chief Operating Officer	To be included in Trust Access Policy training plan		In progress: monitored via action plan.
23.5	Keep clear records of staff trained and alert CPGs to significant gaps.	Chief Operating Officer		Records of individuals attending events.	Complete
23.6	Support the CPGs in the development of a small number of speciality specific indicators (KPIs) that can be used to provide a high level indication of RTT data validity.	Head of Information		100 Data Quality KPIs for monitoring data quality of elective access pathways are in place.	Complete
23.7	Develop speciality specific KPIs for expected numbers of clock stops to assure data accuracy	Head of Information		Normal range of admitted and non admitted clock stops per month has been supplied to CPGs and is included in Elective Access Dashboard	Complete
23.8	Create clinically based validation rules that are tested and applied to large volumes of additional incomplete pathways.	Head of Information		Clinically based validation rules were designed, tested and applied to non-admitted pathways in July 2012.	Complete
23.9	Complete the Elective Access Policy review and SOPs and sets out a clear plan for dissemination and training of all relevant staff .	Chief Operating Officer	23 Standard Operating Procedures (SOPs) associated with the Access Policy are being developed and are to be uploaded onto the Trust's intranet. Training plan being developed with the assistance of the Intensive Support Team (IST) and Cerner and will include clinicians.	Trust Access Policy signed off by Management Board 31/10/12.	In progress: monitored via action plan.

Imperial External Governance Review - Sept 2012 (Hanafin)					
24.	**Elective Access Policy**				
24.1	Complete review of Elective Access Policy and supporting Standard Operating Procedures (SOPs)	Chief Operating Officer	*Elective Access Policy draft shared with CCG chairs through the Clinical Quality Group (CQG) *Elective Access Policy final draft undergoing final review by Intensive Support Team. *Three outstanding SOPs to be completed, IST supporting this work. * Elective Access Policy and SOPs to go to Management Board for ratification	Trust Access Policy signed off by Management Board 31/10/12	Complete
24.2	Plan for dissemination of Elective Access Policy and supporting Standard Operating Procedures (SOPs) and training	Chief Operating Officer	23 Standard Operating Procedures (SOPs) associated with the Access Policy are being developed and are to be uploaded onto the Trust's intranet. Training plan being developed with the assistance of the Intensive Support Team (IST) and Cerner and will include clinicians.	Trust Access Policy signed off by Management Board 31/10/12.	In progress: monitored via action plan.
25.	**RTT Management**				
25.1	Trust and CPGs to set out clear plan for engaging clinical staff in RTT management so that: a. Clinic outcome forms are 'fit for purpose' b. Identify speciality specific KPIs (e.g. expected number of clock stops at 1st Outpatient, expected percentage of new clock starts at DTA) c. Clinically based validation rules can be created, tested and applied to the expected large volume of additional incomplete pathways	Chief Operating Officer	* Timetable for Clinical Outcome form audits * Elective Access Dashboard to be launched in QlikView . *Super user training has included clinical staff	a. Revised clinic outcome form signed off by IST and has been in practice since July 2012. b. Elective Access Dashboard, including CPG and speciality specific KPIs, developed by Information Department. c. Clinically based validation rules were designed, tested and applied to non-admitted pathways in	Complete
26.	**Diagnostics**				

Appendix one

Update against all recommendations from IST reports, Deloitte report and External Governance Review and Waiting List Clinical Review reports as at 20 November 2012

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
26.1	Further automation of the collection of diagnostic waiting times data was urgently required. Separate databases in outpatients, inpatients and radiology had to be interrogated to determine the number of diagnostics patients waiting.	Head of Information	Imaging diagnostics to be included in main diagnostic PTL in Q4 2012/13 following complete review of radiology reporting information flows.	9 of 15 diagnostic modalities are now reported from ICHIS in a single Patient Tracker List since June 2012.	In progress: monitored via action plan.
27.	**Cancer**				
27.1	The establishment of a single point for receipt of urgent 2 week wait referrals (or a single point on each site) in order to add a further level of robustness to the database.	Chief Operating Officer		A single point of receipt of urgent suspected cancer has been established by one team within the Central Booking office and has been in operation since July 2012.	Complete
27.2	Provide each specialty/CPG with information on expected numbers of cancer referrals and treatments.	Chief Operating Officer		Numbers of 2 week wait referrals for urgent suspected cancer by tumour group and CPG are monitored weekly by the Cancer Team Speciality Manager and presented fortnightly at the Waiting List Meeting since September 2012..	Complete
27.3	Complete the Cancer Access Policy and procedures (SOPs) that will underpin cancer performance reporting	Chief Operating Officer	SOPs to support access policy to be completed.	Cancer Access Policy has been integrated into the Trust's Elective Access Policy signed off by the Management Board 29/10/12.	In progress: monitored via action plan.
28.	**Elective Access Management and Reporting**				
28.1	Ensure that the newly introduced management and reporting controls are embedded and sustained when the dedicated programme office is closed down and the new Chief Operating Officer (COO) appointment starts.	Chief Operating Officer		*Weekly Elective Access Waiting List meeting is being chaired by the Chief Operating Officer and attended by the Head of Operations or representatives. *Weekly Cancer Delivery Group chaired by Trust Cancer Manager monitors PTL at individual patient level. *Revised RTT and cancer PTLs reviewed and signed off by IST in place.	Complete
29.	**Data quality and waiting list management**				
29.1	Commission a rolling programme of audits of performance data quality and waiting list management to be conducted by Internal Audit or another suitable group from outside the line management of waiting lists.	Chief Operating Officer/Head of Information		*Agreement with Internal Audit that Waiting List Audits will be conducted in 12/13 and rolling programme of waiting list audits in future years. *Final Audit Reports to go to Audit Committee.	Complete
29.2	Ensure the data quality governance structure in the Trust functions effectively and is given a higher profile and more senior engagement.	Chief Operating Officer/Chief Information Officer	Chief Information Officer/Senior Information Risk Owner to present report to Management Board.	*Selected data Quality KPIs to be included in CPG Performance scorecards from M7/October 2012. *Data quality governance structure aligned with Trust's Performance Management framework. *Regular quality report to Management Board by end November 2012	In progress: monitored via action plan.
30.	**Trust Board**				
30.1	Hold a Board Seminar on waiting list management and performance indicators.	Chief Operating Officer	Trust Board seminar to be held on December 19th to discuss Waiting List management and performance indicator to be used.		In progress: monitored via action plan.
30.2	The Trust Board and Management Board should be more sceptical and proactive in anticipating and identifying major risks and insisting that action is taken and progress monitored. NEDs need to challenge constructively on important matters like waiting times, patient safety, clinical outcomes, etc. and the extent of progress in implementing action plans. The Board needs assurance (evidence) not just words of reassurance.	Trust Board	For discussion by Executives and Trust Board as highlighted in Management Board and Trust Board paper November 2012.		In progress: monitored via action plan.
30.3	In the light of the potentially generic nature of the five causes of the poor data quality for elective waiting times, i.e. - lack of standardised processes rigorously applied - poor computer systems - inadequate internal management reports - weaknesses in knowledge, expertise and engagement - weaknesses in management, the Trust Board should require assurance (evidence) of the accuracy of other key data such as for A&E waiting times, clinical quality, infection control and serious incidents	Trust Board	For discussion by Executives and Trust Board as highlighted in Management Board and Trust Board paper November 2012.		In progress: monitored via action plan.
31.	**Cerner Programme Board**				
31.1	An obvious major risk for the Trust is the changeover of computer systems for cancer and for the PAS etc. to Cerner (planned for next April). A number of other Trusts in London (like Barts and the London) had serious problems and couldn't produce activity or performance data for a number of months after changing to Cerner. The Trust must learn lessons from other Trusts who've implemented Cerner, plan the changeover for cancer and the PAS etc. very carefully and programme manage the implementation vigorously.	Chief Operating Officer	Go/No go live assurance criteria to be agreed by Cerner Programme Board.	Lessons learnt from other Trusts have been reviewed. Priority review and approval of design of elective booking processes in Cerner Millennium. Risks closely managed by Cerner Programme Board and assurance on reporting forms part of go/no go live criteria.	Complete

Waiting List Clinical Review Report (Fryer)					
32.	**Cancer**				
32.1	Produce and appropriately manage accurate cancer patient tracking list	Chief Operating Officer		* The new fully integrated cancer PTL is complete. This tracks 14, 31, 62 day pathways. * Weekly Cancer Delivery Group chaired by recently appointed Lead Cancer Clinician or Lead Cancer Manager monitors PTL at individual patient level. * Rolling audit programme to check for accuracy.	Complete
32.2	Reduce the number of entry points to the Trust for urgent suspected cancer referrals	Chief Operating Officer		*A single point of receipt of urgent suspected cancer has been established by one team within the Central Booking office This has been in operation since July 2012. This team also co-ordinate the response back to the GP's to confirm the appointment date and time. Standard Operating Procedure signed off and in place.	Complete

Imperial College Healthcare NHS Trust

Appendix one

Update against all recommendations from IST reports, Deloitte report and External Governance Review and Waiting List Clinical Review reports as at 20 November 2012

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
33.	**Cancer/ Elective Access**				
33.1	Timely validation of patient tracking lists for cancer and 18 weeks referral to treatment (RTT)	Chief Operating Officer		*Weekly Elective Access Waiting List group chaired by Chief Operating Officer monitors validation timeframes. * Weekly Cancer Delivery Group chaired by Chief Operating Officer/Trust Lead Cancer Manager monitor validation cycle. * All cancer tumour sites to have a mandatory weekly PTL review meeting that started w/c 15th October 2012.	Complete
34.	**Health Records**				
34.1	Reduce and eliminate the number of duplicate health record for patients	Head of Information	*Implementation of electronic patient record in Cerner Millennium will eliminate multiple paper-based health records across sites over time. Individual paper-based health records per site will remain until full EPR available.	*c100,000 duplicate site specific health records eliminated since April 2011 and merged into a single, site specific record. Weekly duplicate record monitoring report produced for Elective Access Waiting List meeting.	Complete
34.2	Reduce and eliminate the number of duplicate hospital numbers for patients	Head of Information	*Implement agreed action plan to limit the number of staff with access rights to register patients to minimise number of new duplicates. NHS Number will be the unique hospital number across all sites in Cerner Millennium.	*c100,000 duplicate site-specific hospital numbers eliminated since April 2011. Weekly duplicate record monitoring report	Complete
35.	**Outpatients**				
35.1	Ensure information on patients who do not attend their outpatient appointments is included in the health records	Head of GP Liaison & OPD	* A gold-standard letter template has been produced and will be rolled out for all services when Cerner goes live.	* From July 2012 a standard DNA letter is now produced that is dictated by the clinician which is sent to the GP, patient and stored on secretaries shared drives and a copy stored in the patients notes.	Complete
35.2	Ensure information is sent to referring GP's when patients do not attend their outpatient appointments	Head of GP Liaison & OPD		* From July 2012 A standard DNA letter is now produced that is dictated by the clinician which is sent to the GP, patient and stored on secretaries shared drives and a copy stored in the patients notes.	Complete
36.	**Other**				
36.1	Ensure relevant information on patient care is included in health records.	Chief Operating Officer	Requires further work up incorporating the Cerner programme.		In progress: monitored via action plan.

	Recommendations	SRO	Comment	Evidence or Key Performance Indicator	Status
Deloitte Recommendations					
37.	**Recommendations**				
37.1	Develop RTT training plan to include all new staff and refresher programme for existing staff.	Chief Operating Officer	Training plan being developed with the assistance of the Intensive Support Team (IST) and Cerner and will include all new staff and refresher for existing staff.	Training plan.	In progress: monitored via action plan.
37.2	Create key KPIs on monitoring adherence to policy and SOPS to include: - Accurate coding of social suspensions - Coding of pseudo pathways - Usage of 'do not use' codes	Head of Information		100 Data Quality KPIs for monitoring data quality of elective access pathways are in place.	Complete
37.3	Develop audit programme on completion of Clinical Outcome Forms and data quality of transfer to ICHIS.	Chief Operating Officer/Head of Information		An internal audit programme has been agreed for quarter 4 in 2013 and future years and on waiting lists and clinic outcome forms to provide assurance on operational performance data quality	Complete
37.4	Develop mechanisms for CPGs understand demand patterns.	Chief Operating Officer/Head of Information		Performance team has supported backlog recovery modelling in pressured specialities and led the procurement of demand & capacity modelling software, which will ensure this becomes part of the routine analysis going forward.	In progress: monitored via action plan.
37.5	Ensure one model for the management of waiting lists across the Trust.	Chief Operating Officer	Review currently being undertaken of routine and urgent referrals to determine what other services should be centrally managed, if any.		In progress: monitored via action plan
37.6	Data quality to be included in the CPG performance reviews and data quality dashboards to be included in the performance scorecards.	Chief Operating Officer/Head of Information		From M7 data quality KPIs will be included in the CPG performance reports and CPG performance reviews.	Complete
37.7	Linking of patient pathways to be developed to enable CPGs to determine the impact of diagnostic waits (by modality) on overall waiting times.	Head of Information	Minor enhancement required to include RTT treatment date on diagnostic PTL.		In progress: monitored via action plan.
37.8	Robust system to ensure good quality data for waiting lists that are not kept on ICHIS.	Chief Operating Officer/Head of Information		PTLs now in place for all waiting lists not held on ICHIS, e.g. Audiology, GUM, Radiology.	Complete
37.9	Ensure a data quality assurance framework.	Head of Information		*Selected data Quality KPIs to be included in CPG Performance scorecards from M7/October 2012. *Data quality governance structure aligned with Trust's Performance Management framework. *Regular quality report to Management Board by end Nov	Complete
37.10	Introduction of validation checks or data entry controls to improve the data quality of dates critical to cancer waiting times in Excelicare.	Chief Operating Officer	Standard Operating Procedure being developed by the Cancer Management team.		In progress: monitored via action plan.
37.11	Reconciliation procedure of the 17 systems used to capture data for reporting cancer information produced in Open Exeter.	Chief Operating Officer	Forwarded to the Cancer Management team.		Complete
37.12	Review of why such a large number of open pathways exist on ICHIS.	Chief Operating Officer		Numbers of open pathways validated and are within National Target of 92%.	Complete
37.13	18 week RTT reporting techniques to be reviewed to determine if the 6 month cut off is appropriate.	Chief Operating Officer		Design specification for RTT PTL agreed by working group of CPG and Information representatives. Use of '6 month' rule discontinued in February 2012.	Complete

Appendix two

15/11/2012

Imperial College Healthcare NHS Trust

Elective Access Programme Action Plan

Week ending

Completed prior to 7/10/12 | 07/10/2012 | 14/10/2012 | 21/10/2012 | 28/10/2012 | 04/11/2012 | 11/11/2012 | 18/11/2012 | 25/11/2012 | 02/12/2012 | 09/12/2012 | 16/12/2012 | 23/12/2012 | 30/12/2012 | 06/01/2013 | 13/01/2013 | 20/01/2013 | 27/01/2013 | 03/02/2013 | 10/02/2013 | 17/02/2013 | 24/02/2013 | 03/03/2013 | 10/03/2013 | 17/03/2013 | 24/03/2013 | 31/03/2013

Link to recommendations with update on action	Recommendations	Progress to date	Detail / Comment	Report (Author)
	RTT/ Waiting List Management			
2.3	Review of access policy and training on implementation particularly in the OP setting to ensure patients are added and removed from the waiting list appropriately, focusing on the front end as a priority. This would involve refresher training for all reception and clerical staff.			
3.1	Review of all outpatient referral points into the system and a debate and agreement as to whether this is best managed centrally or devolved to CPGs ensuring a consistent approach.			
3.2	Agreement on how this will be cascaded into primary care and how this will be managed to ensure compliance.			
4.1	Review existing demand and capacity work focusing on all pressured specialties in order to evidence true capacity gaps and produce robust clearance and sustainability plans based on accurate activity and capacity data.			
4.3	Examine and implement a consistent approach to outpatient and inpatient booking processes, either in a devolved or centralised structure.			
6.3	Focused attention by CPGs is given to cleaning and sustaining the waiting lists and 18 week/cancer PTLs.			
14.3	Where pseudo-pathways are used, a regular process of data quality exception reporting be put in place to audit their appropriate use.			
14.8	Renew focus on resolving the issue of free-text procedure information on the elective waiting list.			
14.11	Embark upon an audit of recent diagnostic waiting times.		To be continued into 2013/14	
15.1	See urgent assurance that the large numbers of patients on the outpatient PTL on separate cancellation list are not 'real' waiting patients.			
15.3	It is recommended that the target date on the first outpatient report should reflect specialty-level target waiting times and that the RTT treatment date be added for information. Head of Information in progress and on track for completion			
15.5	Audit the process for booking follow-up patients to gain assurance that patients are not missing out on follow-up deadlines or on any follow-up.		To be continued into 2013/14	
15.6	Put in place a follow-up PTL report to be used and monitored operationally.			
15.11	Commence reporting both the completeness of RTT validation and aggregated route cause analysis of 18 week breaches to facilitate better understanding of areas of concern and focus for service improvement.			
16.1	That a unified approach to the booking of patients is considered across these two sites with common procedures/processes to ensure appropriate dating of all patients in line with good practice.			
16.3	A review of data links and out coming procedures to ensure all pathways are linked appropriately at the patient's entry into and throughout the pathway.			
16.4	A review is undertaken of patients booked into slots outside the Trust's access policy guidelines and the planned training reflects and supports patients only being booked into the window identified within the access policy.			
16.6	Detailed demand and capacity analysis should be undertaken in high risk specialties as a minimum to identify backlog clearance plans and sustainability plans for 11/12.			
16.7	A review of all patients booked for IP admission following follow up appointment be reviewed to ensure correct clock start date has been applied and assurance be sought that all future booking reflect the RTT date from original referral.		To be continued into 2013/14	
16.8	All staff are trained within the booking office to apply the full range of RTT rules within ICHIS.			
16.10	Unified processes are agreed across these 2 sites for the management of waiting lists/booking of patients and standard operating procedures are developed to ensure equity and correct chronological dating of patients is in place.			
16.11	A standard process is agreed for the booking of patients onto the waiting list for HH patients including completion and transfer of TCI cards from one site to another (with an assurance framework to test this in place).			
17.1	The Trust discuss and agrees a unified approach to waiting list management that looks at either a centralised or decentralised structure.			
17.2	That clear administrative pathways are identified for the management of TCI/DTA cards and patients updated status on ICHIS for all staff.			
18.2	Standard operating procedures should be developed and support this launch in conjunction with the IT and operational teams to ensure all processes are clear to staff.			
18.3	A significant training programme for key staff should be developed and delivered across the whole organization. The recent list of registered users that has been developed could form the basis of prioritising user training.			
19.1	An review is undertaken in respect of the process for updating ICHIS information for all tertiary patients received in the Trust. This needs to address in particular the population of ICHIS with appropriate RTT information in a timely and accurate way.			
19.3	That the trust should clearly clarify outpatient roles and responsibilities for validation with all staff.			
20.1	The Transforming Out Patient Group needs to agree timelines for the implementation of the centralization of all OP referral points into the trust (if agreed corporately) to ensure standardised processes in the management of OP referrals.			
20.2	That communication be sent to all Consultant staff informing them of agreed process and need for referrals to be managed through one source.			
20.3	That referrals received through any entry points other than OP centre be managed pro actively to contact referrer directly and inform them of correct procedure.			
20.4	This issue is raised through the cross economy group being implemented to ensure a clear directive/message is sent to referring GP's of correct process/procedure.			
21.3	Policy and procedures that underpin cancer performance reporting is sign off and disseminated through the Trust			
23.3	Secure early agreement of the revised policy, and completing an appropriate training programme, aimed at all different levels of staff, including clinicians.			

Elective Access Programme Action Plan

Week ending

Completed prior to 7/10/12 | 07/10/2012 | 14/10/2012 | 21/10/2012 | 28/10/2012 | 04/11/2012 | 11/11/2012 | 18/11/2012 | 25/11/2012 | 02/12/2012 | 09/12/2012 | 16/12/2012 | 23/12/2012 | 30/12/2012 | 06/01/2013 | 13/01/2013 | 20/01/2013 | 27/01/2013 | 03/02/2013 | 10/02/2013 | 17/02/2013 | 24/02/2013 | 03/03/2013 | 10/03/2013 | 17/03/2013 | 24/03/2013 | 31/03/2013

Link to recommendations with update on action	Recommendations	Progress to date	Detail / Comment	Report (Author)
23.4	The super-users are mapped to individual services and specialities so that every person that has responsibility for any RTT data entry is aware of how to get day to day advice and support.			
23.9	Complete the Elective Access Policy review and SOPs and sets out a clear plan for dissemination and training of all relevant staff .			
24.2	Plan for dissemination of Elective Access Policy and supporting Standard Operating Procedures (SOPs) and training			
26.1	Further automation of the collection of diagnostic waiting times data was urgently required. Separate databases in outpatients, inpatients and radiology had to be interrogated to determine the number of diagnostics patients waiting.			
27.3	Complete the Cancer Access Policy and procedures (SOPs) that will underpin cancer performance reporting			
29.2	Ensure the data quality governance structure in the Trust functions effectively and is given a higher profile and more senior engagement.			
30.1	Hold a Board Seminar on waiting list management and performance indicators.			
30.2	The Trust Board and Management Board should be more sceptical and proactive in anticipating and identifying major risks and insisting that action is taken and progress monitored. NEDs need to challenge constructively on important matters like waiting times, patient safety, clinical outcomes, etc. and the extent of progress in implementing action plans. The Board needs assurance (evidence) not just words of reassurance.			
30.3	In the light of the potentially generic nature of the five causes of the poor data quality for elective waiting times, i.e. - lack of standardised processes rigorously applied - poor computer systems - inadequate internal management reports - weaknesses in knowledge, expertise and engagement - weaknesses in management, the Trust Board should require assurance (evidence) of the accuracy of other key data such as for A&E waiting times, clinical quality, infection control and serious incidents			
36.1	Ensure relevant information on patient care is included in health records		To be continued into 2013/14	
37.1	Develop RTT training plan to include all new staff and refresher programme for existing staff			
37.4	Develop mechanisms for CPGs understand demand patterns			
37.5	Ensure one model for the management of waiting lists across the Trust			
37.7	Linking of patient pathways to be developed to enable CPGs to determine the impact of diagnostic waits (by modality) on overall waiting times.			
37.10	Introduction of validation checks or data entry controls to improve the data quality of dates critical to cancer waiting times in Excelicare.			

