Imperial College Healthcare NHS
NHS Trust

Public Trust Board Meeting on 24 July 2013

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APPENDIX A

Director of Nursing Report: Hearing What Patients and their Families Say about Care and Treatment at Imperial College Healthcare Trust

1. Background

This paper reports on our proposed approach to compliments, complaints and NHS Choices feedback and gives two short patient stories.

In future months the report will include PALS contacts and NHS Choices feedback. Once Care Connect is live, information and feedback from this will be reported.

A review is currently underway of how we integrate this feedback alongside patient survey feedback and other patient feedback data. The Trust's Medical Director is leading an AHSC work stream and developing a quality strategy that will bring all of these data sources together to drive improvements in services for patients and their families.

In the Francis Report, which reviewed the failure at Mid-Staffordshire NHS Foundation Trust, Sir Bruce Keogh specifically made fourteen recommendations about the complaints process and how it should be '*at the heart of any system for ensuring that appropriate standards of care are maintained'.* Sir Bruce goes on to say that '*a health service that does not listen to complaints is unlikely to reflect its patients' needs'.* With this in mind the Trust has already mapped the complaints recommendations to its current complaints procedure to determine a detailed short and medium term action plan which forms part of the Trust's Mid-Staffordshire action plan.

2. Overview of complaints

2.1 June

The Trust investigated 58 formal complaints in June and responded to 99% of these complaints (against a Trust target of 90%) within the deadline set by the complainant. Overall this represents 0.06% of contacts.

The main reasons for formal complaints in June were:

- Clinical Care 47% approx
- Delayed/Cancelled Appointments (outputs) 16% approx
- Communication/Information to patients 9% approx

In June the following service improvements have taken place as a consequence of formal complaint investigations:-

- Staff in pre-assessment have been reminded of the importance of informing patients as quickly as possible procedure has been cancelled.
- A&E will use a complaint as a case study for junior doctors to ensure early referral to specialist teams.
- Midwives working in the antenatal clinic have been reminded of the process for booking women for homebirth. New posters will now be designed for women to help inform them of their choices regarding place of birth and how to access the correct information. The homebirth team are also now running monthly drop in sessions on the first Sunday of the month for women considering home birth.

- In future women attending clinic for their breast cancer results will have their appointment booked at the end of the clinic to improve the patient pathway. Additionally, all imaging staff will reminded of the correct procedure if they are asked for results.
- Consideration will now be given to the benefits of the onsite Paediatric Surgeon reviewing children attending A&E, aged less than five years of age, at an early point in their pathway. The policy for starting intravenous fluids for children admitted to the wards from A&E will also be reviewed.
- The Trust will review whether further advice should be issued to our Radiology Registrars when the appendix cannot be visualised on ultrasound.
- The nursing staff on Charles Pannett Ward have been reminded to give clear explanations to patients when they give care and to let patients know why they cannot respond to their request immediately but they will do so as soon as possible. Staff has also been reminded to complete a transfer form for any move from one area to another and that patients who are moved out of hours need a medical review, which needs to be documented in the patient's health records.
- A new committee to discuss policy development on latex allergy is in the course of being established.
- DHL drivers will in future ask patients where they would like to be taken to once entering their home.
- To help reduce bed sores new heel troughs have been introduced on Valentine Ellis Ward. Also an education programme for all nursing staff has been agreed to help educate staff on pressure area care and the use of pressure relieving equipment. Staff have also been reminded to review patients regularly to check for any signs of pressure sore development.
- All nursing and clinical staff on the Auchi Acute Dialysis Unit has been reminded of the importance of contacting loved ones in a timely manner following the death of a patient.
- Feedback from a complaint will now be used to help improve patient experience at WEH. Additionally, all patients who now attend and assessed by the triage nurse indicating that their condition is not deemed an emergency will now have their attendance recorded manually. This will ensure that if a complaint is received documentation of the patient's attendance exists to help staff recall the events for their reflection and learning.

2.2 May

The Trust investigated 81 formal complaints in May and responded to 95% of these complaints (against a Trust target of 90%) within the deadline set by the complainant. Overall this represents 0.07% of contacts.

The main reasons for formal complaints in May were:

- Clinical Care — 45% approx
- Admission, discharge and transfer — 9% approx
- Delayed/Cancelled Appointments (outputs) — 8% approx

In May the following service improvements have taken place as a consequence of formal complaint investigations:-

- To help ensure our public toilets are clean the domestic supervisor will now sign the daily cleaning schedules at the end of each day ensuring that his domestic staff has cleaned and checked the area three times a day.
- Our oncology wards at Charing Cross Hospital now have a ward based consultant who will undertake daily ward rounds and will be available to review patients' care plans and symptoms.
- The number of bed pans for 4 South Ward has been increased. Additionally, a microwave cooker has now been purchased for this ward for our patients to heat food.
- Our Laundry Department has been reminded that there must be enough assorted sized gowns available in our clinical areas to help protect our patients' dignity.

- The newsletter for CPG5 carried an article reminding clinicians to explain the different care options available to women who have had a spontaneous rapture of membranes.
- The management of the Urology Clinic is currently being reviewed to ensure patients are seen in a timely fashion.
- During the pharmacists ward round staff are now asked at what time a patient will be discharged to help ensure that their take home medication are available on time so that their discharge is not delayed.
- A doctor who prescribed Tramadol in error has been spoken to formally and staff have been reminded of the importance of checking patients identity bracelets to check if they have any allergies.
- Nursing staff in our walk in centres have been reminded of the importance of washing their hands, or the use sanitising gel, between patients.
- The ENT service are currently considering if they can run a telephone based clinic for their follow-up patients who do not need a physical examination to help increase capacity.

3. Patient’s Story

It is important to hear patients’ views on their care to see care and treatment through the patients’ eyes, to understand what is important and when we do not get it right to learn lessons to make sure it does not happen again. Equally getting positive feedback and descriptions of care can have similar benefits for learning. This section contains two patient stories (for the purpose of this report the stories are anonymised).

3.1 Story one

A couple emailed to express their thanks for the outstanding service that they received at Queen Charlotte's Delivery Suite. The couple are both doctors employed in the Trust.

In June, they attended Queen Charlottes. The patient’s waters had broken and were meconium stained and they obviously very anxious.

On arrival at the delivery suite they were introduced to their first midwife. The couple described that she was fantastic and spent time addressing their fears and concerns and getting them settled. The expressed that they felt confident in her and reassured that everything was under control and proceeding as expected. Without exception, she was always professional, caring and understanding, which is difficult to achieve in a busy environment like the delivery suite, in their experience.

At shift change, another midwife was allocated to look after them. Again, they expressed that she was amazing, spending time explaining the process, making sure the patient had a chance to discuss her wishes for the birth. When baby arrived, it was all relatively sudden and he had the cord around his neck. In their view, the midwife was very calm, dealt with it efficiently and only told them about it after baby was safely out (which was absolutely the right time to tell them in their opinion).

Before they were moved to the labour ward, the night co-ordinator went to see them to explain that they would be moved, and where they would be taken to. Although the couple did not take a note of her name, they were again really impressed by her.

They describe that their care in the delivery suite was absolutely faultless and especially the work of the midwives who they would like to know what a great job they did and that it is really appreciated.

Key features that gave a positive experience:

- Personalised care
- Explanation
- Involvement in decision making and care
- Reassurance

3.2 Story two

The following is an extract from a blog written by a patient currently undergoing breast cancer treatment within the Trust.

Day 81

'Ah, hello' says the anaesthetist 'I'm Dr X' (*I'm afraid I don't remember his name, which is a shame, as he turned out to be so very, very kind*).

'Don't mind me' I say, morosely, 'I just don't want to be a patient yet, and when I get in bed, I'm a patient'.