Reviews/Reports Titles
External Governance Review of the Breakdown in Reliability of Performance Data for Waiting Times: Terry Hanafin. September 2012
Waiting List Clinical Review: Jane Fryer. September 2012
Review of Compliance Against National Waiting Times Standards. NHS North West London and Imperial college Healthcare NHS Trust: Deloittes. March 2012

IST reports
Initial IST report
Access/Waiting list management Report
Cancer Report
RTT Systems Review
Imperial Stocktake

Key	
Key Milestone	◆
Planned Start	○
Planned Process	▭
Planned Completion	△
Actual Start	●
Actual Process	▬
Actual Completion	▲

Imperial College Healthcare NHS
NHS Trust

WOMEN'S AND CHILDREN'S CLINICAL PROGRAMME GROUP

MATERNITY RISK MANAGEMENT STRATEGY 2012-13

<table>
<tr><td>START DATE:</td><td>October 2012</td><td>NEXT REVIEW:</td><td>October 2013</td></tr>
<tr><td></td><td>TRUST BOARD DATE: September 2012</td><td colspan="2">CHAIR'S SIGNATURE:</td></tr>
<tr><td></td><td>ENDORSED BY: CPG Board</td><td colspan="2">DATE:
Date:</td></tr>
<tr><td>DISTRIBUTION:</td><td colspan="3">All staff in the Maternity and Neonatal Units at both St Mary's and Queen Charlotte's and Chelsea Hospital, Lindo Wing, A&E Departments, CPG Quality and Safety Team, Corporate Governance Department</td></tr>
<tr><td>LOCATION:</td><td colspan="3">Trust Intranet Site – CPG 5</td></tr>
<tr><td>RELATED DOCUMENTS:</td><td colspan="3">Risk Management Strategy - Including Risk Management Process 2012– 2013 August 2012
Serious Incident Policy and Procedures, August 2012
Supervisor's of Midwives Strategy for Imperial 2012
Being Open Policy
Supporting Staff involved in Incidents, Complaints, Claims, and Inquests
Incident Reporting Policy and Procedure
Investigating Incidents, Complaints and Claims Policy (draft)
Complaints and Concerns Policy
Claims Policy
Clinical Audit Policy
Risk Assessment Policy
Disciplinary Policy & Procedure
Health & Safety Policy
Raising concerns (whistleblowing) Policy
Statutory and Mandatory Training Policy & Procedure
Risk Awareness Training for Senior Managers Policy
NHSLA Clinical Risk Management Standards for Maternity January 2012
ICHNT Operational Policy for Safeguarding of Children and Young People (Maternity) September 2011
ICHNT Safeguarding Children and Young People Levels 1,2 and 3 Training Policy January 2012</td></tr>
<tr><td>AUTHOR / FURTHER INFORMATION:</td><td colspan="3">Pippa Nightingale Head of Midwifery Women's and Children's CPG (5). Sarah Beake, Jacqui Mallard Risk Management Midwives.</td></tr>
</table>

DOCUMENT REVIEW HISTORY:		DATE EXPIRED:
	Maternity Risk Management Strategy and Policy 2006 (SMH)	SMH Strategy, Oct 2006, extension given Jan 2008
	Directorate Risk Management Strategy 2007 (Hammermith)	Hammersmith Strategy 2009
	Maternity Risk Management Strategy 2009 (Imperial)	2009 (Imperial) expired July 2010
	Imperial Maternity Risk Management Strategy 2010	2010 expired September 2011
	Imperial Maternity Risk Management Strategy 2011/2012	2011 expired October 2012

CONTENTS

Section No.	Title	Page No.
	Executive Summary	4
1.	Introduction	5
2	Scope	7
3.	Leadership	8
4.	Accountability Structures	16
5.	Risk Management Processes	20
6.	Security Arrangements	25
7.	Safeguarding Children and Young People	26
8.	Clinical Audit	26
9.	Communication	27
10.	Implementation Plan	27
11.	Monitoring/Audit	28
12.	Review	30
13.	Equality Impact Assessment	30
14.	Document Control including Archiving Arrangements	30
15.	References	30
Appendix 1	Maternity Risk Manangement Structures	32
Appendix 2	Assurance Pathway to Trust Board for Maternity Risk Management Issues	34
Appendix 3	Risk Register Pathway	35
Appendix 4	Incident Trigger List	36
Appendix 5	Learning Mechanisms	37
Appendix 6	5x5 Matrix	38
Appendix 7	Risk Register – levels of authority	40
Appendix 8	Equality Impact Assessment	42

Executive Summary

The Trust Risk Management Strategy provides the framework for identifying and managing all types of risk. It outlines accountabilities and responsibilities at all levels of the organisation and information flows through high level, sub, and local committees to and from the Trust Board. In addition the strategy supports the Trust's commitment to delivering high quality services, and sustaining regulatory compliance with Care Quality Commission and NHS Litigation Authority requirements.

The framework is designed to support the development of an organisational culture whereby well trained staff proactively identify and manage risks locally. The strategy also provides the structures and processes to provide assurance to the Trust Board on the effectiveness of risk management.

Effective risk management includes an organisational approach to risk assessment which is systematic, comprehensive and continuous, and which provides sufficient flexibility to accommodate planned and responsive assessments.

This Maternity Service Risk Management Strategy is in line with the Trust Risk Management Strategy and sets out the following in relation to maternity services:

Organisational Context of Risk Management
Measurable objectives – for demonstrating that the Strategy has been implemented
Leadership - duties and repsonsibilities of all levels of staff
Accountability Arrangements – reporting mechanisms from ward to CPG to Trust Board
Risk assessment process – proactive risk management – learning before the event
Risk Register – trackable repository of maternity service risk
Open and fair blame culture – reporting to learn not to blame
Incident, complaint and claim reporting and investigation
Mechanisms for learning from incidents, complaints and claims – reactive risk management – learning after the event
Training programmes – in line with the Training Needs Analysis (TNA)
Mechanisms for monitoring implementation of specific aspects of the Strategy

1 Introduction

Successful risk management including the identification and management of risks requires the active involvement of staff at all levels, as staff operating within a service are best placed to understand the inherent risks and to promote necessary change. As an Academic Health Science Centre (AHSC) the Trust Board's intent is to lead the organisation in the delivery of safer and better quality healthcare achieving excellent results in service, research and education, and ensuring this is delivered through the best possible use of public funds.

The maternity services at both St Mary's Hospital (SMH) and Queen Charlotte's and Chelsea Hospital (QCCH), as part of ICHNT, are equally committed to achieving this intent. This Maternity Risk Management Strategy seeks to complement the Trust wide Risk Management Strategy and set out the additional factors required for maternity, specifically in relation to the NHS Litigation Authority requirements as set out in the annual Clinical Negligence Scheme for Trusts Clinical Risk Management Standards for Maternity.

Successful risk management is dependent upon the support and leadership offered by the Trust Board and in particular, the Chief Executive; as well as the support and leadership of the Women's and Children's Clinical Programme Group Board, led by the Clinical Programme Director. The identification and management of risks requires the active involvement of staff at all levels in the maternity service.

The Maternity Service is committed to maintaining and promoting an open, fair culture where staff can report any errors, free from fear and confident that the Clinical Programme Group (CPG) will support them to enable learning to take place. For this to occur there must be commitment and support from staff at all levels.

It is acknowledged that most incidents are normally a system problem that people are operating within. Therefore, risk control solutions must be directed at their causes rather than outcomes to reduce the severity, consequence and cost of incidents, and to produce achievable change.

The Health Service Circular HSC 1999/123 cites a comprehensive definition of risk management as provided by the Joint Australia/New Zealand Standard (1999), which is: 'the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects'.

Risk Management is an important component of Clinical Governance. Key elements are:

- Safe, evidence-based practice using clinical audit to benchmark practice
- Risk assessment (planned/scheduled and responsive)
- High quality record keeping and documentation
- Appropriate clinical policies, procedures and guidelines
- An emphasis on learning, not blame, from formal case reviews
- Appropriate responses to complaints and discontent
- Involvement of all staff at all levels
- Provide detailed feedback to all Staff who report incidents

Risk management is not primarily about avoiding or mitigating claims; rather, it is a tool for improving the quality of care and thereby the experience of women and their families who access the maternity services. Poor-quality care may lead to litigation, so whilst risk management aims to reduce outcomes that lead to claims, this is not its sole or primary purpose. Risk management is as much about learning from claims as it is about mitigating claims.

Incident reporting is one aspect of the identification of risk that enables the investigation and analysis of incidents to take place, within the risk management processes, so that lessons can be learned and change implemented where appropriate. In one sense, incident reporting is on the reactive side of risk management. It is recognised that more emphasis needs to be placed on the

proactive side e.g. planned/scheduled risk assessments, as risk management is more effective when resources are used to minimise the occurrence of patient safety incidents instead of 'fire fighting' after things have gone wrong. Skills drills are an example of proactive risk management.

1.1 Aims

The aim of this Strategy is to develop and maintain a clear and effective structure of leadership and accountability across the Maternity Service.This will be achieved by:

1. Ensuring the Maternity Services Risk Management Strategy is implemented at local level by all groups of staff
2. Ensuring management of risk is approached in a structured manner as part of everyday business in line with the Trust Risk Management Strategy
3. Raising awareness of risk management within the maternity service
4. Providing guidance on how risk management is undertaken within the Maternity Service
5. Complying with external Regulatory Body requirements, for example Clinical Negligence Scheme for Trusts and Care Quality Commisssion
6. Promoting the development of researched and evidenced based practice
7. Promoting an open and fair blame culture where staff are encouraged to report risks, incidents and near misses
8. Identifying, managing and where possible eliminating, or reducing risk to an acceptable clinical or cost effective level. Types of risk are defined as :-

- Patient safety (clinical risk)
- Operational performance
- Strategic
- Health and Safety
- Financial
- Information Governance
- Research Governance
- Partnership
- Reputational

9. Using root cause analysis to determine system weaknesses and ensure that lessons learnt are utilised to bring about service improvement.
10. To openly acknowledge when things have not gone as well as expected, in particular when errors have been made, and to systematically analyse such events in order to learn from them and strengthen supporting systems.
11. Preventing, where possible, any recurrence of clinical incidents through the process of reflective practice and learning from experience.
12. Ensuring staff are adequately trained to identify and manage local risks, in line with the Trust and Maternity Training Needs Analysis (TNA).

13. Ensuring that staff are adequately supported through the investigation process and at any other time when staff request support.

1.2 Measurable Objectives

In order to assure the maternity sevice and the Trust Board that the Strategy is implemented and produces the desired effect a set of measurable objectives have been developed as below:

1. All staff in maternity receive relevant training in risk management and incident reporting at induction (in line with the TNA and Trust induction policy) and that there is ongoing training in accordance with the standards set out in the maternity services training need analysis.

2. Incidents and near misses are reported by all staff through a common reporting system (Datix)

3. All relevant staff take part or assist in planned/scheduled and responsive risk assessments as required

4. Clearly defined roles and responsibilities for the management of risk at all levels in the maternity service are set out and monitored

5. Designated individuals responsible for risk management exercise accountability in maternity services

6. An active risk register is maintained which is reviewed, to ensure that actions are undertaken to control, reduce and/or eliminate identified risks, and updated at least 6 monthly and presented to the Maternity Quality and Safety Committee.

7. Supervisors of Midwives are supported to proactively practice statutory supervision with an aim to achieve standards set by the Local Supervising Authority (LSA)

8. Evidence based guidelines for clinical practice are developed, evaluated and updated

9. Internal and external information and recommendations from National Bodies and Confidential Enquiries are used to benchmark practice and improve clinical care

10. Audit leads to demonstrable improvement in clinical care/outcomes and clinical effectiveness

11. Staff are provided with appropriate support following the reporting and investigation of incidents, complaints and claims, in particular those that are graded as serious and learning points are routinely disseminated.

12. Compliance with statutory requirements including the NHS Litigation Authority Clinical Risk Management Standards for Maternity is maintained and that these standards are used to improve practice and outcomes.

13. Improvements or changes in practice as a result of recommendations following the investigation of incidents, complaints and claims can be demonstrated.

14. National guidance e.g. National Institute for Health and Clinical Excellence (NICE), National Perinatal Epidemiology Unit (NPEU), Royal Colleges and Care Quality Commission, is systematically reviewed, and where appropriate recommendations are implemented

15. Clear and effective cross site communication enables information sharing across the Maternity Services, CPG and the Trust as required.

16. Planned/scheduled and responsive risk assessments are undertaken in line with the Trust Risk Assessment Policy and identify risks that inform the Maternity risk register, which is reviewed and updated at least 6 monthly and presented to the Maternity Quality and Safety Committee.

17. Encourage staff to seek election as Health & Safety Representatives, and ensure that the H&S Reps are given adequate time and facilities to carry out their duties, including attendance at the CPG H&S Meeting.

2. SCOPE

The Maternity Risk Management Strategy is applicable to all members of staff within the Maternity Services on both the St Mary's Hospital and Queen Charlotte's and Chelsea Hospital sites and the A&E Departments at Hammersmith Hospital, St Mary's Hospital and Charing Cross Hospital where pregnant

women may be seen. This Strategy should be used in conjunction with the Trust Risk Management Strategy (2012) and the Trust policies for the reporting and investigating of incidents and serious incidents. It applies to all honorary contract holders, contracted service workers and to all workers of other organisations visiting the Trust sites in the course of their employment or studies

3. LEADERSHIP and ACCOUNTABILITY WITHIN MATERNITY SERVICES

3.1 The Trust Board

The Board has a collective corporate responsibility for risk. It is able to delegate day to day requirements of risk management to designated individuals.

3.2 Chief Executive

The Chief Executive has overall responsibility for ensuring that there is an effective risk management system in place, meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance and all associated legal requirements.

The Chief Executive is required to sign annually, on behalf of the Board, a Statement on Internal Control in which the Board acknowledges and accepts its responsibility for maintaining and reviewing the effectiveness of a sound system of internal control, including risk management.

The role is to ensure that:-

- Responsibilities for the management and co-ordination of risk are clear
- Major risk management policies and procedures are ratified through the appropriate structures
- Required resources, from within available funds, are identified and allocated to implement risk management initiatives
- There is communication with stakeholders on areas of shared risk

3.3 Trust Executive Director

The Executive Director with responsibility for risk management within the maternity services is the Medical Director, who is also accountable for risk management within the organisation. The Medical Director is informed of maternity risk management issues by the CPG 5 Director. This is through a standard monitoring action at monthly performance management meetings.

3.4 Director of Estates Services

The Director of Estates Services is responsible to the Chief Executive for day to day health and safety and welfare arrangements on all the Trust sites including maternity services.

3.5 Director of Nursing

The Director of Nursing has general responsibilities for ensuring the quality of nursing and midwifery care across the Trust. Maternity, nursing and workforce related issues are reported directly from the Head of Midwifery/ Director of Midwifery/Head of Nursing for Maternity Services. Midwifery quality indicators and workforce data is presented to the Director of Nursing monthly at the establishment review meeting. Clinical concerns from this meeting are reported to the Divisional Performance meetings by the Director of Nursing.

3.6 The Director of Occupational Health

The Trust has its own in-house Occupational Health Service where the role is to promote the physical and mental health, safety and welfare of employees. The role includes pre-employment health screening and on going health surveillance; provision of accident and sickness monitoring, assessment of employees following long periods of absence from work and advising Trust Management accordingly. In addition, an immunisation programme and a confidential counselling service are provided.

3.7 Trust Head of Security/Local Security Management Specialist (LSMS)

The Head of Security/LSMS ensures that all appropriate actions are taken to create and continually support a pro-security culture within the Trust and ensure that where security incidents and breaches are detected and reported, the incidents are recorded on the Trust's Security/Crime Incident Reporting System (ENTRUST). The role is supported by security managers.

3.8 Trust Head of Safety and Risk

The Trust Head of Safety and Risk provides advice on general Health and Safety and Welfare. The role is to support Trust Management and to monitor and advise on safety performance.

The Trust has also appointed external Health and Safety Consultants to assist the Head of Safety and Risk to fulfil those functions and assist the Trust to meet its health and safety and welfare obligations.

The Head of Safety and Risk has a co-ordinating role in relation to general safety issues including health and safety training, review of risk assessments and audit of the Trust Safety arrangements.

3.9 Clinical Programme Group Director (CPG 5)

The full management structure can be found on the Source.

The CPG Director takes a lead on quality and safety and has overall responsibility for clinical risk management and risk related issues across the CPG. Quality and Safety is delegated to the CPG Divisional Chiefs of Service and they are responsible for managing quality and safety risks associated with meeting business objectives. They are also responsible for ensuring that staff are appropriately trained to carry out their responsibilities as well as for ensuring that patient care is delivered safely and effectively in an environment that meets all standards of infection control and prevention. The CPG Director chairs both the CPG Board and the CPG Quality and Safety Board and is responsible for escalating concerns at Trust level as well as representing the CPG at Trust wide meetings.The CPG Director or a deputy is responsible for presenting the CPG Risk Register (which includes maternity risks) to the Governance Committee annually. These include but are not limited to the following:-

- To ensure that appropriate and effective risk management processes exist within their delegated areas of responsibility and CPG activity is compliant with national standards and where applicable international guidance, e.g. NHS Litigation Authority Risk Management Standards, Care Quality Commission (CQC)
- To ensure that risk assessments are undertaken throughout areas of responsibility at least annually, with the risks prioritised and action plans formulated, implemented and monitored
- To ensure that the risk register is developed with due consideration of all types of risks
- To ensure that risk identification and management is included in all business cases
- To draw to the attention of the Trust's Governance Committee extreme risks with the potential of an organisational wide impact
- To ensure staff are given the necessary information, training and equipment to enable them to work safely

- To ensure that all adverse events (clinical incidents and accidents) are reported, investigated and action taken to prevent recurrence and the reporting and investigation policy is adhered to

3.10 Director of Midwifery/Head of Nursing

The Director of Midwifery and Head of Nursing, together with the CPG Director, is responsible for ensuring that risk management processes are in place across the CPG and for escalating concerns to the CPG Board as well as representing the CPG at Trust wide meetings.

3.11 Head of Operations

The Head of Operations for CPG 5 reports to the CPG Director. This role is supported by the General Manager for Maternity & Neonatology. The Head of Operations is responsible for:

- Ensuring that all staff working within CPG 5, which includes Maternity Services, understand and carry out their individual responsibilities for the management of risk. The Head of Operations is a member of the CPG Board and reports monthly to the Divisional Performance Board.
- Ensuring risk issues within CPG 5 are considered at executive level within the Trust via the CPG Board.

3.12 Chiefs of Service

The are 2 Chiefs of Service for the Maternity Services, one for each site, and they are responsible for ensuring that risk management processes are in place and for reporting on concerns to the CPG Board. The CPG5 Director and the Chiefs of Service for Obstetrics are responsible for ensuring that the training requirements of all consultants and Trust grades are met. Responsibility for ensuring that the training requirements for trainee medical staff are met is delegated to The College Tutor for Obstetrics and Gynaecology.

3.13 Head of Midwifery

The Head of Midwifery is responsible for the day to day management of midwifery services and ensuring that quality and safety and risk management processes are in place for midwifery and for escalating concerns within the CPG to CPG Director/ Director of Nursing. The Head of Midwifery is supported in this role by a midwifery management team which includes site specific Maternity Risk Managers. Responsibilities include:

- Developing and implementing a risk management strategy
- Ensuring local frameworks exist to identify, address and improve risk related issues as necessary where compliance and improvements are required.
- Overseeing the project management of external assessments such as NHSLA CNST Standards for Maternity Services
- Overseeing the progress of maternity specific assessments such as the CQC and UNICEF BFI accreditation.

3.14 Clinical Leads for Risk Management

The overarching Clinical Lead for Maternity risk management has overall responsibility for coordinating clinical risk activity within the maternity services and chairs the Maternity Quality and Safety Committee. The Clinical Lead also reports into the CPG Quality and Safety Board and the Trust Clinical Risk Management Committee. Each site has its own designated clinical risk management lead who is responsible for risk on that site and for chairing the local risk management meetings. The Clinical Lead on the QCCH site is also the overarching Clinical Risk Management Lead for the CPG. They are also responsible for providing learning feedback to staff directly involved in an incident.

3.15 Lead Consultant Obstetrician for Delivery Suite

There is a Lead Consultant Obstetrician for Delivery Suite on each site and they support the risk management process by reviewing maternity records and undertaking investigations. They are involved in the education and supervision of junior medical staff. The lead consultant on QCCH is also the overarching Clinical Risk Management Lead for the CPG. They are also responsible for providing learning feedback to staff directly involved in an incident

3.16 Lead Obstetric Anaesthetists

There is a Lead Obstetric Anaesthetist for risk management and complaints for each site and they are specifically responsible for ensuring anaesthetic risks are reviewed and followed up and for reporting to their local risk management meetings. The Lead Obstetric Anaesthetists for risk management and complaints are members of the local risk management committees. There is also a dedicated Clinical Anaesthetic Lead who works closely with the maternity team and has direct communication links with the Lead Consultant Obstetricians for the Delivery Suites, Delivery Suite Leads and the CPG Clinical Director. Both Leads also attend all Consultant meetings and ensure that there is attendance on the Blood Transfusion Committee. They and/ or the Lead Anaesthetist for Risk Management have responsibility for:

- Providing advice and guidance on relevant training standards and best practice standards
- Ensuring that the training requirements of all consultants and staff grades are met
- Providing guidance on National Patient Safety Agency (NPSA) alerts pertaining to anaesthetics
- Escalating risks and monitoring trends in relation to maternity high dependency care, theatre management, recovery and operative case management
- Undertaking an annual audit of medical staffing levels to ensure that levels are appropriate to delivering high quality care.
- Liaising with the Clinical Director to develop business and contingency plans to address any staffing shortfalls identified
- Identifying relevant areas of risk that need to go onto the Risk Register
- Regular attendance at the CPG Quality and Safety Committee.
- They are also responsible for providing learning feedback to staff directly involved in an incident

3.17 Consultant Midwife

There is currently one Consultant Midwife who has the remit for Normal Birth. The Consultant Midwife provides leadership, continuing development of midwives, provide expert advice, lead on midwifery education, work in clinical practice, and significantly contribute to the audit, research and wider clinical governance agenda within maternity services. The Consultant Midwife attends the Maternity Standards Group, Maternity Quality and Safety Committee and local Risk Management Meetings and is also responsible for providing learning feedback to staff directly involved in an incident.