Dr X could have pointed out that since I am in hospital wearing a hospital gown, surgical stockings and plastic identity bands on my wrists, and am going to undergo surgery within the next couple of hours, it is a bit late to start talking about not wanting to be a patient. Instead, with a great deal of forbearance, and considerable kindness, he humours me.

'No problem' he says, 'I know just how you feel. I had an operation myself recently. Why don't I just come and sit up there with you for a few minutes, while we do this?'

He repeats my procedure of climbing up the metal side parts of the bed and launching himself thence onto the window sill, and we sit there for a few moments in companionable silence. After a while he begins to ask the questions relevant to the imminent administration of general anaesthetic, all of which have been asked before more than once, but which presumably must be triply and quadruply checked to make absolutely sure that there is no error, that no point of danger is overlooked.

I explain the whole 'escaping to Goa' plan to Dr. X, telling him how it can't possibly be right that I have breast cancer because have I not swum 23 miles this summer in the swimming pool of THIS VERY HOSPITAL, and do I not have terrific upper body strength with excellent triceps, which I would display to him were it not for this pesky hospital gown? And he nods and listens, and holds my hand as I start to cry, and for some time afterwards, and tells me how I can go to Goa later on, when I'm better. He gently suggests that a tranquiliser might be a good idea to help with my anxiety, and after he leaves I come down from the window sill, get into the bed, and go to sleep for a while'.

Day 108

Mr H pauses for a second and his mouth does a thing which is like the opposite of a smile. 'Unfortunately, we *did* find something in your Sentinel Lymph Node. A micro-metastasis, very tiny, just a cluster of a few cells.'

'Cancer cells?'

Stupid question, I know perfectly well that any use of the word 'metastasis' signifies spreading cancer cells, but there's part of my brain which insists on having it spelled out in case there has been some kind of mistake – you always think there's been some kind of mistake,

'Yes, I'm afraid so. It indicates that the cancer was just starting to spread beyond its primary location in the tumour in your breast.'

R is holding my hand very, very tightly and the world has gone all blurry as I struggle to stay composed.

'So what does this mean?'

'Well, one micro-metastasis in the sentinel lymph node is the smallest possible indication of spread, and it's quite possible that these are literally the first few cells that have made it into your lymph nodes or elsewhere. But we can't be sure of that: it means that we need to think about

some further treatment, in case there are any more cancer cells to be picked up, in your lymph nodes or anywhere else.'

My blood goes cold.

'What kind of treatment?'

'In this situation there are several possibilities. One is to have the rest of the lymph nodes under your right arm removed – a complete Axillary Node Clearance. Alternatively, you could have radiotherapy on your armpit – on your lymph nodes, as well as on your breast. The third option, which is the one I would recommend, is a course of chemotherapy.

<u>Day 111</u>

The harm that medical interventions can do is much on my mind today because at the moment I'm very weak, my brain is fuzzy and my vision is blurred, and sitting at the computer to write is really quite hard to do. Going for a walk, which I tried to do this afternoon, was more of a challenge still; my legs feel floppy and rubbery, my whole body is suffused with weakness, and this is what the chemo has done to me, not the cancer.

<u>Day 134</u>

I'd like to thank all the staff at the Charing Cross Hospital for their dedication and patience in treating a very reluctant and sometimes less than compliant patient, and in particular the wonderful Matron A *– aka World Mum/Mother Goddess/PICC line Wrangler Supreme –* Matron of the Chemo Day Ward, who transformed my chemo experience for the better once she became involved in my care. Matron A, I am eternally grateful. You will get your reward in heaven, but in the mean time I will fulfil my promise to bake cakes for the chemo ward in due course.