3.18 Lead Clinical Midwife for Labour Ward

The Lead Midwives have a responsibility to ensure that any risks identified on Labour Ward are managed appropriately through incident reporting and investigation.

Other responsibilities include:

- Regular attendance at the local risk management meetings

- Ensuring lessons learnt through incident investigation are shared either formally or informally
- Contributing widely to the monitoring and audit of CNST standards that impact on Labour Ward
- Identifying areas of risk that need to go onto the Risk Register
- Contributing to the Directorate Education and Training Programme.
- They are also responsible for providing learning feedback to staff directly involved in an incident

3.19 CPG Head of Quality and Safety

The role of the Head of Quality and Safety is to take a lead on the strategic direction and operational management of Quality and Safety across the CPG. Together with other members of the Quality and Safety team, this includes ensuring that there is effective provision for clinical risk management, patient safety, patient concerns and complaints, clinical effectiveness, clinical audit services and learning from events. The Head of Quality and Safety is a member of the CPG Quality and Safety Board, Maternity Quality and Safety Committee and represents the CPG at the Trust Health Safety Fire and Security Committee. This role is supported by the CPG Deputy Head of Quality and Safety and CPG Quality and Safety Co-ordinator. The Head of Quality and Safety, Deputy Head of Quality and Safety and Quality and Safety Co-ordinator make up the CPG Quality and Safety Team.

3.20 Supervisors of Midwives (SOMs)

It is the responsibility of the supervisors of midwives to offer supervision to all midwives and to support those midwives involved in clinical incidents. A supervisor of midwives will attend the local maternity risk management meeting on each site and a representative sits on the Maternity Quality and Safety Committee and the Maternity Standards Group. SOMs are expected to participate in all aspects of risk assessment and risk management whether formal or informal. They are also actively involved in developing and updating maternity policies, documentation and guidelines through membership of various groups.

In addition they provide a vital role within the maternity service in raising concerns over capacity or serious incidents (SIs), form part of the investigation team when required to do so and or proactively support staff through training and development issues arising out of adverse incidents that are identified. SOMs also participate in general case reviews during annual supervisory review and in formal case reviews for Sis.

They will conduct annual supervisory reviews to ensure the supervisees are fit to practice, and identify training or personal developmental needs to ensure they are fulfilling their PREP requirements. They are also responsible for providing learning feedback to staff directly involved in an incident

3.21 Midwifery Managers

This group includes the Lead Midwives, Senior Midwives for Labour Wards and Consultant Midwives as well as Band 7 midwives and shift co-ordinators. They are responsible for ensuring that clinical incidents are reported in their clinical areas and may also have a responsibility for approving and investigating incidents. Where investigations are undertaken they will liaise with the Risk Management Midwives. They are also responsible for providing learning feedback to staff directly involved in an incident.
There is also an expectation that they will undertake risk assessments as requested and review risks so that the risk register can be updated and maintained across the maternity service.

3.22 Risk Management Midwives

There are two Maternity Risk Management Midwives, one for each site and they are responsible for ensuring that all reported incidents are investigated and that the significant incidents are presented and discussed at the site specific local Maternity Risk Management Meetings. They are also responsible for:

- Working with the Clinical Lead for Maternity Risk Management, Lead Consultant for Labour Ward, Midwifery Managers and Maternity Governance Lead.

- Obtaining statements from staff

- Updating Datixweb; the web based incident reporting system and reporting security related incidents to local risk officers

- Undertaking investigations including root cause analysis

- Working with the Trust Patient Safety Manager and Trust Risk Managers on investigating Serious Incidents (SIs)

- Reporting on learning outcomes at the local Risk Management Meetings and Maternity Quality and Safety Committee

- Overseeing the completion of the maternity dashboard on a monthly basis and cascading information to the local Risk Management Meetings

- Producing the bi-monthly maternity newsletter 'Risky Business'

- Providing training to staff in risk management

- Providing learning feedback to staff to staff directly involved in an incident

3.23 Clinical Effectiveness Midwife

The Clinical Effectiveness Midwife is responsible for:

- Ensuring that clinical guidelines are evidence based and that recommendations from national guidance e.g. NICE, CMACE are incorporated.

- Ensuring that clinical guidelines are reviewed and outcomes resulting in a change of practice following an investigation into a clinical incident or complaint are incorporated

3.24 Departmental Safety Co-ordinators

In line with the Health & Safety Policy Departmental Safety Co-ordinators may be appointed by Departmental Managers. Departmental Safety Co-ordinators assist the Managers to meet their health and safety and welfare responsibilities. The Head of Quality and Safety maintains a list of all the CPG local safety coordinators.

3.25 Safeguarding Lead for Children and Young People and Vulnerable Adults

Maternity Services has a Named Midwife for Safeguarding Children and Young People and Vulnerable Adults. This post supports all activities necessary to ensure that the organisation meets its responsibilities to safeguard/protect children and young people and vulnerable adults.

The Named Midwife is responsible to and accountable within the managerial framework of Imperial College Healthcare NHS Trust, and sits on the trust board for Safeguarding Children and Young People and the trust board for Safeguarding Vulnerable Adults. Trust wide issues are fed back into the maternity services via exception reporting to the CPG5 board, and as standing agenda items at the Maternity Quality and Safety Committee and the Senior Midwives Meeting chaired by HOM

The Named Midwife:

- Contributes to the planning and strategic organisation of safeguarding children and young people and vulnerable adult protection services.
- Ensures advice is available to the full range of specialties within the organisation on the day to-day management of children and adults where there are safeguarding concerns including relevant legal frameworks and documentation.
- Ensures the outcomes of health advisory group discussions at an organisational level are communicated to the team, as appropriate.
- Works closely with the board-level executive lead for safeguarding within Imperial College Healthcare NHS Trust.
- Ensures that the organisation/maternity has safeguarding children/adults protection policies and procedures in line with legislation, national guidance, and the guidance of the local boards.
- Contributes to the dissemination and implementation of organisational policies and procedures.
- Advises Imperial College Healthcare NHS Trust on the implementation of effective systems of audit.
- Contributes to monitoring the quality and effectiveness of services, including monitoring performance against indicators and standards.
- Contributes, as clinically appropriate, to serious case reviews/case management reviews/ significant case reviews, and individual management reviews/ individual agency reviews/internal management reviews.
- Disseminates lessons learnt from serious case reviews/case management reviews/significant case reviews, and advises on the implementation of recommendations.
- Ensures provision of effective safeguarding appraisal, support and supervision for colleagues in the organisation.

3.26 Education Leads

The obstetric, neonatal and midwifery education leads are responsible for ensuring the development of the maternity TNA and associated documentation.

3.27 Practice Development Midwives (PDMs)

There are 3 PDMs who are responsible for the ongoing support and continuing education of all qualified midwives. They report to the Lead Midwives and attend the Midwifery Education Committee, local Risk Management Meetings and Maternity Standards Group.

3.28 Screening Coordinators

The Antenatal and Newborn Screening Coordinators (QCCH and SMH) are joint designated leads for antenatal screening for the maternity service. They are supported by the specialist midwives for infectious diseases. At trust level the multidisciplinary Imperial Screening Steering Committee which meets quarterly has the responsibility for overseeing management, governance and quality of antenatal and newborn screening across both maternity sites. Three sub groups representing each screening programmes (Sickle Cell and Thalassaemia Screening (linked antenatal/newborn programme), Fetal Anomaly Screening and Infectious Diseases Screening) feed into the committee which is accountable to the Division of Maternity.

3.29 CPG Supporting Staff

The Trust provide support staff who carry out work/functions within the CPG
Human Resource Advisors
Local Estates Officers
Infection control link nurses
Blood Transfusion
Radiation Protection Supervisors
Medical device lead
Pharmacy Lead
Safety Consultant (contracted)
Sterile Services Lead (contracted – cleaning, portering)

3.30 All Maternity Staff including Honorary Contract Holders, Bank and Agency and locum Staff

All Maternity Staff including those with Honorary Contracts, contracted services and Agency Staff have a personal responsibility to ensure:-

- Risk management is everyone's responsibility and as such, is a fundamental requirement of all staff carrying out their duties effectively.

- All staff have a responsibility to identify and assess risk, taking appropriate action to reduce risks to an acceptable level by participating in planned/scheduled and responsive risk assessments relating to their areas of work, in line with the Trust Risk Assessment Policy and Procedures document.

- All staff have a responsibility to report clinical and non-clinical incidents, accidents, and 'near misses' using the Datixweb incident reporting system and security incidents to the local security officer for entry into ENTRUST the Trust security incident database

- All staff have a responsibility to inform managers or a member of the risk management team of any unacceptable levels of risk outside their sphere of responsibility or authority

- Contribute to the investigation of adverse events as requested

- Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks

- Are aware of how to access the Maternity and Trust Risk Management Strategies and how to seek advice within the Trust on risk management issues

- Are aware of their duty under legislation to take reasonable care for their own health, safety and welfare and that of all others that may be affected by the Trust's business

- Maintain confidentiality of patient information, as required by law

- Maintain confidentiality for Trust information within the limits of the Public Interest Disclosure Act 1998

- Identify training needs in relation to risk management and attend agreed specific training as identified by the TNA and in line with the Statutory and Mandatory Training Policy.

- To follow Trust policies

3.31 Trades Unions

The Trust recognises a number of Trades Unions, whose role is to represent their Members. The Maternity Services welcomes the recognised Unions' cooperation and partnership working, for the

smooth running of the Services. Facilities and paid-time-release for Trades Unions' Duties will be given to ensure that Trades Unions' Representatives fulfil their Trades Unions' duties.

4. ACCOUNTABILITY STRUCTURES

The reporting structures below indicate the responsibilites and the relationships beween the Maternity Service and various boards and committees at a Trust level as well as within the CPG. Through the reporting process, both the CPG and the Trust should receive assurance that the Maternity Service has robust risk management processes in place.

4.1 The Trust Board

The Trust Board is fully committed to leading the organisation in delivering high quality services and achieving excellent results. It receives reports relating to Serious Incidents and maternity risk management issues that require escalating. It is responsible for giving final approval to this Maternity Risk Management Strategy.

4.2 Trust Governance Committee

The Governance Committee provides the leadership and strategic direction to integrate all aspects of governance processes to ensure that the Trust provides safer, high quality care in the best environment, meets business objectives, manages the risks necessary to facilitate innovation in healthcare and uses accurate clinical information to bring about improved outcomes. It has delegated responsibility for non – financial risk from the Audit Committee, to which it reports on these activities. The committee approves the extreme risk register before presentation to the Trust Board.

4.3 Trust Quality and Safety Committee

The Trust Quality and Safety Committee meets monthly and has a responsibility to receive reports from each of the CPGs and to act as an advisory body on the quality and safety of clinical care that will assure the Trust Board that there are effective structures and processes in place to support the Trust in its mission to achieve excellence in patient care, teaching education and research. It also has a responsibility to set the strategic direction for quality and safety initiatives across the Trust. The CPG Director and Director of Midwifery/Head of Nursing are members of the committee and represent the Women's and Children's CPG.

4.4 Trust Health, Safety, Fire and Security Committee

The Health, Safety, Fire and Security Committee (HSFSC) is chaired by the Director of Estates and reports to the Trust Board via the Governance Committee. It approves and monitors policies to promote the health, safety and welfare of employees and all other people affected by the work of the Trust, through consultation and communication. The CPG Head of Quality and Safety is a member of this committee and provides a channel of communication between the committee and the all divisions within the CPG. The Health and Safety Policy and Procedures contain further information.

The CPG Head of Quality and Safety chairs the CPG Health and Safety Committee which meets 5 times per year and reports into the CPG Quality and Safety Board and the Trust Health, Safety, Fire and Security Committee. The CPG committee consists of staff representatives who are Departmental Safety Co-ordinators and identify hazards, perform risk assessments and inspections in line with Trust policy.

4.5 The Trust Radiation Safety Committee

TRSC advises the Trust regarding compliance with legislation concerning the safe use of ionising radiation and with health and safety legislation and best practice related to the use of non-ionising radiation. The committee formulates policies regarding the safe use of ionising and non-ionising radiation. It reports to the Health, Safety, Fire, and Security Committee. As Fetal Medicine utilise

radiation equipment the CPG representative attends these meetings and feeds back issues relating to radiation safety.

4.6 Trust Clinical Risk Committee

The Trust Clinical Risk Committee reports to the Trust Quality and Safety Committee. A CPG 5 Clinical Lead for Risk Management is a member of this committee and is responsible for informing the committee of actions taken and lessons learned as a result of clinical incidents and for feeding trust-wide risk issues back to the maternity service.

4.7 Trust Security Committee

The Security Committee is responsible for coordinating and discussing security related activity within the Trust. The Committee reports to the HSFSC after each meeting. The Trust Security Policy contains further details. The maternity service is part of the local Paediatrics/Maternity Security sub-committee. The sub-committee monitors crime and security incidences that occur within maternity and the local completion of planned/scheduled and responsive risk assessments and reports to the Trust Security Committee after each meeting.

4.8 Other Key Trust Committees with responsibilities for specific aspects of risk

These be found in Appendix 3 of the Trust Risk Management Strategy and all Terms of Reference may be found on the Source.

A range of theme-specific groups or working parties may support the key committees from time to time.

4.9 CPG 5 Board

The CPG Board has a responsibility to ensure that quality and safety is appropriately reflected in all aspects of the CPG's strategic planning, performance scrutiny and its own agenda and activities. It receives reports from the Chiefs of Service for Maternity Services and ensures that appropriate and effective risk management processes exist within their delegated areas of responsibility including compliance with national standards, e.g. Care Quality Commission, NHS Litigation Authority Clinical Risk Management Standards.

4.10 CPG 5 Performance Board

This meeting meets monthly and is chaired by the Medical Director and Director of Nursing, Its function is to report the divisional performance in relation to clinical risk, workforce, infection control, patient experience and finance. All clinical SIs are reported to this Board.

4.11 CPG 5 Quality and Safety Board

This Board meets quarterly and is responsible for setting the quality and safety strategy for all 4 of the divisions within the CPG (maternity, gynaecology and reproductive medicine, paediatrics, neonatology) and monitoring the progress against that strategy. It receives feedback from the Chairs of the Divisional Quality and Safety Committees in relation to risk management, together with action plans and progress reports in relation to SIs. The Clinical Lead for Risk Management in the CPG, who chairs the Maternity Quality and Safety Committee, is therefore a member of this Board.

4.12 Division of Maternity Services Committee

Risk management is an agenda items at this meeting. Risk identification and risk management are also included in all business cases and strategic and capital developments where appropriate.

4.13 Maternity Quality and Safety Committee

The Maternity Quality and Safety Committee has a responsibility for encouraging all staff to report adverse events and to discuss incidents, SI, claims and complaints as part of the integral learning approach.The committee meets bi-monthly and reports to the CPG 5 Quality and Safety Board.

In relation to risk management these are:

- To encourage staff to report adverse events and to ensure adverse events are investigated and actions taken to prevent recurrence and that the adverse event reporting and investigation policy is adhered to.
- To ensure that planned/scheduled and responsive risk assessments, both clinical and non-clinical, are undertaken throughout the maternity services, and the risks prioritised and action plans formulated, implemented and monitored.
- To ensure that the maternity risk register is populated with all risks (clinical, non-clinical and financial) and ensure that their staff are given the necessary information and training to enable them to work safely.
- To draw to the attention of the Chiefs of Service of the Maternity Division any pertinent risk management and quality issues
- To draw to the attention of the CPG Director any significant risks which cannot be managed within the Division and require escalation.
- To work with the Chiefs of Service for the Maternity Divisio and the CPG Director, to ensure that risk identification and risk management is included in all business cases, strategic and capital developments.
- To ensure that any lessons learned and that any action plans are monitored.

4.14 Local Maternity Risk Management Meetings

The Maternity Service has two local Risk Management Meetings, one at St Mary's Hospital (SMH) and the other at Queen Charlotte's and Chelsea Hospital (QCCH). These are multiprofessional meetings and are held monthly to discuss and investigate all significant incidents. It is the responsibility of these meetings to ensure that the incidents are discussed thoroughly and in a fair and open manner so that appropriate actions can be taken to minimise the risk of recurrence. Where themes and trends are identified and lessons are to be learned these will be recorded and disseminated to all staff in maternity through Maternity Newsletter, "Risky Business". Minutes are reported to the Maternity Quality and Safety Committee.

4.15 Divisional Establishment Meetings

These are chaired by the Director of Nursing. Nursing and midwifery workforce and the clinical qualtiy care matrix are reported here, as well as all Datix risks relating to staffing.

4.16 Supervisor of Midwives Meetings

The Supervisors of Midwives (SOM) discuss any risk concerns from a supervisory perspective so that these can be taken to the local risk management meetings. They are also required to demonstrate their involvement with risk for the annual audit for the Local Supervising Authority. The Local Supervising Midwifery Officers' annual action plan is received by Lead SOM and reported to SOMM for review and onward reporting. The annual action plan is also reviewed at the SOMM. Progress and compliance with the action plan is monitored at the SOMM.

4.17 Maternity Guidelines Group

The Maternity Guidelines Group is a multiprofessional group that is repsonsible for the review and approval of maternity guidelines. The Group meets monthly and reports to the Maternity Quality and Safety Committee. Guideline development and review is also presented to the Maternity Standards Group. Clinical Guidelines approved at this Group are ratified by the CPG Quality and Safety Committee.

4.18 Maternity Standards Group

The Maternity Standards Group meets on a monthly basis. It includes representation from both sites and across all disciplines and reports to the Maternity Quality and Safety Committee. The Group is responsible for driving and monitoring progress in standards compliance, reviewing and reporting on audit results, formulating action plans and reviewing actions taken. The Group is particulalrly concerned with compliance against NHSLA Risk Management Standards for Maternity Services which incorporates NICE guidance, and links to the Care Quality Commission Standards for Better Healthcare.

4.19 Midwifery Education Group

The Midwifery Education Group meets on a bimonthly basis, is chaired by the Consultant Midwife (Normal Birth). Membership includes the Consultant Midwife, Practice Development Midwives, Clinical Practice Facilitators, a named Supervisor of Midwives and a named Manager. The Group is responsible for:

- steering and developing the midwifery and maternity support staff training and education strategy and training needs analysis
- devising training programmes that will meet those needs
- taking account of the results of audits, learning from incidents, complaints and claims and other information sources as part of the ongoing review of training programmes.

The Group reports to the Quality & Safety Committee.

4.20 Maternity Services Liaison Committee

MSLC's are locally based groups of all those involved in planning, providing and receiving care including users so they are well placed to advise on developments in local maternity services and to monitor progress towards agreed standards. MSLC meetings discuss maternity services as a whole, not just labour and delivery. Information leaflets, labour ward statistics, breastfeeding support, user surveys, midwifery staffing levels are all examples of topics that can be discussed at a meeting.

4.21 Maternity Information Steering Group (MISG)

The MISG meets on a monthly basis to monitor compliance with the Trust and Maternity Policies for Patient Information and agreed standards and ensure clear processes for the production and ratification of in-house maternity information resources and the procurement and approval of externally produced maternity information materials. This work ties in to the Trust Patient Information Network (PIN) process to ensure the quality and accuracy of information. The group works closely with the Guidelines Group where patient information is linked to clinical guidelines.

5. RISK MANAGEMENT PROCESSES

5.1 NHSLA Clinical Risk Management Standards for Maternity Services

The CPG recognises the importance and influence the NHSLA Risk Management Standards and assessments have on improving quality and safety. Healthcare organisations are regularly assessed

against these risk management standards which have been specifically developed to reflect issues which arise in the negligence claims reported to the NHSLA. There is a set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health and safety risks. In addition there is a separate set of maternity clinical risk management standards (CNST) defined by the NHSLA for our CPG as we provide maternity care at Queen Charlotte's and Chelsea Hospital and St Mary's Hospital. In 2009 the maternity service was successful in achieving Level 2 and is now preparing for the next assessment in November 2012.

5.2 Registration and Continuous Monitoring of Compliance with Care Quality Commission (CQC) Regulations

The Trust updates compliance with CQC regulations at a minimum of quarterly. Exception reports and an annual report are reviewed by the Governance Committee, this includes risks associated with areas of non – compliance and actions.

In addition the CQC Quality and Risk Profile is monitored via the Trust Performance scorecard at Board level and reviewed in more detail as the reports arrive via the Trust Directors meeting and the Governance Committee.

5.3 Research

The Trust and the governance team have a close working relationship with the NHIR funded Patient Safety and Service Quality Centre and the Business School at Imperial College London. The Trust will identify areas of risk that would benefit from further study and collaborate on this research with its partners and where possible other Academic Health Science Centres.

5.4 Assessing All Types of Risk

The Trust risk matrix is used as the primary tool to assess and grade all types of risk.
This is a 5 x 5 matrix which provides the means to assess and score the likelihood of impact and consequences related to a particular risk. The risk matrix is shown in Appendix 5. All new risk assessments are discussed by the multidisciplinary team at least 6 monthly at the Maternity Quality and Safety Committee and the decision is made about the appropriateness of grading and inclusions on the Maternity Risk Register. Also discussed are any re-grading or removals from the Risk Register for any residual risks.

5.5 Organisational Approaches to Risk Assessment

Effective risk management includes an organisational approach to risk assessment which is systematic, comprehensive and continuous, and which provides sufficient flexibility to accommodate planned and responsive assessments.

5.6 Risk Assessments

For each risk assessment mitigating actions should be identified, and responsibility for these actions allocated to a designated lead. Risk assessments should endeavour to reflect the types of risk as outlined in section 3.2 and should be carried out in accordance with the Risk Assessment Policy.

Planned and responsive risk assessments are in use across the Trust:-

- Planned or scheduled risk assessments should occur at least annually in all local areas and should cover all types of risks. Risks should be documented on local risk registers and all risks rated 8 and above sent to CPG Quality and Safety Co-ordinators or Corporate Directors.

Each CPG and Corporate department will maintain their own combined risk register, developed from each local area, will review progress against the risk mitigation actions at least annually and present their top ten highest graded risks to the Governance Committee annually.

- Responsive risk assessments are conducted on a needs basis in response to events or issues that have come to light e.g. following external agency reviews. They are conducted in the same manner as planned/scheduled risk assessments.

These risk assessments cover all areas of the Maternity Service and inform the maternity risk register.

5.6.1 Identification and Assessment of Patient Specific Clinical Risk

It is an essential part of midwifery and obstetric practice to identify any risks that are present in the care of a particular woman and her baby at the earliest possible opportunity. These patient-specific risk assessments (e.g. antenatal risk assessment) are contained within each relevant clinical guideline.

5.7 Maternity Risk Register

The maternity risk register draws together information from various sources that have been used locally to identify risks, such as recommendations from incident investigations; Health & Safety risk assessments, service planning, business objectives, feedback from staff and PALS key themes etc. The Trust's Risk Matrix is used to evaluate the current severity of each risk.

Local registers are used as a risk management tool and integrated within the annual business planning cycle, to ensure alignment where necessary with budget setting. Risks identified which fall under the jurisdiction of another service are reported to the responsible person for that service.

The maternity risk register is presented at the Maternity Quality and Safety Committee following each update (usually every 6 months). This then forms part of the CPG Risk Register, which is presented to the CPG Quality and Safety Board (usually every 6 months) and annually to the Trust Governance Committee. Key risks then become part of the Trust Risk Register.

The Trust Risk Register is reported in its entirety to the Governance Committee annually. To ensure the Board has an awareness of local risks, the top ten highest scoring risks which have an organisational wide impact and are graded as at least 12 from each CPG and corporate directorates are be presented annually to the Governance Committee and assurance given on local risk management processes.

5.8 Trust Extreme Risk Register

Any risks scored as "extreme" are managed through the Trust Extreme Risk Register. To be included on the extreme risk register, the risk and its management actions must be approved and escalated by the Governance Committee. The risks are assigned to a named Executive Director or CPG Lead.

The Trust Board reviews the extreme risk register at a minimum of twice a year and ensures that key risks are being managed and mitigated. Extreme scoring risks from the Assurance Framework are also managed by this process.

Appendix 7 outlines the process for developing risk registers at all levels of the organisation, management responsibilities per levels of risk and the Trust risk escalation process.

5.9 Process for Communication and Assurance between Maternity Service and the Board Lead Executive

As above in Section 3 and as detailed in Appendix 1, the Maternity Trust Board Lead Executive is the Medical Director. Communication and assurance between the Maternity Service and the Board Lead Executive normally takes place at the Performance Management Board and the Trust Clinical Risk Committee and Trust Quality and Safety Committee.

5.10 Process for Immediately Escalating Risk Management issues from the Maternity Service to Board Level

As above, most maternity risk management issues will be reported to the Board Level via the committee reporting structure. However, there may be certain occasions when maternity risk management issues require immediate escalation from the maternity service to Board Level; these will generally be issues of a serious nature and will generally fall into the following categories:

- Potential/actual serious incidents, complaints and claims or never events
- Imminent danger to staff, patients and visitors eg security threat
- Closure of the maternity unit(s)

Urgent and immediate escalation of risk management issues should be via the CPG Director to the Medical Director. This is usually via a telephone call in the first instance with a follow-up e-mail later to clarify details and meetings and further discussion as required.

In the absence of the above persons this will be reported from the Director of Midwifery or Head of Operations who will take on this responsibility together with the Head of Midwifery who will contact the Trust Associate Director of Quality and Safety/Patient Safety Manager and ask for advice.

In an acute event the risk management issue may have resolved as quickly as it was generated and need no further investigation. Any outstanding issues will be discussed with the DoM/Head of Midwifery and the CPG Director and included within the next scheduled committee reports as appropriate.

Potential serious incidents and Never events are reported by the Risk Management Midwives via a 'possible SI report' that is e-mailed to the Patient Safety Manager.

5.11 Developing an Open and Fair Culture

In the interest of openness and the process of learning from mistakes (incidents, complaints and claims), formal disciplinary action will not usually be taken as a result of a risk management investigation. However, a serious breach of health and safety regulations or serious negligence causing loss or injury are examples of gross misconduct – The Disciplinary Policy, provides more details. Disciplinary action may, therefore, be considered appropriate where it is found that an employee has acted: -

- illegally or unlawfully
- maliciously - intending to cause harm which s/he knew was likely to occur
- or recklessly - deliberately taking an unjustifiable risk where s/he either knew of the risk or s/he deliberately chose to ignore its existence.

Should disciplinary action be appropriate, this will be made clear as soon as the possibility emerges, and in line with Trust HR policies. The investigation would then be modified to take account of advice from the Director of People and Organisational Development or other agencies as appropriate. The Trust's policy, 'Supporting Staff Involved in an Incident Complaint or Claim' should be used to identify and source support for staff involved in incidents, complajnts and claims.

All staff may contact and seek the support and advice of their Union representatives, and/or professional bodies during any investigation into an incident,complaint or claim.

When disciplinary action is being considered, all staff are strongly encouraged to seek the support and advice of Union representatives and/or professional bodies.

5.12 Incident Reporting and Investigation

The Trust is committed to openly reporting all types of incidents so that through a process of investigation and fact finding it can understand why such things happen and can identify what change is necessary to bring about improvements. All incidents are reviewed and approved as part of the risk management process. Any lessons to be learned and actions to be taken are made and disseminated with the aim of improving the quality of care.

The Trust has adopted the Datix online adverse event reporting system throughout the organisation for reporting all incidents, including "near misses", whether patient or staff related, clinical or non-clinical. Security incidents should be reported to the security service and will be uploaded onto ENTRUST the trust security incident database. This enables a systematic approach to the monitoring, investigation, follow up and aggregation of data to identify trends. All incidents are graded using the Datix risk matrix and the level of risk determines the investigation and follow up process. NHS London and the NPSA (until replaced by a successor body) determine certain maternity incidents that must be reported – commonly referred to as the '**Trigger List'**. The maternity service trigger list can be found at Appendix 3.

One means of learning from collective adverse events is to identify trends and themes as a result of incidents and the maternity dashboard (see also 5.18) is a tool that is used to assist in this processs. The maternity dashboard is presented to the local Maternity Rsk Management Meetings and the Maternity Quality and Safety Committee.

The Trust reports all clinical incidents to the NPSA, or successor body, at a minimum of monthly and provides a monitoring report to the Clinical Risk Committee (CRC) following the issue of NPSA benchmarked data. The Clinical Risk Committee review any organisational risks arising from national incident data reports or quarterly Trust reports. The maternity service Clinical Risk Lead is a member of the CRC and feeds back information to the maternity service committees/groups.

5.13 Serious Incident Reporting & Investigations

SIs are defined in the Trust's SI Policy. All such incidents are reported within the policy process and time-scales as defined by NHS London. The over-riding purpose of serious and critical incident investigation procedures is is not to apportion blame, but to analyse the circumstances in which the SI occurred, and refine the system of work to minimise recurrence. NHS London review the quality of the Trust investigations.

The risk of recurrence (likelihood) and the consequences there of, are risk assessed as part of a completed SI investigation and documented on the investigation report template. SI risks are managed through local risk registers (unless graded 12 or above).

The SI policy can be found on the Source.

To assist with this process the Head of Quality and Safety for CPG 5 is informed of all incidents which could potentially become a SI.

The Trust Patient Safety Manager is responsible for coordinating the investigation of SIs, including root cause analysis, in conjunction with the maternity risk management teams. Where appropriate and deemed necessary, unbiased external input will be sought and this is detailed within the investigation report. The Medical Director (or nominated deputy) signs off SI investigation reports. The Trust Board receives reports on all SIs. All SIs are logged on a SI tracker database so progress and completion can be monitored. NHS London approve all SI investigation reports to demonstrate that the investigation and subsequent actions have been completed throughly and appropriateley. This sign off is logged on the SI Tracker database.

Lessons learned from SIs and action plans will be implemented and monitored and reported at the local Risk Management Meetings,the Maternity Quality and Safety Committee and the CPG Quality and Safety Board..

5.14 Being Open

The Trust is sensitive to women and families in response to the National Patient Safety Agency (NPSA) policy: Being Open: communicating patient safety incidents with patients, their families and carers. It is acknowledges that open and honest communication with patients is at the heart of health care. Research has shown that being open and saying sorry when things go wrong can help patients and staff to cope better with the after effects of a patient safety incident. The maternity service is seeking to offer feedback to families at the time of an SI and following the completion of SI investigations. Further guidance can be found in the Trust Being Open Policy.

5.15 Never Events

The NPSA introduced a policy on Never Events in 2009. These are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. One of these is in-hospital maternal death from post-partum haemorrhage after elective caesarean section, excluding cases where imaging has identified placenta accreta. Primary Care Trusts (PCTs) are required to monitor the occurrence of Never Events within the services they commission and publicly report them on an annual basis. The list of Never Events can be found in the Serious Incident Policy. NHS London will be ultimately responsible for closure of Never Event SIs in all trusts. Closure of the SI will only be achieved where the trust is able to demonstrate evidence of implementation of all actions points in the action plan.

5.16 Complaints and Concerns

Complaints and concerns are managed in accordance with the Complaints and Concerns Policy. All are risk assessed which determines the level of investigation. Maternity issues are discussed at the local monthly Maternity Risk Management Meetings, the Maternity Quality & Saferty Commmittee and at the Trust Clinical Risk Committee as part of the trust scorecard. The CPG Head of Quality and Safety co-ordinates complaints on behalf of the Director of Midwifery/Head of Nursing. Each division has a nominated investigator to carry out the investigation, draft a response letter and to implement learning outcomes into the divison. It is recognised that close collaboration is required with the Trusts claims, litigation and complaints departments, which are managed corporately. The Head of Midwifery presents a summary report of maternity complaints and learning outcomes to the Maternity Services Liaison Committee (MSLC) for discussion.The Trust Complaints Forum meets quarterly and shares learning, improvement and best practice among local leads, the CPG Head of Quality and Safety attends and feedback to the Divsions if appropriate.

Lessons learned from complaints and claims are also included in the Maternity Newsletter, “Risky Business.

The policy can be found on the Source

5.17 Claims

Each claim received is managed by the Trust’s Claims Managers via Datix. The Claims Policy details the management process. Information on new and settled claims is made available to CPG 5 and other corporate directorates every quarter.

The Risk Management letters arising from settled claims, are distributed by the NHSLA for organisational learning. Upon receipt of the risk management letters, the Claim Managers forwards a copy of the report to the nominated CPG Leads, in maternity these are the Maternity Risk Managers who feedback to the Claims Managers the learning outcomes implemented or other information as requested. Six monthly reports on learning and improvement actions from settled claims and solicitors risk management reports from the NHSLA are monitored at the Clinical Risk Committee to share learning and changes to practice and for non – clinical claims six monthly reports will be monitored at the Health, Safety, Security and Fire Committee (HSFSC) to share learning and improvements. The CPG Clinical Lead for Risk feeds back from the Clinical Risk Committee and the the Head of Quality and Safety for the CPG feeds back issues

from the HSFSC. Maternity issues are discussed at the local monthly Maternity Risk Management Meetings, the Maternity Quality and Safety Committee and the CPG Quality and Safety Board.

Lessons learned from complaints and claims are also included in the Maternity Newsletter, "Risky Business.

The policy can be found on the Source

An over view of personal, local and organisational learning routes can be found in Appendix 4

5.18 Maternity Dashboard

The maternity service has implemented the maternity dashboard as recommended by the RCOG to monitor clinical activity, workforce issues, and clinical outcomes. It can be used to benchmark activity and monitor performance against locally agreed standards on a monthly basis. This enables early identification of 'deviation from agreed goals' and initiating of timely and appropriate action to avoid future patient safety incidents and improve clinical care.

The maternity dashboard is reported on at the local Maternity Risk Management Meetings and the Maternity Quality and Safety Committee. Any concerns are escalated to the appropriate CPG and Trust committees.

5.19 Training

To ensure the successful implementation and maintenance of the risk management strategy, all members of maternity staff receive appropriate training. This occurs in a variety of ways including at induction and as part of the ongoing mandatory training of staff based on the training needs analysis (TNA). A regular training programme for updates is provided, based on training need.

In addition the Trust Risk Management Department provides a variety of training opportunities to enable staff to take responsibility for managing risk in their own environment, including courses relating to general risk awareness, risk assessment, the Datixweb adverse event reporting system and root cause analysis for staff involved in the investigation of adverse events. Further information can be found under the 'Working Life section of the intranet.

Results of audits, learning from incidents complaints and claims and other sources of information are considered by the Maternity Education Leads and the Midwifery Education Group on an ongoing basis and the training programmes amended to take account of such information.

Reports on the training programmes delivered and the progress towards achieving at least 75% compliance with attendance for clinical staff is presented 6 monthly to the Maternity Quality and Safety Committee.

6. TRUST SECURITY ARRANGEMENTS FOR MATERNITY SERVICES

The Trust has paediatric units located at both Hammersmith and St Mary's Hospital sites and maternity services located at Queen Charlotte's and Chelsea Hospital and St Mary's Hospital. It is imperative that robust security management arrangements are in place at these units.

These will include:

CRB checks by Human Resources

The maternity service endorse UNICEFs rooming in and therefore there are no nurseries in maternity

Labour Wards and maternity wards are locked

Staff are issued with security swipe cards with photographs to only permit entry to permitted areas

Education about security is given at staff induction

Panic alarms sited at strategic locations

Comprehensive CCTV that is monitored in real time by security in the relevant control rooms

The ability to activate an electronic lockdown system as part of the Trust Access Control measures and Trust Lockdown Plan

Regular security patrols to reassure staff and patients and alleviate any security concerns

As required, and in collaboration with the senior managers, the deployment of a permanent security presence to address a specific security or crime risk

The conducting of security walkarounds and risk assessments to address any specific threats

A focus group (the Paediatric/Maternity Security sub committee) has been set up to meet on a quarterly basis to monitor the suitability of the security measures and compliance with the provisions of the Trust Security Policy and Procedures.

7. SAFEGUARDING CHILDREN AND YOUNG PEOPLE

All staff working in maternity have a responsibility for safeguarding children and young people. In addition to the Trust Operational Policy for the Safeguarding of Children and Young People, there is further guidance in the Maternity Operational Policy. It is the responsibility of all staff to ensure that they adhere to these policies. Within maternity the Consultant Midwife for public health is the named midwife for safeguarding children and young people and sits on the Trust board for Safeguarding Children and Young People and the Trust board for Safeguarding Vulnerable Adults. Trust wide issues are fed back into the maternity services via exception reporting to the CPG5 Board, and as standing agenda items at the CPG Quality and Safety Board, the Maternity Quality and Safety Committee and the Senior Midwives Meeting chaired by Head of Midwifery.

8. CLINICAL AUDIT

8.1 Trust Local Clinical Audit Programme

Clinical audit is a valuable tool in reviewing performance against agreed standards and identifying actions against related risks. CPGs are required to include at least one risk related clinical audit in their annual clinical audit priority plans. All staff are encouraged to participate in clinical audit and to ensure that they follow the registration process in order that the CPG Quality and Safety Coordinator can vet their audit proposal and register the audit with the Trust Clinical Effectiveness Manager. Each CPG is required to produce an annual priority audit plan which is monitored through the Trust Clinical Standards Committee. The CPG also contributes data to National Audits where relevant.

NHSLA Risk Management Standards for Maternity Services set out specific audits that the maternity service must undertake. Some audits are process based (performance measured against a defined structural process) and some are health records based (performance measured against the relevant clinical guideline). The mechanisms for conducting these audits are contained within the Maternity Services Annual Audit Plan and there is a continuous audit book on each labour ward. All staff are requested to complete their health records as fully as possible and are encouraged to take part in the auditing process.

8.2 National Clinical Audit Programme

The Trust's priority Clinical Audit programme will include participation and follow up of all applicable national clinical audits. This activity will be monitored through an annual report to the Audit Committee at least twice a year. Non – compliance with national clinical audit requirements will be risk assessed and included in the report to the Audit Committee.

The Trust Clinical Audit Policy details the approval and follow up process for clinical audit, and may be found on the Soruce

8.3 Compliance with NICE Guidance, National Confidential Enquiries and Safety Alerts

The Trust process for implementing NICE guidance is outlined in the Policy for the Management of NICE Guidance, National Confidential Enquiries and National Guidance and the process for complying with safety alerts is outlined in the Central Alerting System (CAS) Procedure.

Where long standing non – compliance with either of the above is identified (defined as 12 months after the date of publication) a risk assessment should be carried out, actions to mitigate the risk where possible identified and a lead named. The risk/s are managed via local risk registers.

The policy may be found on the Source.

9. COMMUNICATION

The Maternity Risk Management Strategy is disseminated throughout the Maternity Services and staff notified through the Maternity Newsletter, "Risky Business". It is also available to access on the Source and paper copies can be printed for use in staff sitting rooms/notice-boards etc.
Awareness of and information regarding the Maternity Risk Management Strategy is also included on the maternity induction programme for new staff and as part of ongoing risk management training.

Information on lessons learned from incidents, complaints and claims and other relevant risk information such as audit results is disseminated by the following mechanisms:

- Through the newsletter "Risky Business", this is distributed electronically every 2 months and is made available in clinical areas.
- Memberships of the various groups and committees
- Planned training programmes
- Annual supervision meetings
- Weekly range of Obstetric & Gynaecology medical teaching sessions
- Ad hoc training events and leaflets/posters in local areas
- During feedback to those involved in the investigation process
- Via email to designated clinical leads and A&E medical lead

10. IMPLEMENTATION PLAN

1. The maternity risk management strategy will be distributed to all clinical areas in the Maternity Service, and can be accessed directly on the Trust intranet.

2. It will be included on the agendas of meetings within the Maternity Service.

3. It will be included in induction programmes and ongoing risk management training and mandatory updates.

11. MONITORING / AUDIT

An annual compliance review against the strategy and processes will be carried out within the maternity governance team and the results presented to the Maternity Standards Group, the Maternity Quality and Safety Committee and the CPG Board. This will include a compliance review on the processes for managing local risks. Any necessary plans to improve any deficiencies will be monitored by the Maternity Standards Group and Maternity Quality and Safety Committtee and reported to the CPG Board.

Auditable Standards

i) Measurable objectives
An annual update will be compiled detailing acheivements against the measurable objectives set.

ii) Maternity Services Risk Register
An annual review of the maternity service risk register to ascertain whether the risk register:

- contained a range of risk sources including risk assessments and associated action plans
- was reviewed 6 monthly and presented to the local Risk Management meetings and the Maternity Quality and Safety Committee.
- CPG risk register was presented to the CPG Quality and Safety Board
- Top ten risks were presented to the Governance Committee on an annual basis

iii) Maternity service's risk management structure
Annual review of committtee terms of reference, meeting agenda's schedules and minutes to ensure compliance.

iv) Local Supervising Midwifery Officers' Annual Action Plan
Annual review of Supervisor of Midwives Meetings (SOMM) minutes to ascertain receipt, review and actions taken.

v) Immediate escalation of risk management issues from the maternity service to board level
Annual request for evidence to demonstarte the immediate escalation, and review of meeting minutes to evidence ongoing progress.

vi) Communication and assurance between board lead executive and the maternity service
Annual review of meeting schedules, ToRs, reports and commmittee meetings to ensure information was provided.

vii) Individual's Duties
Annnual review of job descritions and meeting minutes to ensure proper discharge of duties and appropriate attendance at required committees.

viii) Maternity specific data set for incident reporting

Annual review of incidents on trigger list being reported on Datix.

ix) Active Dissemination of learning from all incidents, complaints and claims, including case reviews

Annual review to ascertain that lessons learned were shared, this includes:

- Review of committee minutes and papers for sharing of lessons learned and case reviews
- Review of Risky Business for inclusion of lessons learned and case reviews
- Review of the content of annual supervision meetings to ensure case reviews take place
- Review of statatory mandatory training sessions for inclusion of learning and case reviews

x) All incidents, complaints and claims are regularly reviewed and discussed of by the local Risk Management meetings,Maternity Quality and Safety Committee and CPG Quality and Safety Board

Annual review of the meeting minutes and papers to ensure incidents, complaints and claims were regularly reviewed.

xi) All serious untoward incidents (SIs) underwent a root cause analysis, involving as appropriate unbiased external input

Annual retrospective review of maternity cases logged on the SI Tracker database over the preceeding 12 months to look for NHS London sign off and closure.

Annual review of 20 SI final reports over the preceding 12 months to look for appropriate unbiased external input

xii) Updates on implemented and monitored lessons learnt from SUIs were provided to the Trust Board

Annual review of Trust Board minutes and papers to ensure that SI investigation actions and learning point updates were reported on a quarterly basis.

xiii) Training

Annual review of training arrangements, meeting minutes, papers, training programmes etc to ensure that:

- Induction programmes and mandatory study days, as outlined in the Maternity Division Training and Skills Policy, included risk management and lessons learned
- Reports on the training programmes delivered and the progress towards achieving at least 75% compliance with attendance for clinical were presented 6 monthly to the Maternity Quality and Safety Committee
- results of audits, learning from incidents, complaints and claims and other information sources were considered as part of the ongoing review of training by the Education Group and Maternity Quality & Safety Committee.

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xiv) Recommendations from national guidance

Annual review of Maternity Quality and Safety Committee meetings to ensure that such issues, e.g. NICE, CMACE, Care Quality Commission, were discussed and action plans developed where appropriate.

Key Performance Indicators

KPIs provide an objective means of measuring the Trust's success in managing aspects of risk. In addition to national and local essential duties to manage risk the following KPIs will be introduced

- 95% attendance at Trust induction
- At least 75% attendance at mandatory update training in line with the TNA
- The adverse events reported on Datix reflect the full range of the service's activities
- Maternity quality and safety scorecard is maintained and monitored
- Terms of reference include all essential items and reporting requirements were met.
- Achievement of NHSLA Risk Management Standards for Maternity Services

12. REVIEW

This strategy has been developed in the light of currently available information, guidance and legislation that may be subject to review. The strategy will be reviewed annually and submitted to the Maternity Quality and Safety Committee for approval then to the CPG Board for ratification and to the Trust Board for final sign off.

This strategy supersedes the strategy approved in 2011.

13. EQUALITY IMPACT ASSESSMENT

All public bodies have a statutory duty under equality legislation covering race, disability and gender to undertake equality impact assessments on all policies/guidelines and practices. The Trust's equality impact assessment tool also includes religion/belief, sexual orientation, age, deprivation and human rights.
This policy has been equality impact assessed and the findings are in Appendix 9.

14. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGMENTS

14.1 Register/Library of Procedural Documents

The author of the procedural document is responsible for updating documents onto the appropriate site on the Trust's intranet.