Key features of this story:

- Compassion
- Kindness
- Patient safety
- Keeping the patient informed
- Explaining treatment options
- Patience

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APPENDIX B

Director of Nursing Report: Update on the Trust's action plan against the Mid Staffordshire NHS Foundation Trust Inquiry recommendations

1. Purpose of the report

The following paper provides an update to the Board on the actions taken in relation to the Mid Staffordshire NHS Foundation Trust Inquiry, further to the paper presented in March. It provides an overview of the key recommendations relevant to the Trust and outlines our progress in implementing these. Additionally, by reviewing the recommendations in full the Trust is meeting the obligation set out in the inquiry to *'publish on a regular basis its progress on implementation, not less than once a year'*[1]. The Director of Nursing has been leading the Trust's review of the Mid Staffordshire NHS Foundation Trust Public Inquiry working with colleagues across the Trust.

2. Context/Background

Robert Francis QC, Chairman of the Inquiry published his final report following consideration of over 250 witnesses and over one million pages of documentary evidence on 6th February 2013. Board members received a copy of the inquiry after its publication and an initial summary of the Trust's response and actions to the findings were presented at its public Board meeting on 27th March 2013.

The overall message from the Inquiry report is a real sense of shocking failure whilst noting that no single person is to be held responsible as the failure was at; individual organisation level and system oversight. In addition, the report raised a series of profound questions for all parts of the NHS and is comprehensive and far reaching.

2.1 The key aims of the findings

The Inquiry made 290 recommendations designed to change culture and ensure 'patients not numbers come first' by creating a common patient centred culture across the NHS. Francis says no single one of the recommendations is on its own the solution to the many concerns identified. The essential aims of what has been suggested are to:

- Foster a common culture shared by all in the service of putting the patient first.
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff that have to provide the service.
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service.
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.

[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry; Executive summary, p.19

- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

3. Progress against the Trust's action plan

A review of the recommendations is detailed in figure 1 overleaf and highlights the areas as a Trust we need to action. All of the actions have either been completed or are work in progress due to be completed by the target date. The Trust action plan has been presented to the; Quality and Safety Committee on 3rd June, discussed at the Clinical Quality Group (attended by GPs and commissioner colleagues) on 17th July and presented to the Management Board on 22nd July.

Figure 1: Trust's action plan in response to the Mid Staffordshire NHS Foundation Trust Inquiry recommendations

RAG Rating Key:

Colour	Meaning
Red	Work in progress and not on target
Amber	Work in progress and on target
Green	Action/Milestone achieved

Theme (recommendation nos.)		Action/Milestone	Date of delivery	Exec. Lead	Service Lead	Progress as at 08/07/2013	RAG rating
Implementing the recommendations							
1	Implementing the recommendations	Consider the findings and recommendations of the report and agree an action plan	27/03/2013	JS	PR	The Board formally accepted the recommendations at its meeting on 27/03.	
		Publish an annual report outlining progress against the recommendations	Feb 2014	JS	PR	An interim report outlining progress against this plan will be presented at the July Trust Board meeting.	Future Date
Putting patients first							
2	Culture and values/ Staff feedback	Ensure revised Trust objectives align with our values and this recommendation	30/06/2013	MD	-	Draft Trust objectives were agreed at the Board seminar in June.	
198		Consider the roll-out of a cultural barometer across the Trust to measure cultural health of organisation	31/09/2013	JM	SG	Currently looking at developing a 'pulse' survey in addition to the national survey.	
		People and OD strategy to be reviewed in light of the recommendations	31/09/2013			People and OD Strategy has been completed and incorporates Francis Report	
4	NHS Constitution	Continue to embed the core values from the NHS constitution into all areas of the Trust.	N/a	JM	SG	The Trust will continue to do this through existing forums e.g. induction, appraisals, objectives.	
		Implement actions from the staff survey	Ongoing for 2013			Each CPG and Corporate Directorate now has a local Engagement Plan which responds to their Staff Survey feedback. There are planned progress review dates at Management Board in August, November and in February 2014.	