Each author has an account and can only publish according to the security on each account. Where there is no active author the web team can load new documents or change existing documents where required.

A register/library of procedural documents and the library of Clinical Guidelines is maintained on the Intranet. Ownership of the original procedure document (together with supporting documents such as the Dissemination Plan) will remain with the author/s. Members of staff will be trained locally to upload documents on to the Intranet. Where no local member of staff has been trained, the communications team will upload documents.

14.2 Archiving Arrangements

Every document that is uploaded has an individual ID which is assigned by Stellant (content management system) when uploaded onto the system ie (id_014604). The intranet automatically shows the new version and archives the old version. (When this happens Stellant records the date, times and author)
A spreadsheet exists of all the corporate policies. This is managed by the web team and mirrors the documents held in the corporate policies area on the intranet. The system has the capability to assign a named person/persons to each policy and a review date and expiry date can be added so that the document details are emailed on a specified date to be checked or expired from the system. Once the author updates the policy, they can upload the new version if they have an account or this should be returned to the web manager who will upload the new version. The old policy will be archived automatically. Archived versions can be requested from the author or from the Web Manager.

15. REFERENCES

Confidential Enquiry into Maternity and Child Health. (2007). Saving Mothers Lives: Reviewing maternal death to make motherhood safer - 2003-2005. London: CEMACH. Available at: www.cmace.org.uk

Confidential Enquiry into Maternity and Child Health. (2004). Why Mothers Die 2000-2002. London: RCOG Press. Available at: www.cmace.org.uk

Confidential Enquiry into Stillbirths and Deaths in Infancy. (1998). 5th Annual Report. London: Maternal and Child Health Research Consortium. Available at: www.cmace.org.uk

Department of Health. (2000). An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS. Chaired by the Chief Medical Officer. London: The Stationery Office. Available at: www.dh.gov.uk

Department of Health. (2007). Maternity Matters: Choice, access and continuity of care in a safe service. London: COI. Available at: www.dh.gov.uk

Department of Heath. (2007) On the State of Public Health: Annual Report of the Chief Medical Officer 2006. Chapter 6: Intrapartum-related deaths: 500 missed opportunities. London: The Stationery Office.

Healthcare Commission. (2006). Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005. London: Commission for Healthcare Audit and Inspection. Available at: www.healthcarecommission.org.uk

Healthcare Commission. (2008) Learning from investigations. London: Commission for Healthcare Audit and Inspection. Available at: www.healthcarecommission.org.uk

Health Service Circular HSC 1999/123. (1999) Governance in the new NHS. London: NHS Executive.

King's Fund. (2008). Safe Births: Everybody's business - Independent Inquiry into the Safety of Maternity Services in England. London: King's Fund. Available at: www.kingsfund.org.uk

NHS Litigation Authority. (2011). Risk Management Standards for Acute Trusts, Primary Care Trusts and Independent Sector Providers of NHS Care. London: NHSLA. Available at: www.nhsla.com

NHS Litigation Authority. (2012). Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards Version. 1 2010/11. London: NHSLA. Available at: www.nhsla.com

National Patient Safety Agency. (2009). Being Open: communicating patient safety incidents with patients, their families and carers. London: NPSA. Available at: www.nrls.npsa.nhs.uk/beingopen

National Patient Safety Agency. (2009). Never Events Framework 2009/10. London: NPSA. Available at: www.nrls.npsa.nhs.uk/resources/

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Helath. (2007). Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. London: RCOG Press. Available at: www.rcog.org.uk

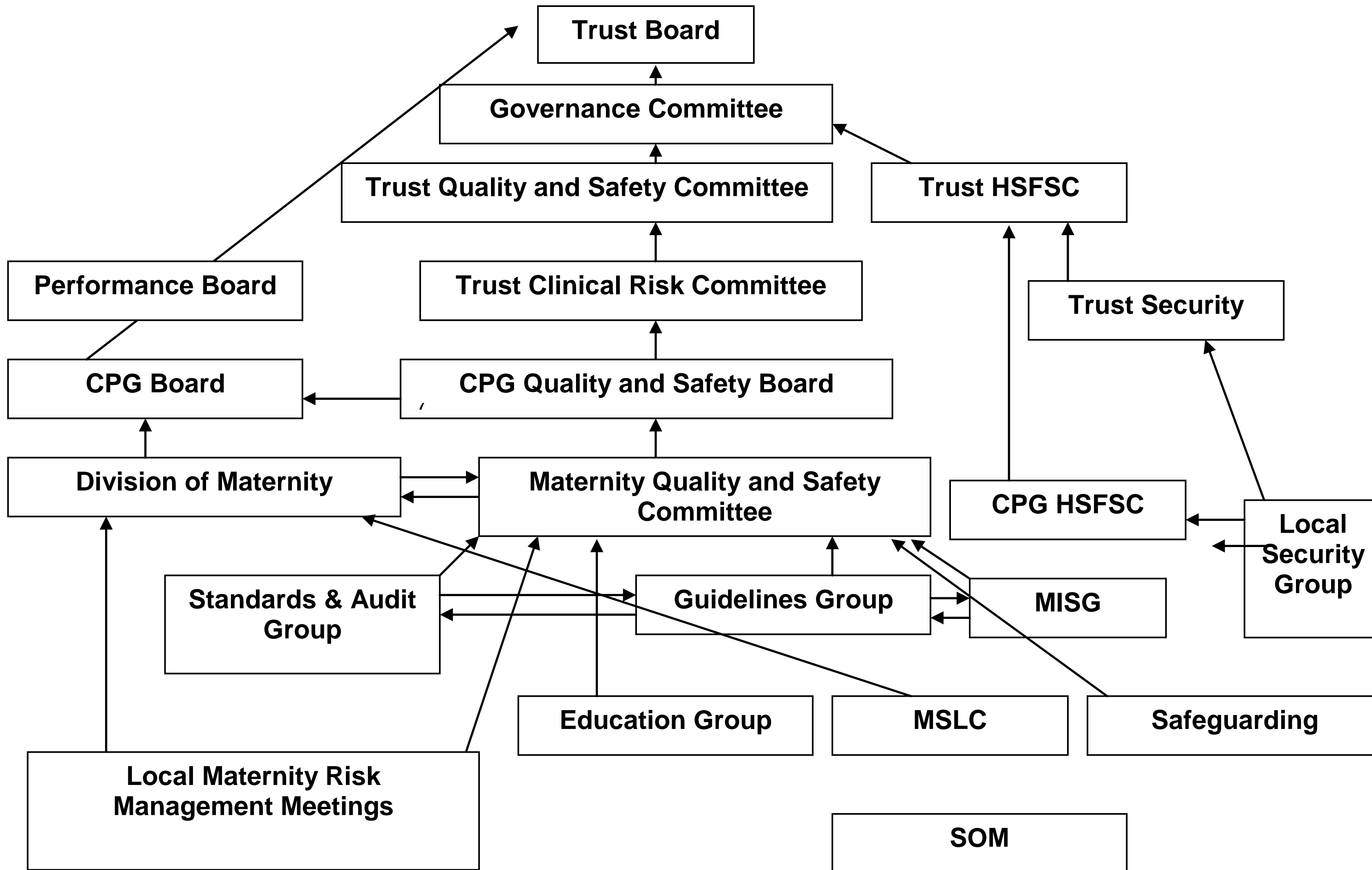
Royal College of Obstetricians and Gynaecologists. (2008) Maternity Dashboard: Clinical Performance and Governance Scorecard. Good Practice No. 7. London: RCOG Press. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. (2009). Improving Patient Safety: Risk Management for Maternity and Gynaecology. London: RCOG Press. Available at: www.rcog.org.uk

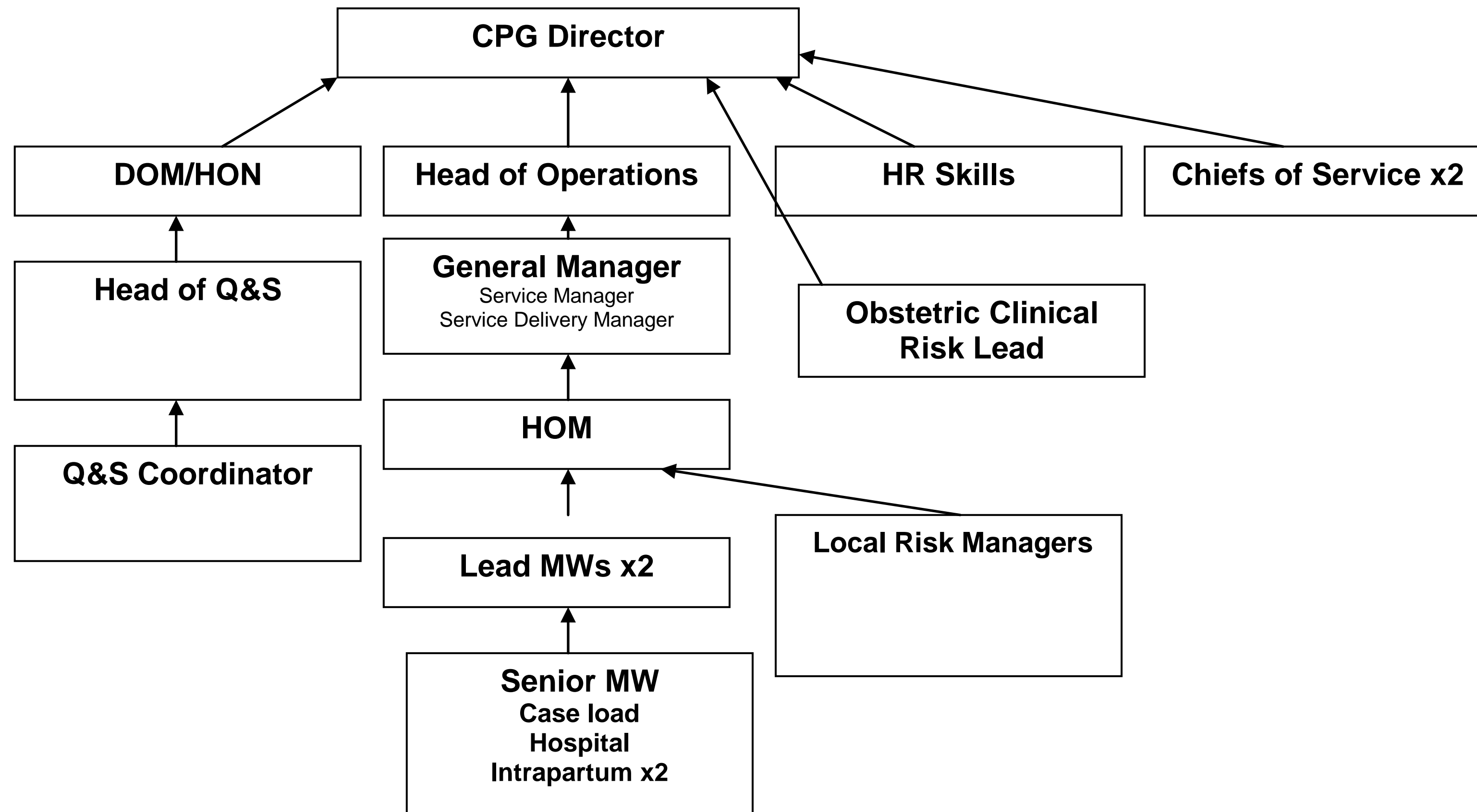
Standards Australia and Standards New Zealand. (2004). Risk Management, AS/NZS 4360:2004 . Strathfield: Standards Association of Australia (Risk Management Standards, Third edition, 2004).

Appendix 1 – Maternity Risk Management Structures

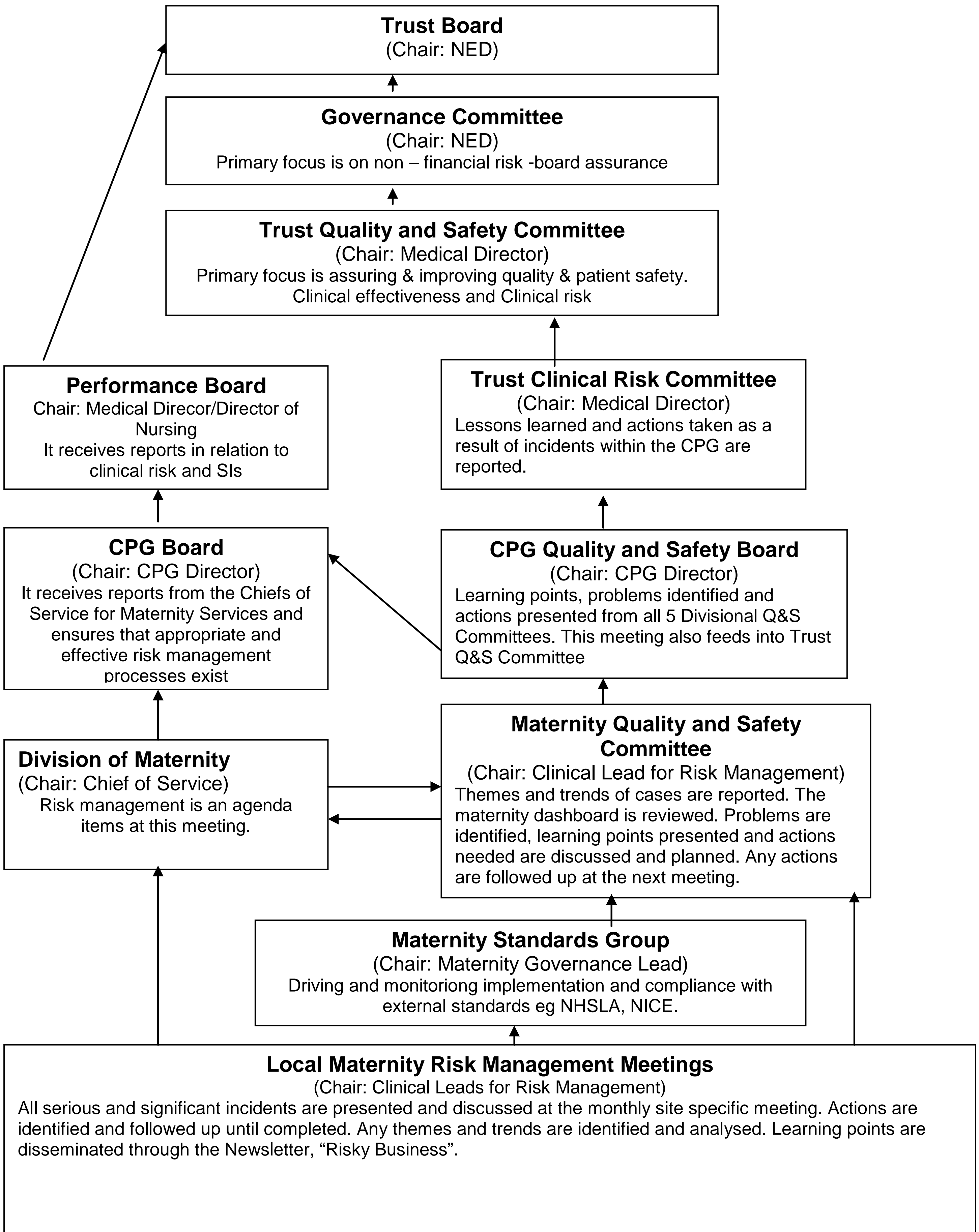
Committees/Groups



People – Leadership Structure

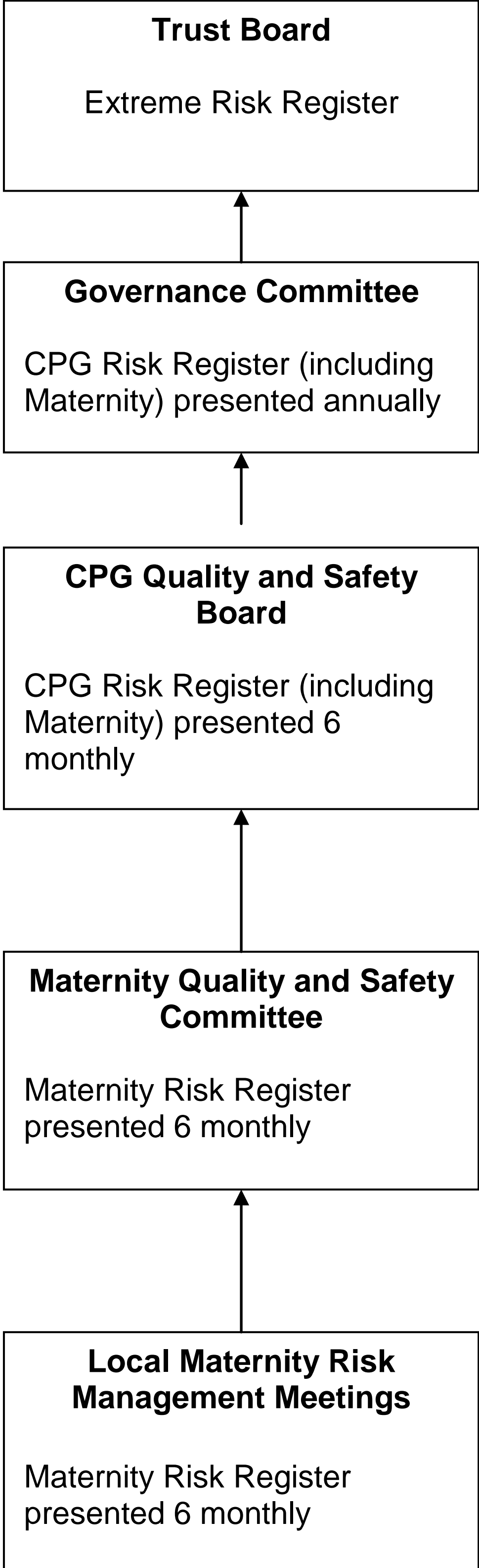


Appendix 2



Appendix 3

Risk Register Pathway



Appendix 4

Incident Trigger List

The following incidents are specific to the labour and delivery section on the unified Datixweb reporting system introduced across ICHNT in July 2009. This list is not exhaustive and where specific categories are not indicated on Datixweb, the most appropriate category for the incident should be recorded.

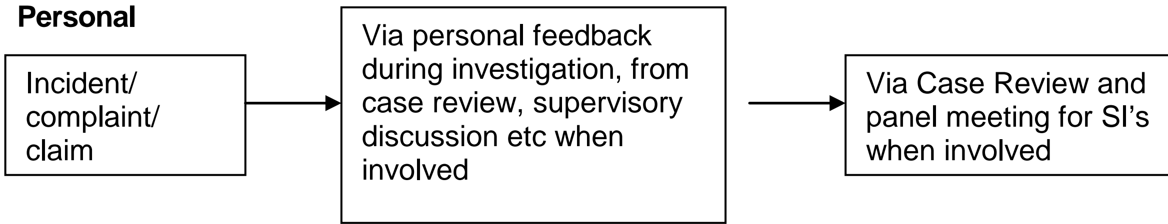
Anaesthetic problem connected with labour or delivery such as failed intubation
Misdiagnosis of antenatal screening tests
Born before arrival
Undiagnosed breech presentation in labour
Cord prolapse
Difficult delivery including: delivery using more than one instrument
Failed instrumental to caesarean section

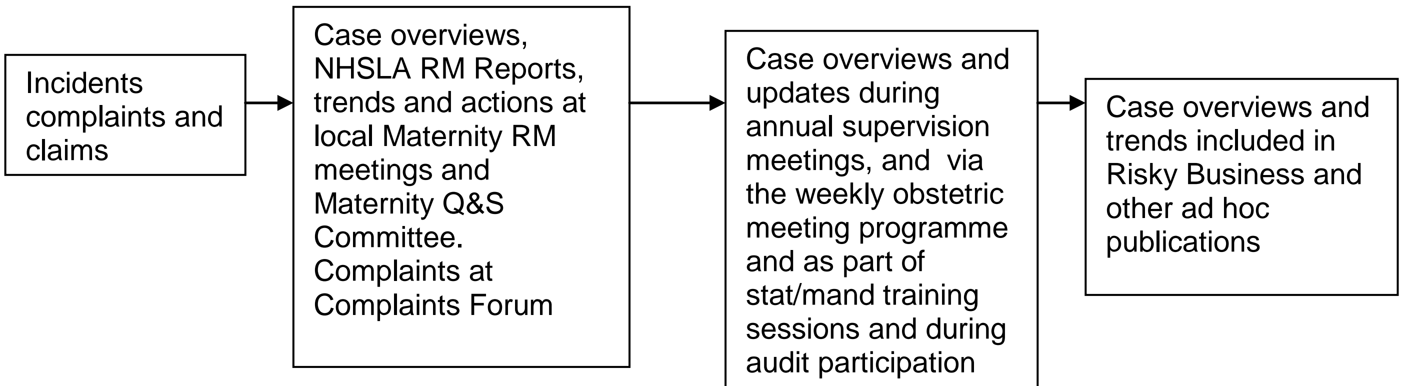
Eclampsia
Intrapartum haemorrhage
IUGR or placental insufficiency
Maternal resuscitation
Maternal death
IUD/Stillbirth > 24 weeks
Pathological CTG including all Grade 1 caesarean sections
Post-partum haemorrhage > 1,000ml
Ruptured uterus
Third or fourth degree tears
Trauma to bladder or other organs
Labour or delivery other
Shoulder dystocia
Apgars <6 at 5 mins
Cord PH < 7.10
Unexpected fetal abnormality detected at birth
Fetal laceration at time of incision
Unexpected term admission to Neo-Natal Unit
Unexpected birthweight < 2kg at term
Neonatal death
Unplanned maternal admission / transfer to specialist care unit including ITU
Unplanned hysterectomy
Unplanned return to theatre
Retained instrument or swabs

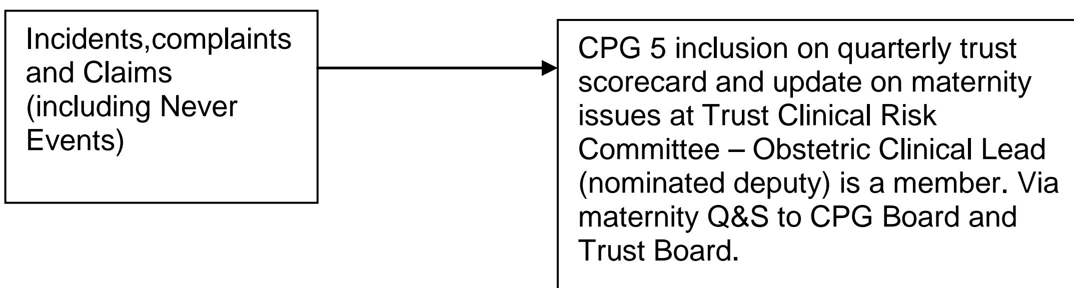
Other considerations not included under labour and delivery