	Theme (recommendation nos.)	Action/Milestone	Date of delivery	Exec. Lead	Service Lead	Progress as at 08/07/2013	RAG rating
5	NHS Constitution	Ensure that the expectations of the NHS Constitution and local Values & Behaviours are clearly evident in documentation e.g. for recruitment (JDs, contracts etc)	30/06/2013	JM	SG	The NHS Constitution and Values have been inserted into all Job Descriptions and new Contracts for staff including those from Agencies managed by HR (Reed, Brook Street) issued from 1st July onwards. Review of contracts from other services e.g. ISS is currently underway.	
7		Enter a commitment to abide by the NHS values and the Constitution into our contracts with staff	30/06/2013	JM	SG		
8		Review contracts for outsourced services to ensure they include the NHS Constitution/values into their employment/service contracts	30/06/2013	JM	SG		
11	Managing professional disagreements	Define a process for the Medical Director and Director of Nursing to manage professional disagreements	30/06/2013	JS/NC	SG	There are existing forums in place to manage professional disagreements e.g. MDT meetings, the clinical ethics forum and nurse establishment reviews.	
178	Staff contract	Review contracts of employment to ensure they include and are consistent with the inquiry recommendations	30/06/2013	JM	SG	Complete	
Governance to ensure compliance with fundamental standards							
15	Governance structure	Review Trust governance structure to ensure all the required elements of governance are brought together into one comprehensive standard.	End of July 2013	CP	S Gu	The revised governance structure was discussed at the Board seminar in June and will be approved in July.	
37	Quality Accounts	Include full and accurate information about the Trust's compliance with each standard and publish on the Trust website.	30/06/2013	CP	S H-W	Full and accurate information has been included and the 2012/13 account is published on the Trust website and also on NHS Choices.	
247		Share our quality account with commissioning organisations, local Healthwatch and systems regulators.	20/05/2013	CP	S H-W	Complete. Our account has been shared with several stakeholders.	
248		Ensure independent audit of our Quality Account		CP	S H-W	Complete. This was undertaken by Deloitte on 17th June 2013.	
249		All directors in office at the date of the account to sign a declaration certifying that they believe the contents of the account to be true (or a statement explaining why they are unable/refused to sign).	15/06/2013	CP	S H-W	This has been completed and all Executives have certified that they believe the contents of the account to be true.	
Board Accountability							
79	Fitness to practice	Ensure that all Directors are and remain fit and proper persons for the role.	Ongoing	CP	SGu	This will be addressed during appraisal and meetings with the CEO.	

Theme (recommendation nos.)		Action/Milestone	Date of delivery	Exec. Lead	Service Lead	Progress as at 08/07/2013	RAG rating
Effective complaints handling							
40	Complaints data	Ensure that complaints reports include both qualitative (narrative) and quantitative data	N/a	CP	KI	All reports currently include both types of data.	
109	Registering of complaints	Review our current methods and points of access for registering a complaint/comment to ensure they are readily accessible and easily understood.	03/06/2013	CP	KI	This has been reviewed and the Trust has multiple gateways via; PALS, in person, email to complaints and PALS email address, web site form and letter. The new Care Connect system will be anther platform to register a complaint/comment.	
110	Management of complaints	Review complaints policy to ensure intended litigation is not a barrier to the processing or investigation of a complaint at any level.	Waiting DH guidance	CP	KI	Our current policy has been reviewed and does not include any guidance regarding this recommendation. We are awaiting new DH complaints guidance and the policy will be reviewed in light of this.	
111		Consider commissioning Trust audit of learning from complaints –as part of bi-annual concerns and complaints audit	01/09/2013	CP	KI	The new divisional patient safety managers will be responsible for ensuring the learning from complaints. They are yet to take up post.	
		Review ‘How to make a comment or complaint’ leaflet and ‘PALS’ leaflet	01/09/2013	CP	KI	Currently being re-drafted.	
		Review feedback and learning from complaints to include Trust Board and role of NED.	29/05/2013	CP	KI	A paper was presented to the Trust Board on 29/05 outlining themes from complaints for the previous month and recommending the use of patient stories at Board meetings. This was approved and the next update will go to the Board at its 24/07 meeting.	
		Review Trust’s web site to ensure it collects lodged concerns and complaints and sends these to a central account managed by PALS for triage.	01/08/2013	JS	KI	In progress.	