- Closure of unit – lack of availability of beds
- Delay / difficulty in obtaining clinical assistance
- Drug Errors
- Extended stay / episode of care
- Inadequate staffing levels
- Readmission both maternal or neonatal

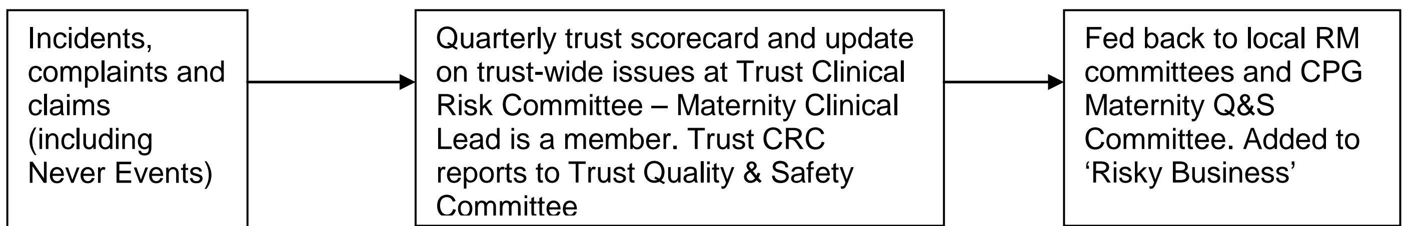
Appendix 5 - Learning Mechanisms







Organisational – from Trust to Maternity



Appendix 6 - Risk Matrix 5x5

1.Consequence

	1	2	3	4	5
Descriptor	Insignificant	Minor	Moderate	Major	Extreme
Achievement of Objectives / External Standards	No effect	External standards being met. Minor impact on achieving objectives	Adverse effect on delivery of secondary objective	Major adverse effect on delivery of key objective. Affects Quality Care Commission rating.	Does not meet key objectives. Prevents achievement of a significant amount of external standards
Patient Harm	No obvious harm	Non permanent harm. Increased length of stay 1-7 days	Semi-permanent harm. Increased length of stay 8-15 days.	Major permanent harm. Increased length of stay >15 days or death. Significant claim	Multiple deaths.
Injury (not patient)	Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	Lost time injury or RIDDOR /Agency reportable > 3 days absence	Fractures, amputation, extensive injury or long term incapacity/ RIDDOR reportable	Death or major permanent incapacity
Service / Business Interruption	Loss / interruption more than 1 hour	Loss / interruption more than 8 hours	Loss / interruption more than 1 day	Loss / interruption more than 1 week	Permanent loss of service or facility
Financial/ Litigation	local management tolerance level	Loss less than 0.25% of budgeted operating income	Loss less than 0.5% of budgeted operating income. Improvement notice	Loss less than 1% of budgeted operating income. Significant claim. Prosecution or Prohibition Notice	Loss more than 1% of budgeted operating income. Multiple claims.
Quality	Minor non-compliance with internal standards	Single failure to meet internal standards or follow protocol	Repeated failures to meet internal standards or follow protocols	Failure to meet national standards. Failure to comply with IR(ME)R	Gross failure to meet professional standards
Reputation	Rumours	Local media – Short term. Minor effect on staff morale	Local media – Long term. Significant effect on staff morale	National Media less than 3 days. Major loss of confidence in organisation.	National media more than 3 days. MP Concern (Questions in House). Severe loss of public confidence.

2. Likelihood

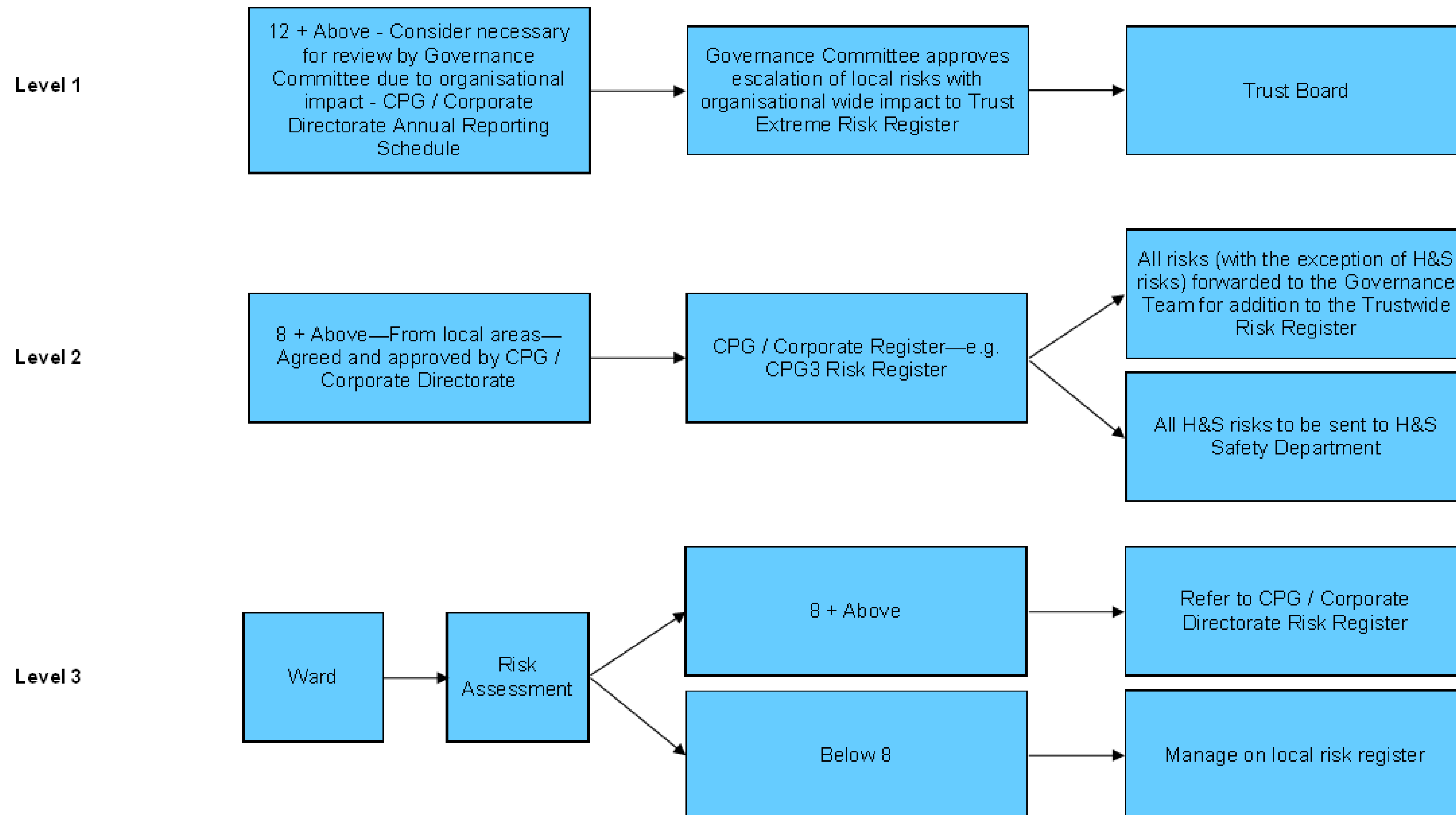
	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

3. Risk Matrix

	Consequences				
Likelihood	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
5 (almost certain)	5 (M)	10 (H)	15 (E)	20 (E)	25 (E)
4 (likely)	4 (M)	8 (H)	12 (H)	16 (E)	20 (E)
3 (possible)	3 (L)	6 (M)	9 (H)	12 (E)	15 (E)
2 (unlikely)	2 (L)	4 (L)	6 (M)	8 (H)	10 (E)
1 (rare)	1 (L)	2 (L)	3 (M)	4 (H)	5 (H)

Appendix 7

Risk Register Process - Management Responsibility for Different Levels of Risk



Appendix 8

Equality Impact Assessment

1 Equality Impact Screening

1.1 Title of Policy/Procedure/Function/Service Maternity Risk Management Strategy 2012-13	
1.2 Directorate/Department Women's and Children's CPG	
1.3 Name of Person Responsible for This Equality Impact Assessment Gaynor Pickavance – Maternity Governance Lead	
1.4 Date of Completion	17 / 09 / 2012
1.5 Aims and purpose of Policy/Procedure/Function/Service 1. To improve the quality of care to mothers, babies and their families by a process of early identification and analysis of potential and actual adverse events. 2. To promote an open and fair blame culture so that clinical incidents and service failures can be reported, investigated and discussed. 3. To disseminate information to staff about the lessons learned following the investigation of clinical incidents. 4. To outline the processes by which the maternity services can be proactive in the avoidance of risk as well as defining the reactive approaches to investigate adverse outcomes of clinical incidents. 5. To prevent, where possible, any recurrence of clinical incidents through the process of reflective practice and learning from experience. 6. To ensure that the principles of risk management are viewed as integral to the provision of high quality maternity care.	
1.6 Examination of Available Evidence – Tick evidence used:	
Census Data for UK	☐
Census Data for London	☐
Census Data for Local Authority Area	☐
Trust Workforce Data	☐
National Patients Survey	☐
Trust Patients Survey	☐
Trust Staff Survey	☐
Other Internal Research/Survey/Audit (list below)	☐

Other External Research/Survey/Audit (list below) ☒ This is a NHS Litigation Authority requirement to comply with mandatory risk management processes in Maternity Services
1.7 What is the summary of the available evidence? There is no known evidence to suggest that there is likely to be any significant impact on any one or any group. Datix web does not currently record ethnicity for incident reporting. This is being addressed.
1.8 Does the evidence indicate that there is (or is likely to be) any significant impact on anyone or any group in relation to the following Equality Strands? Select from drop-down list.

	Yes/No/ Not Enough Data	Impact is Justified
Ethnicity/Race	Not Enough Data	Not Applicable
Disability	Not Enough Data	Not Applicable
Gender/Sex	Not Enough Data	Not Applicable
Religion/Belief	Not Enough Data	Not Applicable
Sexual Orientation	Not Enough Data	Not Applicable
Age	Not Enough Data	Not Applicable
Human Rights	Not Enough Data	Not Applicable
Deprivation	Not Enough Data	Not Applicable

1.9 If further evidence is required to complete this report, take steps to obtain it before proceeding with the assessment. If the review of evidence indicates that there is a significant unjustified impact, a Full Equality Impact Assessment must be carried out.
1.10 No further action required. ☒
1.11 Full Equality Impact Assessment required. Go to section 2 below. ☐

Imperial College Healthcare NHS Trust

Service Quality and Patient Safety

Annual Report

Executive Summary

2011/12

1. Introduction

The Service Quality and Patient Safety Annual Report for 2011/12 demonstrates the Trust's achievements in reducing harm and improving care and quality of services. It is a comprehensive document that outlines a commitment to providing safer, evidence based healthcare delivered by well-trained staff working within a culture that supports continuous learning and where possible links research to practice.

The report analyses the Trust's performance in relation to reported incidents, Serious Incidents (SIs), complaints and claims. It benchmarks Trust and peer performance where possible and evidences improvement actions. Regulatory compliance remains an area of strength however, to prevent complacency, actions which support continuous monitoring are discussed.

This executive summary is designed to be a summary of key messages, examples of actions and priorities for the upcoming year.

2. Regulatory Compliance

The Trust is registered 'without conditions' with the Care Quality Commission (CQC) for its 5 main physical sites (SMH, HH, CXH, WEH, and QCCH) and for its 7 renal dialysis satellite units.

To continuously review compliance with CQC regulations a process of leadership walkrounds was introduced. This involves a multi – professional team site assessment including a review of the environment and interviews with staff and patients to better understand their experiences of care and working lives. Action plans are developed and implemented by the local teams after the reviews and numerous improvements have been made. Examples of improvements arising from this process include:

- Improvements to cannula care and documentation
- Improvements to the display of waiting times information in the Outpatients Department
- Use of MRSA screening stickers in notes
- Up to date Healthcare Associated Infection information to be displayed on all wards
- Out of date patient information leaflets in clinical areas have been removed and replaced with up to date leaflets

During 2011/12 the following inspections were carried out by the CQC at the Trust:

Table 1. Review of CQC Inspections 2011/12

Type of Inspection	Site	Outcomes Reviewed	Key Findings	Actions
Reactive	QCCH	**Outcome 4** – Care and welfare of people who use services **Outcome 13** – Staffing **Outcome 14** – Supporting staff	Outcome 4 – compliant Outcome 13 – compliant with actions Outcome 14 – compliant	Action plan produced including the requirement to review nursing establishment, improve staff communication skills
Reactive	CXH	**Outcome 6** – Co-operating with other providers **Outcome 8** – cleanliness and infection control	Outcome 6 – compliant Outcome 8 – compliant	No actions required.
National review	HH SMH	Review of compliance against the Abortion Act	No formal report received, but initial feedback	No actions required.

Type of Inspection	Site	Outcomes Reviewed	Key Findings	Actions
			was that the Trust was compliant	

The Trust is currently at level three for NHSLA. The next inspection is due on 30th and 31st August 2012.

3. Quality and Safety

3.1 Incident Reporting

An important measure of an organisation's safety culture is its willingness to report adverse events, learn from them and deliver improved care. Incidents are graded according to their impact on the individual or service affected. Our aim is to increase the number of reported incidents to the national average whilst remaining below the national average of incidents causing major or extreme harm.

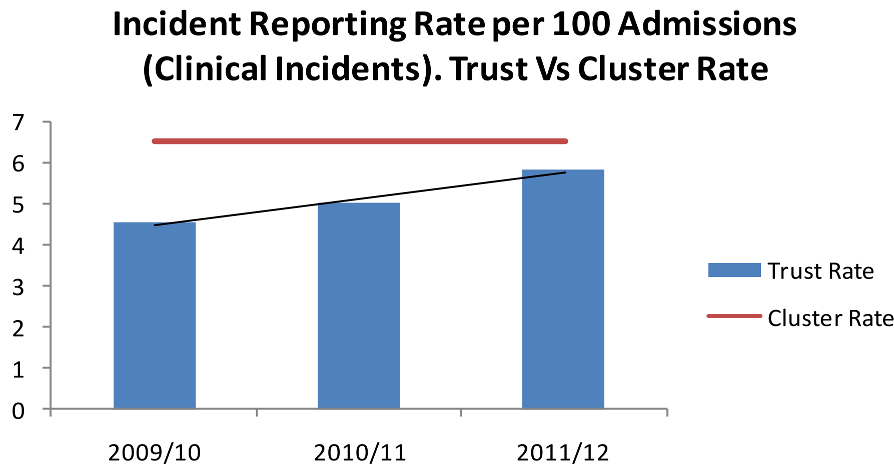
The Trust is required to report all clinical incidents to the NPSA and where these incidents meet certain criteria of reporting or severity, to Commissioners, NHS London, CQC and other external bodies. Unless otherwise stated the data source for this report is Datix (Refreshed data for 2011/12) and includes all reported incidents. The incident data was extracted from Datix on 03/04/12 and the SI data was extracted on the 24/04/12.

3.2 Incident Reporting Rate (Clinical Incidents)

The Trust clinical incident reporting rate for 2011/12 is 5.83 per 100 admissions. The average incident reporting rate across our peers - Acute Teaching Trusts is 6.5 per 100 admissions.

In 2010/11 the clinical reporting rate was 5. There was an increase in reporting rates throughout 2011/12 and the reporting rate for Q4 was 6.5.

Graph 1. Incident Reporting Rate per 100 admissions (Clinical Incidents). Trust Vs Cluster Rate 2009/10-2011/12



The number of reported incidents has increased steadily from 2009/10 through to 2011/12. The numbers reported in 2011/12 increased from 2010/11 by 15%.

Actions to sustain the improved reporting rate include a number of local initiatives in all CPGs such as ward level teaching, feedback of incident trends and 'Reporting Counts Walkrounds' targeting wards where reporting is low.

3.3 Reported Incidents (Clinical) by Degree of Harm

Table 2. Clinical Incidents - Comparative Data. Trust Vs Acute Teaching Trusts 2009/10 to 2011/12 by Degree of Harm

Degree of harm	2009/10 Trust	2009/10 Cluster	2010/11 Trust	2010/11 Cluster	2011/12 Trust	2011/12 Cluster
No Harm	75%	70%	60.4%	73.5%	62.5%	71.6%
Minor (Low)	17%	24%	28.4%	20.1%	27.9%	22%
Moderate	7%	6%	10.6%	5.6%	9.3%	5.8%
Major (Severe)	0.8%	0.7%	0.3%	0.6%	0.2%	0.5%
Extreme	0.3%	0.2%	0.1%	0.2%	0.1%	0.1%

When compared to its peers the Trust reported a lower percentage of 'no harm' incidents in 2011/12 (Trust, 62.5%, all Acute Teaching Organisations, 71.6%). The Trust reported higher percentages of both 'minor' and 'moderate' incidents. Importantly, the Trust reported a lower percentage of 'major' and an equal percentage of 'extreme' incidents.

Year on year from 2010/11 to 2011/12 Trust figures show an increase in the percentage of 'no harm' incidents, a decrease in the percentage of 'minor' 'moderate' and major incidents. The percentage of 'extreme' incidents has remained the same over the last two years.

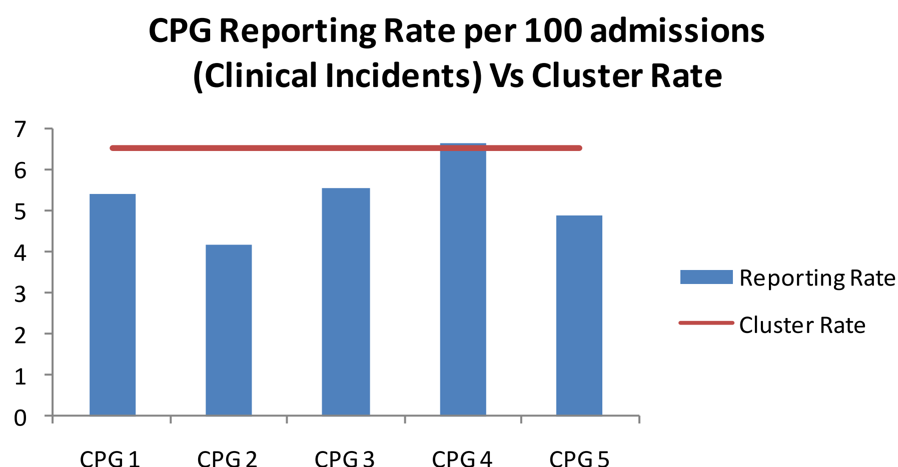
When considered across the three year period major incidents decreased by 55% and extreme incidents decreased by 21%.

3.4 Clinical Incidents by CPG/Site

Clinical incidents have been broken down by site and CPG to understand any variance across the organisation.

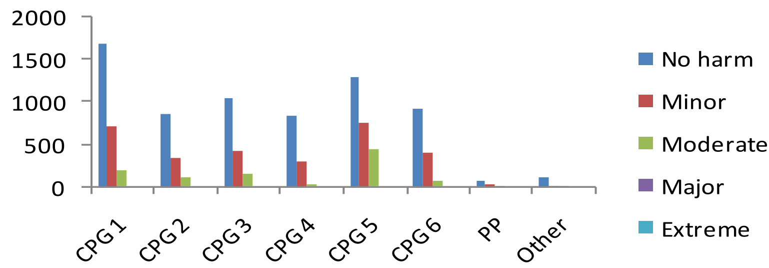
CPG 1 reported the highest number of incidents, followed by CPG 5, as seen in 2010/11. However, it is worth noting that when activity data is considered CPG 4 reported the highest number of incidents per 100 admissions, followed by CPG 3.

Graph 2. CPG Reporting Rate per 100 Admissions (Clinical Incidents) 2011/12 Vs Cluster Rate



CPG 4 was the only CPG to meet the cluster rate.

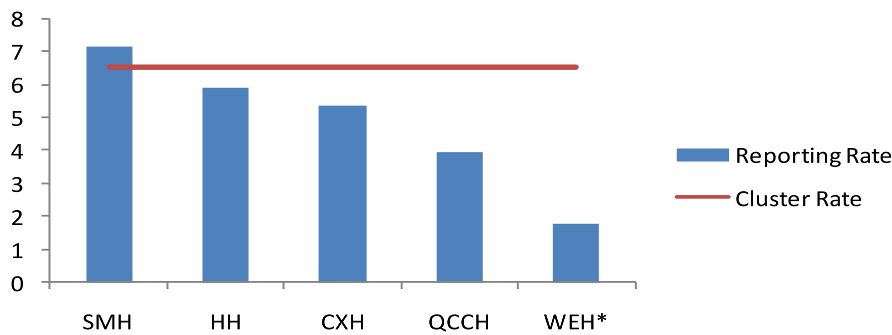
Graph 3. Number of Reported Clinical Incidents 2011/12 by CPG and Degree of Harm



All CPGs reported more 'no harm' incidents compared to any other grade. CPG 1 had the highest number of major incidents. CPG 5 had the highest number of extreme incidents.

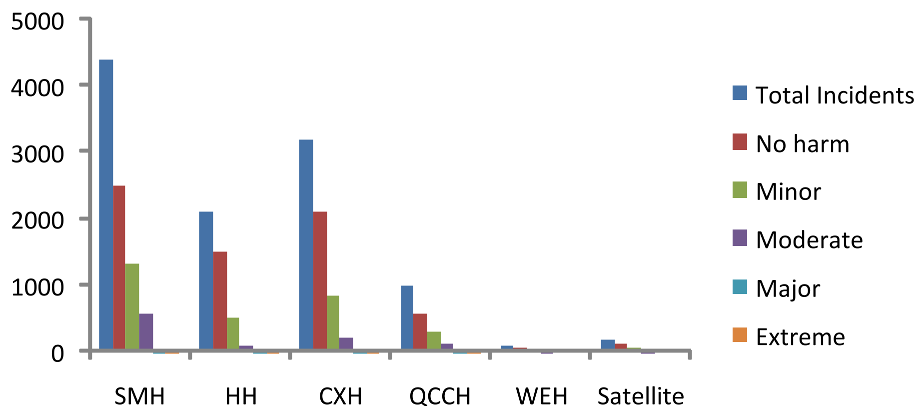
SMH reported the highest number of incidents, followed by CXH. When activity data is considered SMH also had the highest number of incidents per 100 admissions.

Graph 4. Site Reporting Rate per 100 Admissions (Clinical Incidents) 2011/12 Vs Cluster Rate



SMH was the only site to meet the cluster rate.

Graph 5. Number of Reported Clinical Incidents 2011/12 by Site and Degree of Harm



All sites reported more ‘no harm’ incidents compared to any other grade. SMH had the highest number of major and extreme incidents.

3.5 Themes of Reported Incidents (Clinical and Non-Clinical) 2009/10 to 2011/12

The top three reported incident (clinical and non-clinical) categories by volume are: accident that may result in personal injury, medication and clinical assessment (investigations, images and lab tests).

The top three themes of incidents across our peers are accident that may result in personal injury, treatment/procedure, and medication.

Table 3. Top Three Themes 2009/10 – 2011/12

Top 3 Incidents by Category	**09/10 Total**	09/10 incidents by 100 admissions	09/10 incidents by 1000 OBD	**10/11 Total**	10/11 incidents by 100 admissions	10/11 incidents by 1000 OBD	**11/12 Total**	11/12 incidents by 100 admissions	11/12 incidents by 1000 OBD
Accident that may result in personal injury	23.1% (2019)	1.12	4.34	21.0% (1933)	1.06	3.63	17.9% (1,964)	1.04	4.14
Medication	14.7% (1285)	0.71	2.76	14.1% (1298)	0.71	2.43	14% (1,541)	0.81	3.25
Clinical assessment (investigations, images and lab tests)	6.1% (532)	0.29	1.14	6.7% (623)	0.34	1.17	12.5% (1,377)	0.73	2.90
Total of all clinical incidents	8,759	4.86	18.83	9,221	5.08	17.31	10,989	5.83	23.18

There has been a small amount of variance in the top three themes from 2010/11 to 2011/12. In 2010/11 “infrastructure or resources (staffing, facilities, environment)” was the third most frequently reported category of incidents. This is no longer in the top themes for 2011/12 and has been replaced by “clinical assessment (investigations, images and lab tests)” which comprised 13% of all reported incidents. Incidents in this category have more than doubled across the two years. This is attributed to the increased reporting by pharmacists each time they discover a medication chart where the VTE assessment part of the chart is blank. If VTE incidents (39% of incidents in this category) were not included in the reporting figures then “access, appointment, transfer and discharge category” would become the third highest reported incident.

Further analysis of each of the top three themes is provided below. For detailed aggregated analysis of top themes at individual CPG and site level see Trust risk profile.

3.5.1 Accident that May Result in Personal Injury

Incidents in this theme represent 18% of the total reported incidents for 2011/12. This theme made up 23% of incidents reported across the cluster.

The total of incidents in this category has increased from 2010/11 to 2011/12 by 2%. This is supported by the fact that incidents per 1000 occupied bed days have increased across the two years.

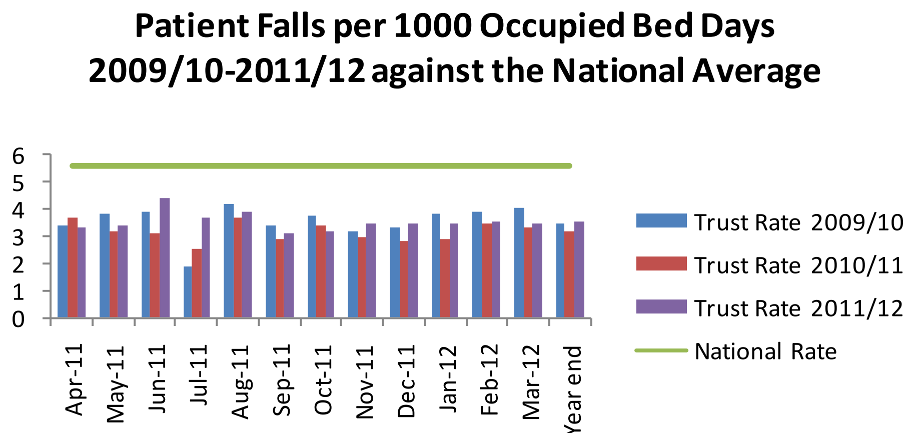
Incidents under the sub-categories 'needle stick injury or some other injury connected with sharps' and 'exposure to electricity, hazardous substance, infection etc' increased from 2010/11 to 2011/12. Incidents under the sub-category 'injury caused by physical or mental strain' reduced across the two years.

Slips, trips, falls and collisions have decreased by 1% across the two years. This decrease remains when considering activity data. Further analysis on this specific sub-category can be seen below. Slips, trips, falls and collisions will be referred to as patient falls from here onwards.

3.5.1.1 Patient Falls

NPSA data (2011) demonstrates that nationally the highest category of all reported incidents is patient falls.

Graph 6. Patient Falls per 1000 Occupied Bed Days 2011/12 against the National Average



Graph 6 demonstrates the Trust had a lower number of falls per 1000 occupied bed days than the national average (of 5.6) for each month in 2011/12 with no exceptions. The data ranged from 3.1 to 4.4 and averaged at 3.5. This is a small increase on the average of 3.2 in 2010/11.

In 2011/12 there were 1674 patient falls, representing 13% of all reported incidents. This compares with 15% in 2010/11 and 2009/10.

CPG1 reported the highest number of falls. This pattern remains when considering falls per 1000 occupied bed days. This may be linked to a predominantly older patient population often with complex medical and mobility needs and fits with the national profile.

In 2011/12 the total number of patient falls that resulted in injury was 616 (37%) across the Trust. CPG 1 had the highest number replicating the trend in the total number of falls reported. Year on year this compares to 531 (31%) falls that resulted in injury in 2010/11 and 405 (25%) falls that resulted in injury across the Trust in 2009/10. In four out of six CPGs there was an increase in the number of patient falls with injury from 2010/11 to 2011/12. CPG 4 and CPG 5 reduced their numbers of falls with injury from 2010/11 to 2011/12.

34% of reported patient falls in 2011/12 were classified as being from a height, bed or chair. This is a reduction on the 2010/11 figure of 37% and the 2009/10 figure of 40%. The majority (63%) of falls from height resulted in no harm. 2 patient falls were classified as major and 1 was classified as extreme.

Improvement Actions 2012/13

- Falls are included as a national reporting requirement for Quality Accounts 2012/13. It is one of the four priorities within a new national initiative called the

'safety thermometer' which has been introduced to reduce harm to patients from pressure ulcers, falls, venous thromboembolism (VTE) and catheter related urinary tract infections (March 2013)

- We have identified a medical champion for minimising falls and we will review the membership and work of the falls management group to further develop our multi –professional approach to minimising falls (March 2013)
- We will continue to collect information on all in -patient falls and review this with local clinical teams and at our quality and safety meetings (March 2013)
- Rollout of post-falls review policy with education program (March 2013)
- Review and relaunch the Falls committee (March 2013)

3.5.2 Medication Errors

Incidents in this theme represent 14% of the total reported incidents for 2011/12. This theme made up 13% of incidents reported across the cluster.

The total of incidents in this category has increased from 2010/11 to 2011/12 by 19%. This is supported by the fact that incidents per 100 admissions and incidents per 1000 occupied bed days have increased across the two years.

An increase was noted in all of the sub-categories except for 'other medication error'. This may be a reflection of improved classification of incidents and improved data quality.

Improvement Actions 2012/13

- Work is ongoing to ensure that the risk grading of medication errors reported on the Datix system is based on actual harm, not potential harm (March 2013)
- To reduce the risk of patients being prescribed a drug to which they are allergic (March 2013)
- To reduce omitted and delayed doses in line with the NPSA alert in this area (March 2013)
- To reduce the incorrect supply of medication on discharge (March 2013).

3.5.3 Clinical Assessment (Investigations, Images and Lab Tests)

Incidents in this theme represent 13% of the total reported incidents for 2011/12. This theme made up 6% of incidents reported across the cluster.

The total of incidents in this category has increased from 2010/11 to 2011/12 by 121%. This is supported by the fact that incidents per 100 admissions and incidents per 1000 occupied bed days have increased across the two years.

Improvement Actions 2012/13

- Staff training in how to carry out risk assessments (ongoing)
- Audit of VTE assessment and treatment (August 2012)
- Review and feedback to clinical areas regarding non completion of VTE assessments and develop local action plans for non compliance (Ongoing)

3.6 Other Incident Types

3.6.1 Inadequate Staffing Incidents

From December 2011, the Trust included incident numbers in relation to reported inadequate staffing issues on its scorecard data. This was a response to the findings of the 2010/11 annual report that 'infrastructure of resources (staffing, facilities, environment) had entered the top three themes for the first time.

There have been 333 reported incidents of inadequate staffing since April 2011. This represents 3% of the total reported incidents for 2011/12.

All CPGs, except for PP and Other, reported more incidents in Q4 compared to Q1. This may be due to the effects of awareness raising. CPG 1 reported the most incidents in relation to staffing, 70 (22%), followed by CPG 2, 70 (21%). This is in line with CPG 1 reporting the highest number of total incidents.
All sites, except for the satellite units, reported more incidents in Q4 compared to Q1. Again, this may be due to the effects of awareness raising. SMH has reported the most

incidents of this type, 128 (38%), followed by CXH, 116 (35%). This is in line with SMH reporting the highest number of total incidents and CXH reporting the second highest.

Improvement Actions 2012/13

- Review incident data in relation to establishments and skill mix to fully understand the issues identified (ongoing)
- CPGs to work with the clinical areas to ensure that reporting is accurate and issues are escalated appropriately at the time they occur (ongoing)

3.6.2 Inadequate Response to Change in Patient Status

53 incidents (49 resulting in harm) were reported involving an inadequate response to the change in a patient's status. This represents an increase on the number from 2010/11 when there were 25 reported incidents and 2009/10 when there were 33 cases.

Table 4. Inadequate Response to Change in Patient Status Incidents by CPG 2010/11-2011/12

CPG	Total number of incidents 2010/11	Total number of incidents 2011/12
1	9	14
2	2	14
3	5	10
4	3	8
5	4	5
6	1	2
Other	1	0
Total	25	53

CPG 1 and CPG 2 had the highest number of incidents related to an inadequate response to the change in a patient's status. CPG 1 also had the highest number of incidents in 2010/11.

Table 5. Inadequate Response to Change in Patient Status Incidents by Site 2010/11-2011/12

Site	Total number of incidents 2010/11	Total number of incidents 2011/12
SMH	10	17
CXH	8	22
HH	6	12
QCCH	1	2
Total	25	53

CXH had the highest number of incidents relating to the inadequate response to the change in a patient's status. SMH had the highest number of incidents relating to the inadequate response to the change in a patient's status in 2010/11.

Please see full version of report for detailed analysis of a recent audit.

Improvement Actions 2012/13

- Implementation of actions identified in the failure to rescue pilots across all areas of the Trust (August 2012)

3.6.3 Patient Wrongly Identified

35 incidents (11 resulting in harm) were reported relating to patients being wrongly identified. This compares to 22 incidents relating to patients being wrongly identified in both 2010/11 and 2009/10. This represents an increase of 59%.

Table 6. Patient ID Incidents by CPG 2010/11-2011/12

CPG	Total number of incidents 2010/11	Total number of incidents 2011/12
1	9	14
2	2	4
3	3	4
4	0	3
5	2	5
6	6	4
Other	0	1
Total	22	35

CPG 1 had the highest number of patient identification incidents. This may reflect the fact that this CPG had the highest number of occupied bed days. The same results were seen in 2010/11.

Table 7. Patient ID Incidents by Site 2010/11-2011/12

Site	Total number of incidents 2010/11	Total number of incidents 2011/12
SMH	9	16
CXH	10	12
HH	2	7
QCCH	0	0
WEH	1	0
Total	22	35

SMH had the highest number of patient identification incidents. This may reflect the activity data which shows SMH to have had the highest number of admissions and reported the greatest number of incidents. The same pattern was seen in 2010/11.

Improvement Actions 2012/13

- All incidents related to patients wrongly identified will continue to be reviewed monthly at the Clinical Risk Committee to identify any themes and Trust wide learning and develop a Trustwide improvement action plan. (Ongoing)
- Trustwide actions to be identified and implemented through the CPG leads. (Ongoing)

3.6.4 Near Misses

There were 1133 reported near misses (10% of all reported incidents) in 2011/12. This represents a 4% increase from 2010/11. CPG 3 reported the greatest number of near misses in both 2010/11 and 2011/12. The top three themes for near misses 2011/12 were “medication”, “accident that may result in personal injury” and “patient Information (records, documents, test results and scans)”. This is a slight change in the top three themes for near misses in 2010/11 which were “medication”, “treatment, procedure” and “accident that may result in personal injury”.

Improvement Actions 2012/13

- To promote incident reporting through the content of the newly implemented quality and safety newsletter (Ongoing)
- To introduce an e-learning module (June 2012)

4. Serious Incidents (SIs)

The principal definition of a SI, previously known as a Serious Untoward Incident (SUI) is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service. SIs are not exclusively related to clinical issues (NHS London SI Policy 2010). The Trust has well established proactive mechanisms and retrospective reviews to identify SIs including encouraging self–reporting by staff of incidents for consideration, review of all inquest cases, daily review of all reported incidents and review of complaints rated as severe.

4.1 SI Trends

There were 60 SIs in 2009/10, 84 in 2010/11 and 94 in 2011/12. There were 12% more SIs in 2011/12 compared to 2010/11.

In 2010/11 NHS London introduced new SI requirements for pressure ulcers (PUs). All PUs graded as 3 or 4 are now reported as SIs. This recent category has resulted in an increase of 13 SIs this year. If this new category was removed the total number of SIs for 2011/12 would be 81.

The top three SI categories showing an increase are PUs, Maternity Services and Surgical Errors. The increase in surgical errors relates to the retained swab incidents which occurred during 2011/12 and significant improvement actions have been implemented. The increase in PUs is thought to relate to improvement in the processes for identification and reporting within the Trust

The top three SI categories showing a decrease are Clostridium Difficile outbreak, Clostridium Difficile death on certificate and communicable disease.

4.2 SIs by CPG

Table 8. SIs per CPG 2009/10 - 2011/12

	2009/10	2010/11	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Total 2011/12
CPG 1	13	22	4	0	8	8	20
CPG 2	2	4	1	2	0	1	4
CPG 3	8	9	3	3	3	3	12
CPG 4	6	8	1	0	4	6	11
CPG 5	31	40	15	9	10	14	48
CPG 6	2	5	0	0	0	0	0
Other*	1	2	2	0	0	1	3

*includes PP

CPG 3, CPG 4, CPG 5 and Other had increased numbers of SIs from 2010/11 to 2011/12. CPG 2 had the same number of SIs in 2011/12 as in 2010/11. CPG 1 and CPG 6, however, had reduced numbers of SIs from 2010/11 to 2011/12.

4.3 SIs by Site

SMH, QCCH and WEH had more SIs in 2011/12 than 2010/11. CXH and HH had fewer Sis in 2011/12 than 2010/11.

See appendix 1 of the full report for further details on site breakdown for SIs

Table 9. Top SI Themes by Site 2009/10 - 2011/12

Site	Top themes 2009/10	Top themes 2010/11	Top themes 2011/12	Re-occurring themes
SMH	• Maternity Service • Clostridium Difficile Death on Certificate	• Maternity Service • PU Grades 3 and 4 • Serious Incident	• Maternity Service • PU Grades 3 and 4	• Maternity Service • PU Grades 3 and 4
CXH	• Clostridium Difficile Outbreak	• Clostridium Difficile Outbreak • PU Grades 3 and 4 • Clostridium	• PU Grades 3 and 4 • Unexpected death	• Clostridium Difficile Outbreak • PU Grades 3 and 4

		Difficile Death on Certificate		
HH	• Unexpected Death	• Clostridium Difficile Outbreak • Communicable Disease • Unexpected Death	• PU Grades 3 and 4 • Unexpected death	• Unexpected death
QCCH	• Maternity Service	• Maternity Service	• Maternity Service	• Maternity Service

The most consistent theme across all sites for 2011/12 was PU Grades 3 and 4. The most consistent themes across all sites for 2010/11 were maternity service and clostridium difficile outbreak. The most consistent theme across all sites for 2009/10 was maternity service.

4.4 Actions Following Serious Incident Investigations

94 SI cases have been reported in 2011/12, and currently 82 of these have been fully investigated. The remaining 12 are under investigation and are expected to be completed within the NHS London deadline. The response rate for completed investigation to NHS London deadline (n = 82) is 93%. The total number of outstanding actions at year end was 5 out of 325 which represents 2%

Appendix 2 of the full report shows progress on each individual action arising from SI investigations 2011/12.

4.5 “Never Events”

Never Events are serious, largely preventable patient safety incidents that should not occur. They are reportable events to the Commissioners and to NHS London. They include: retained swabs, wrong site surgery, wrong procedure and mis-placed naso – gastric tube. The date of reporting the incident is based on when the Never Event was identified and in the case of retained swabs may be some months after the initial procedure.

There have been 6 Never Event incidents in 2011/12. 4 out of the 6 Never Event incidents have been fully investigated, 2 are still under investigation, to deadline.

Table 10. Never Events 2009/10 - 2011/12

Event	2009/10	2010/11	Q1	Q2	Q3	Q4	2011/12
Wrong Site Surgery	3	1	1				1
Retained Surgical Swab	2	1	1			2	3
Mis-placed Naso-gastric tube		1					
Retained Vaginal Swab				2			2
Total	5	3	2	2		2	6

Actions 2012/13

- To initiate a high profile ‘Safer Hospital’ campaign to review theatre systems and processes, multidisciplinary team working, to re-launch the WHO checklist (in particular the section related to swab counting), to review the robustness of accountability within the swab count policy, to oversee a programme of regular audits related to compliance with swab count policy and to monitor related training. (March 2013)
- To ensure close working of the Safer Hospital Board with the existing theatre utilisation group in particular around theatre efficiency rates.
- Increased collaboration between theatre staff – medical and nursing in promoting working together to improve safety. (Ongoing)

- Continuation of research study. Medical staff interviews to be conducted and analysed. (March 2013)

Please see Appendix 3 of the full report for a list of all actions following Never Event investigations.

5. NICE Compliance

Compliance monitoring of implementation of all categories of National Institute for Health and Clinical Excellence (NICE) guidance is well established in the Trust. In line with Trust Policy, quarterly reports are produced summarising compliance rates by CPG. These reports are monitored by Clinical Standards Committee and also circulated to CPG Directors, Heads of Nursing and Heads of Operations. The current Trust position for NICE implementation is as follows:

- Number of 'live' NICE guidance- 750
- Not applicable to ICHT - 235 (31%), with 515 guidelines applicable to ICHT. Of these:
- Compliant - 417 (81%)
- Partially Compliant - 33 (6%)
- In progress - 15 (3%)
- Blanks - 50 (10%), awaiting confirmation of lead and/or compliance.

This represents an improvement in declared compliance from 76% at year end 2010/11. An exercise to examine partial compliance with guidance to determine gaps and prioritise implementation is currently being undertaken.

6. Central Alerting System (CAS) compliance

100% of alerts were closed to deadline. This represents a significant improvement on the Trust's position at year end 2010/11 (when there were 34 overdue alerts), following concerted efforts to risk-assess, implement and close remaining actions on all categories of alert.

7. NCEPOD

The Trust participated in all NCEPOD enquiries it was eligible for. These were Bariatric Surgery, Cardiac Arrest, Surgery in Children and Peri-operative Care. The Trust is currently participating in NCEPOD studies on Alcohol-related Liver Disease and Sub-arachnoid Haemorrhage. The Trust monitors implementation of the recommendations from NCEPOD reports using NCEPOD's recommendations template tools. Implementation is complete for Surgery in Children and Parental Nutrition recommendations and work is being undertaken on the following reports:

- Death in Acute Hospitals
- Emergency and Elective Surgery in the Elderly
- Pre-operative Care
- Cardiac Arrest

8. Service Quality

A formal complaint is a written expression of dissatisfaction with the care, services or facilities provided by the Trust that requires a response. The number of formal complaints increased 9% this year.

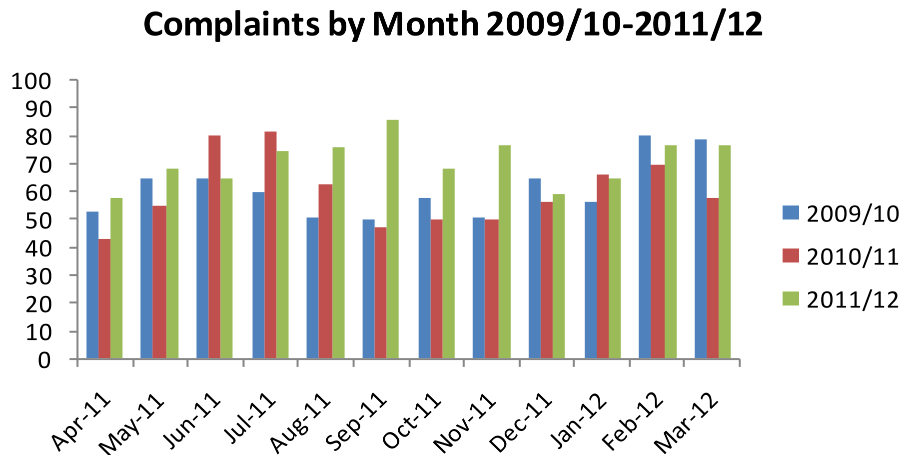
The increase in part reflects the on going focus to encourage service users to report their concerns directly to the Trust. This helped to reduce the number of enquires dealt with by the Parliamentary and Health Service Ombudsman (PHSO), which over the year fell by 55%. PHSO enquiries reduced from 101 enquires in 2010/11 to 45 in 2011/12.

The complaints process was further improved with the introduction of a monthly joint report which reviewed themes from the complaints team and PALS. A number of themes were identified which directly led to service improvements.

8.1 Formal Complaints

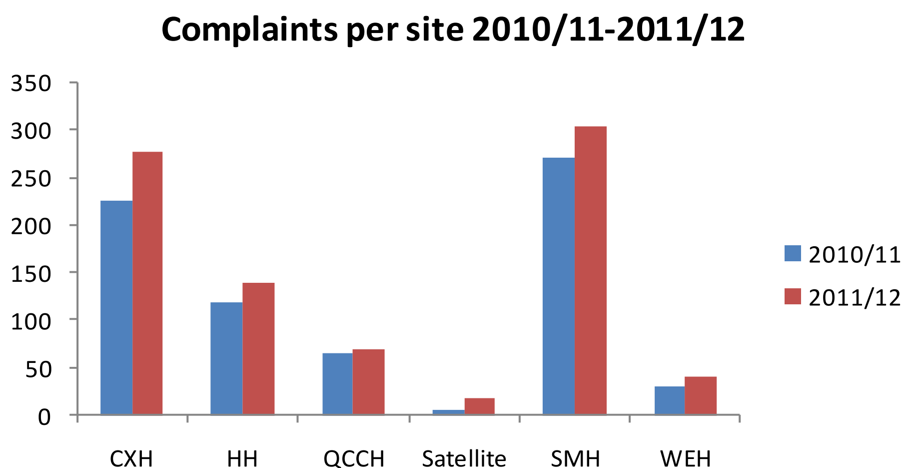
A total of 987 formal complaints were received. 851 were investigated formally and 136 were resolved by PALS with the agreement of the complainant within 5 working days. The average number of formal complaints received per month was 82, up from 75 last year. Graph 7 shows the number of formal complaints received each month for 2009/10-2011/12.

Graph 7. Complaints by Month 2009/10-2011/12



All CPGs received more complaints this year with one exception. CPG6 complaints fell by 13% (39 to 34). CPG5 complaints rose by 24% (111 to 138) reflecting an increase in complaints concerning gynaecology (16 to 23) and obstetrics and maternity (71 to 79). CPG3 complaints rose by 19% (175 to 209) with complaints relating to ophthalmology increasing by 27% (29 to 37). A clear improvement plan has now been agreed by the WEH clinicians to resolve a number of issues and help reduce complaints. Complaints regarding orthopaedic surgery fell 36% (68 to 50) following the transfer of the operating list to a new facility based at SMH. Transport has seen a significant increase in complaints (15 to 36) following a change in service provider.

Graph 8. Total number of complaints received per site *2010/11-2011/12



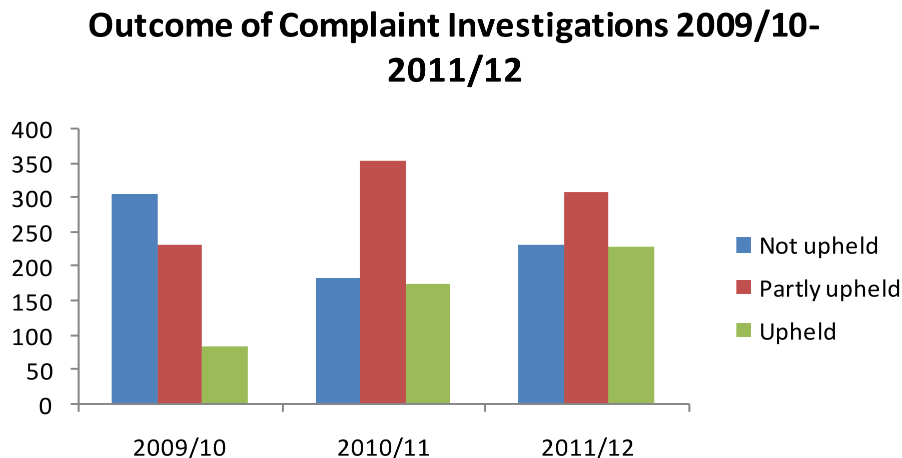
*2010/11 was the first year that the Trust was able to split its data by site. It is for this reason that 2009/10 data is not included on this graph

All sites received more complaints in 2011/2012 compared to 2010/2011. The greatest increases were seen in CXH and SMH.

The Trust took an average of 34 working days to respond to each formal complaint. The target of 25 days was met in every month ranging from 25 to 37. 93% of all formal complaint responses were completed within timeframe. This compares to 92% in 2010/11 and 89% in 2009/10. The target of 90% was met in every month except for July when the response rate was 88%. In 2011/12 CPGs 1, 4, 5 and 6 met the target. CPGs 2, 3 and other did not meet the target.

8.2 Outcome of Complaint Investigation

Graph 9. Outcome of Complaint Investigations 2009/10-2011/12



851 formal investigations were completed during the year of which 30 have returned with further concerns at the time of this report and were being reinvestigated. 29% of complaints were not upheld.

8.3 Severity of Complaints

Following a complaint investigation the Trust reviews the risk grade initially assigned to the complaint when it was triaged. The information below indicates the risk grade following each complaint investigation, which is a function of harm and frequency.

Last year for the first time each CPG was asked to confirm that the risk grade allocated when initially triaged was still correct following their formal investigation/ clinical review. This led to a large number of risk grades being reassessed from medium to low. Low risk grade complaints have increased 53% (524 to 802) whilst moderate complaints fell 78% (185 to 40) as a result of this data accuracy check.

A high risk complaint is categorised as the consequence of the care provided increasing a patient's stay by more than 15 days, causing permanent harm or resulting in death. In 2011/12 the Trust received 9 high risk grade complaints, 8 of which were investigated as serious incidents. Table 11 analyses the themes from high risk grade complaints.

Table 11. Analyses of high risk grade complaints

Delayed diagnosis	33% (3)
Infection control	11% (1)
Medication	11% (1)
Surgical error	11% (1)
Unexpected death	22% (2)
Unexpected neonatal admission	11% (1)

8.4 Themes from Complaints

There has been a slight variation in the top 3 themes for complaints from 2010/11 to 2011/12. The top three themes were Clinical Treatment (394, 46%),

Communication/Information to Patients (101, 12%) and Outpatient Appointments/Delays (99, 12%).

The top three themes changed because of a reduction in complaints about the attitude of staff, which fell by 28%. These had been targeted through the Quality Accounts and the complaints forum where CPGs reported what steps they had taken to help reduce complaints about poor staff attitude. Staff who had complaints made against them about their attitude were provided with extra support from the iCare programme.

Complaints about outpatients appointments/delays also fell both in volume and as a percentage of the total received.

For detailed aggregated analysis of top themes at individual CPG and site level see Trust risk profile.

Example Improvements to our Services linked to Clinical Treatment:

- A check list has been created to ensure information has been given to endoscopy patients prior to their procedure
- A review of consent for patients requiring procedures undertaken by the Dermaroller has started
- The A&E and Ear, Nose and Throat (ENT) team have reviewed their referral protocol
- A teaching session stressing the difficulty in diagnosing certain conditions in patients with diabetes has been designed following a formal complaint investigation to ensure lessons can be shared
- Pharmacy staff will now check all stocks of medicines on a monthly basis to ensure they have not passed their expiry date

Example Improvements to our Services linked to Communication/Information:

- Staff have been reminded to record when they have requested relatives to bring in extra clothing for patients and to complete the Trust's property disclaimer form in case property is misplaced or lost.
- The IT department has been asked to explore the possibility of producing discharge information in large print format
- New patient documentation will provide detailed information on the contacting of relatives and 'next of kin'
- The secretaries from the Hepatobilary Surgery Department now have a rota system to answer phone calls and to check and respond to messages left on the answer telephone
- Where there is no response to a bleep urology nurses have been reminded to escalate this to a senior staff member

Example Improvements to our Services linked to Outpatients:

- To help improve waiting times the number of appointments for the Urology Clinic has been reduced
- The Orthopaedics Department is currently improving its letter templates with IT
- The ENT Department has now discussed different pathways ENT patients can take with Chelsea and Westminster Hospital to ensure that the correct pathway is followed regarding ENT appointments
- The pathway for referrals for physiotherapy appointments from neurosurgery has been reviewed which now takes account of staff being on leave to help improve the patient experience
- A flexible appointment booking system has been created to provide more capacity and therefore reduced the waiting times for appointments

9. Claims

The Legal Services Team manages all aspects of legal claims against the Trust. The Claims Managers attend each CPG's quarterly Quality and Safety Meeting in order to discuss new, ongoing and settled claims, and to address risk management issues that have been highlighted during the claims process.

9.1 Claims Received

The Trust received a total of 185 new claims for 2011/12. This includes claims covered by the NHSLA's Clinical Negligence Scheme for Trusts (CNST), Existing Liabilities Scheme (ELS) and Liabilities to Third Parties Scheme (LTPS), as well as the local Strategic Health Authority.

A significant majority (87%) of claims received fell under the NHSLA's Clinical Negligence Scheme for Trusts, with an equal percentage of claims relating to employers' liability and public liability. One claim, which related to an alleged asbestos injury, was sent to NHS London as the Trust's Strategic Health Authority. No claims were received this year under the NHSLA's Existing Liabilities Scheme.

The total number of claims received by the Trust in 2011/12 increased 30% compared to 2010/11. This was due to an increased number of claims received for each CPG, excluding CPG 3 which received 8 less claims. Estates also received 1 less claim compared to the last financial year.

On average, 15 claims were received each month in 2011/12.

9.2 Claims Settled

The level of damages for claims settled in 2011/12 was £6,194,503. This figure represents the level of damages to be paid to the claimant if **all** periodical payment orders are made in full. The death of a claimant or a material change in their circumstances may reduce this figure. This figure does not include interim damages payments, which are made before settlement has been agreed, or legal costs.

There was a decrease of 42% from the previous year's total of £10,586,846, due to a decreased number of settled claims and a second year of no confirmed high value settlements for Obstetrics and Maternity at the Trust. There are currently six high value Obstetric and Maternity claims against the Trust where confirmation of settlement or closure is awaited. The total reserve for these ongoing claims is £32,000,000. Two claims settled in 2011/12 had a final damages figure of over £1,000,000.

Table 12 details the number of settlements for the last three financial years by CPG while Table 13 details the total damages amounts for settled claims for the last three financial years.

Table 12. Claims Settled for 2009/10 - 2011/12 by CPG

CPG	**2009/10**	**2010/11**	**2011/12**				
			Q1	**Q2**	**Q3**	**Q4**	**TOTAL**
CPG 1	4	1	1	1	1	1	4
CPG 2	4	7	3	1	1	5	10
CPG 3	20	21	3	2	1	4	10
CPG 4	5	3	2	2	3	2	9
CPG 5	8	14	5	1	0	2	8
CPG 6	0	2	0	1	0	2	3
Other	4	7	2	0	1	2	5
Trust	**45**	**55**	**16**	**8**	**7**	**18**	**49**

Table 13. Value of Claims settled for 2009/10 - 2011/12 by CPG

CPG	**2009/10**	**2010/11**	**2011/12**				
			Q1	**Q2**	**Q3**	**Q4**	**Total**
CPG 1	£117,000	£3,000	£30,000	£19,047	£3,000	£2,411,903	£2,463,950
CPG 2	£295,000	£564,433	£214,500	£30,000	£3,500	£1,264,250	£1,512,250
CPG 3	£3,344,520	£8,175,923	£948,634	£110,000	£75,000	£238,500	£1,372,134
CPG 4	£1,392,827	£1,013,172	£170,001	£24,672	£20,947	£60,000	£275,620
CPG 5	£12,344,	£717,901	£391,11	£2,000	£0	£135,50	£528,615

	278		5			0	
CPG 6	£25,376	£47,500	£0	£6,500	£0	£9,225	£15,725
Other	£55,884	£64,917	£16,392	£0	£1,000	£8,817	£26,209
Trust	**£17,574,885**	**£10,586,846**	**£1,770,642**	**£192,219**	**£103,447**	**£4,128,195**	**£6,194,503**

9.3 Litigation

The NHSLA has reported that only 4% of clinical claims commenced against the NHS proceed to settlement in Court. This figure is inclusive of settlements which require the Court's approval such as those claims in which a Litigation Friend has been appointed because the Claimant is either a minor, or has been assessed as a Protected Party under the Mental Capacity Act 2005. Very few cases reach the stage of Trial in Court. Claims that reach Trial can have significant implications for the Trust in terms of both costs and publicity.

During 2011/12, the Trust successfully defended a High Court Trial of a claim brought by a Claimant who had sustained neurological injuries following a stroke after undergoing a vascular surgery procedure in March 2007. The Trust's defence of this claim was accepted by the judge who summed up that a non-negligent complication had occurred and it was not negligent of the treating surgeon to have not undertaken any interventions once the complication had been identified. The Trust was however criticised for not informing the Claimant of all the available treatment options. This highlights that patients must be properly informed of all treatment options even though the treating doctor may have a preference for just one option and may not be able to offer the other options.

9.4 Themes from Clinical Claims

The most common themes which formed the basis of claims made against the Trust were a failure to diagnose/delay in diagnosis, failed/delayed treatment and failure to recognise complication of treatment. These themes are listed by CPG and site in Table 14 and Table 15.

Please note that some claims have multiple themes.

Table 14. Top Three Themes by CPG 2011/12

Site	**Failure to Diagnose/ Delay in Diagnosis**			**Failure to Recognise Complication of Treatment**			**Fail/Delay Treatment**		
	2009/10	2010/11	2011/12	2009/10	2010/11	2011/12	2009/10	2010/11	2011/12
CPG1	7	7	14	0	0	2	1	1	1
CPG2	6	3	7	2	3	0	1	2	3
CPG3	4	5	9	6	2	3	3	8	5
CPG4	1	2	1	6	4	5	2	2	2
CPG5	7	2	6	3	5	4	1	0	3
CPG6	0	0	1	0	1	1	0	0	0
Private Patients	0	0	0	0	0	0	0	0	1
Trust	25	19	38	17	15	16	8	13	15

Table 15. Top Three Themes by Site 2009/10 - 2011/12

Site	**Failure to Diagnose/ Delay in Diagnosis**			**Failure to Recognise Complication of Treatment**			**Fail/Delay Treatment**		
	2009/10	2010/11	2011/12	2009/10	2010/11	2011/12	2009/10	2010/11	2011/12
CXH	6	8	11	8	5	4	3	7	6
HH	2	2	7	2	1	3	1	1	1
QCCH	4	1	2	2	4	2	0	0	1
SMH	12	6	17	5	4	7	4	5	7

WEH	1	2	1	0	1	0	0	0	0
Trust	25	19	38	17	15	16	8	13	15

The most common theme across all CPGs excluding CPG 4 was a failure to diagnose/delay in diagnosis. This theme is common to 21% of the total claims received in the last financial year.

This theme was most common in A&E, which provides unplanned care to patients. Of the 12 claims received with a theme of failure to diagnose/delay in diagnosis at a Trust A&E, four alleged a failed diagnosis of a fracture at the A&E, SMH.

For detailed aggregated analysis of top themes at individual CPG and site level see Trust risk profile.

9.5 Types of Non-Clinical Claims

Table 16 captures the number of claims made by Trust employees by hospital site, while Table 17 captures the claims made by patients and visitors to Trust premises.

Table 16. Employers' Liability Claims by Incident Type 2009/10 - 2011/12

	09/10	**10/11**	**11/12**
Charing Cross Hospital	**1**	**5**	**5**
Failure of a device or equipment	0	1	0
Accident of some other type or cause	0	0	1
Lifting or moving a patient or other person	0	1	0
Fall on level ground	0	2	3
Stress-related illness possibly arising from employment	1	0	0
Suspected fall	0	0	1
Tripped over an object	0	1	0
Hammersmith Hospital	**3**	**2**	**2**
Accident of some other type or cause	0	1	2
Fall on level ground	0	1	0
Stress-related illness possibly arising from employment	1	0	0
Person struck by a projectile	1	0	0
Tripped over an object	1	0	0
Queen Charlotte's & Chelsea Hospital	**0**	**0**	**1**
Accident of some other type or cause	0	0	1
Satellite Locations	**0**	**0**	**1**
Fall on level ground	0	0	1
St. Mary's Hospital	**3**	**4**	**3**
Stretching or bending injury, other than lifting	1	0	0
Collision with an object	2	0	0
Lifting or moving an object other than a load	0	0	1
Accident of some other type or cause	0	0	1
Physical abuse, assault or violence	0	1	0
Fall on level ground	0	2	0
Stress-related illness possibly arising from employment	0	0	1
Trapped in lift, locked in a room, other traps	0	1	0
Totals:	7	11	12

Table 17. Public Liability Claims by Incident Type 2009/10 - 2011/12

	09/10	**10/11**	**11/12**

	09/10	10/11	11/12
Charing Cross Hospital	**2**	**6**	**5**
Affray, fights, disorderly behaviour	0	1	0
Collision with an object	0	0	1
Records missing, believed lost, damaged or stolen	0	1	0
Abuse - other	0	1	0
Accident of some other type or cause	0	0	2
Lifting or moving a patient or other person	0	1	0
Fall on level ground	1	2	2
Tripped over an object	1	0	0
Hammersmith Hospital	**2**	**1**	**2**
Collapse of a structure or fitting	0	1	0
Injury from dirty sharps	0	0	1
Fall from a height, bed or chair	0	0	1
Accident of some other type or cause	1	0	0
Fall on level ground	1	0	0
Satellite Locations	**0**	**0**	**1**
Unsafe environment (personal safety, light, temp, noise, air)	0	0	1
St Mary's Hospital	**2**	**5**	**2**
Collision with an object	1	0	0
Injury from dirty sharps	0	1	0
Accident of some other type or cause	0	0	1
Fall on level ground	1	0	1
Person struck by a projectile	0	1	0
Tripped over an object	0	3	0
Totals:	6	12	10

There have been no significant changes in the types of non-clinical claims against the Trust. Although there was a marked increase in the total number of such claims received in 2010/11 when compared to 2009/10, this figure has remained relatively static between 2010/11 and 2011/12.

Example improvements to our service as a consequence of settling a claim

- All diabetic patients having surgery are cared for in line with the Diabetes and Surgery in Adults Guidelines. Where there are concerns about patients with diabetes, the patient is automatically referred to the Diabetes Specialist Nursing Team who review their management going forward. There are now stocks of appropriate oral fluids on every ward for use in the management of hypoglycaemic episodes.
- The maternity service has implemented the use of 'fresh eyes' CTG stickers.
- The guidelines group has been asked to consider whether guidelines should be amended to accommodate for actions resulting from irritable uteruses, including requests for obstetric management.

10. Quality Accounts Priorities

Quality Accounts (QA) are annual reports to the public from providers of NHS healthcare which detail the quality of the services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they provide and communicate how well they are achieving this and reference a commitment to areas of improvement.

The rationale and details for each QA priority were developed in consultation with senior clinical and management staff across the Trust, patients, shadow members – that is patients and members of the public, Local Involvement Network (LINKs), Primary Care colleagues and the Overview and Scrutiny Committees. Each priority has an

improvement target and an action plan to deliver the improvement outcomes. The priorities for 2011/12 are:

- To ensure high performance against the safety thermometer

a) Venous thromboembolisms (VTE)
b) Falls
c) Pressure ulcers
d) Urinary catheter related urinary infections

- To reduce healthcare acquired infections

a) To reduce the rate of C.Difficile infections
b) To reduce the rate of MRSA infections
c) To ensure compliance with the Trust policy for appropriate use of anti-infectives

- To use reporting of patient safety incidents to bring about improvements in care and reduce harm
- To remain better than the national average for mortality rates as measured by the Summary Hospital Level Mortality Indicator (SHMI)
- To reduce the number of emergency readmissions to hospital within 28 days of discharge
- To increase patient satisfaction as measured by Patient Reported Outcome Scores (PROMs)
- To reduce delays in outpatient clinics
- To improve the patient experience related to discharge
- To improve the responsiveness to inpatient needs
- To remain above the national average for staff who would recommend the Trust to friends/family needing care

11. Key Areas of Focus

The 2012/13 key areas of focus have been developed through the use of a risk profile. The top theme for incidents, complaints and claims was analysed at Trust level, at individual CPG level and at individual site level. The outcomes were then aggregated to identify areas of concern that should be prioritised. The complete risk profile is available in the full version of this report.

Alongside the Trust wide top theme for incidents (accident that may result in personal injury) labour or delivery, clinical assessment and infrastructure or resources were also present as a top theme at various level of the analysis. The top theme for complaints (clinical treatment) remained the same at every level of the analysis. Alongside the Trust wide top theme for claims (failure to diagnose/delay in diagnosis) birth defects, failure to recognise complication of treatment and failure to interpret x-ray correctly were also present as a top theme at various levels of the analysis.

Table 18. Action plan

Issue	Action	Lead	Deadline	Monitoring forum
Falls	Review outcomes of Falls Group at Clinical Risk Committee and Quality and Safety Committee	David Mitchell	1st October 2012	Quality and Safety Committee
Complaints related to communication/information to patients	Review at Complaints Forum and develop	Keith Ingram	20th September 2012	Clinical Risk Committee

	action plan to be presented at the Clinical Risk Committee in September			

Key Areas of Focus 2012/13

1. To develop a service quality and patient safety three year strategy in collaboration with CPSSQ
2. To achieve zero Never Events
3. To reduce the number of failure to rescue incidents
4. To reduce the number of patient identification incidents
5. To reduce complaints related to poor communication and lack of information to patients
6. To reduce claims relating to failure to diagnose / delay in diagnosis

12. Research and Development

The Trust Governance Department currently has a joint-post researcher with CPSSQ at Imperial College. The purpose of introducing this joint post position was to increase the research links between the college and the Trust emphasising the fact that we are an effectively developing Academic Health Science Centre. This post allows the Trust to increase their research output and also increases the practical applications of the work around patient safety that is a thoroughly explored topic at CPSSQ. The development of this role has led to a number of innovative projects and academic achievements.

Presentations of work conducted as part of this post have taken place at the British Psychological Society Division of Health Psychology Annual Conference and the Kings Fund Risk and Patient Safety Annual Conference during 2011/12.

Ongoing work includes research surrounding the attitudes of scrub nurses and surgeons to swab counting at the Trust. The aim of the swab count project is to improve the practices of swab counting in theatres at the Trust. Interviews have been conducted with 27 scrub nurses about their attitudes to the current counting system and ideas for improvement. Data analysis has taken place and outcomes have been presented to a local clinical, corporate and academic audience. The work has also been selected to be presented in September 2012 at the Division of Health Psychology's Annual Conference and in October 2012 at the Association for Perioperative Practice Annual Congress. A research paper has been submitted to the British Medical Journal - Quality and Safety. This project will be followed up by a set of interviews with surgeons to compare and contrast with the views of nurses. This is a translational patient safety research project which aims to generate local quality improvement alongside generalisable research lessons.