Theme (recommendation nos.)		Action/Milestone	Date of delivery	Exec. Lead	Service Lead	Progress as at 08/07/2013	RAG rating
111 (cont)	Management of complaints (cont.)	Consider how collective feedback can be obtained from poor performing areas	30/06/2013	CP	KI	The introduction of divisional patient safety managers will ensure a single point of contact to collate and analyse all sources of feedback to include; complaints, PALS and incidents.	
		Review reports to ensure they include detailed analysis of trends, themes and quotations from individual complaints.	30/06/2013	CP	KI	Reports have been reviewed and contain analysis of trends, themes and quotations from complaints.	
		Consider if the existing complaints and PALS joint report can feed into patient experience data.	01/08/2013	CP	KI	Work is in progress to look at how this data can be triangulated with patient experience data.	
		Consider auditing how CPGs use information to learn from feedback.	31/05/2013	CP	KI	Complete. Discussions have taken place with CPG Heads of Nursing about learning and feedback from complaints and it is in response to this that the proposal for each division having a single point of contact, has been made.	
115	Independent investigations of complaints	Ensure the 4 triggers (SI, expert clinical opinion required, professional misconduct, nature of services commissioned) are included in our complaints policy	Awaiting DH guidance	CP	KI	To be reviewed in light of DH guidance.	Future Date
116	Support for complainants	Include a flowchart in our Concerns and Complaints Policy to ensure it reflects current guidance regarding the recording of meetings	30/06/2013	CP	KI	A draft flowchart has been completed and will be incorporated into the new policy which will be revised once the DH guidance has been published.	
		Include a standard letter in the Concerns and Complaints Policy to be used when inviting complainants into local resolution meetings.	30/06/0213	CP	KI		
117	Independent complaints advocacy service	Ensure we have a facility available to independent complaint advocacy services and their clients for accessing expert advice in complicated cases.	Awaiting DH guidance	CP	KI	To be reviewed in light of DH guidance.	Future Date

	Theme (recommendation nos.)	Action/Milestone	Date of delivery	Exec. Lead	Service Lead	Progress as at 08/07/2013	RAG rating
118	Learning and information from complaints	Consider how we can work closely with a NED who periodically reviews complaints/ concerns and our responses to ensure effective learning.	30/06/2013	CP	KI	Linked to recommendation 111. Director of Nursing to discuss this with the Chairman.	
		Ensure that all board members receive a sample of complaints each year.	29/05/2013	CP	KI	A sample of complaints has started going to the Board in the form of patient stories.	
		Review the publication of responses to formal complaints after the launch of Care Connect with our web team and patient experience lead to help foster openness and transparency of the complaints process.	30/06/2013	CP	KI	This will take place after the launch of Care Connect.	Future Date
		Reference the publication of complaints in our Quality Strategy and associated work plan.	30/06/2013	NC	SM	The quality strategy is currently being drafted and will address this action.	
Patient experience							
112	Patient feedback	Review how we manage feedback that is not deemed to be a formal complaint.	30/06/2013	JS	CC	The Trust has a robust PALS service in place to address these actions.	
		Devise an escalation process that ensures a timely response occurs.	30/06/2013	JS	KI		
255	Using patient feedback	Ensure that results and analysis of patient feedback including qualitative information are made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	30/06/2013	JS	SF	Itrack results are available to all stakeholders within 24hrs via Qlikview. Monthly reports are also sent to all CPGs.	
Medical Training							
159	Medical student/trainee feedback	Modify the Trust's internal survey of trainees to include further questions on standards of care, family test etc.	December 2013	JL	RA	In progress. To be updated in December.	Future date
160		DCS and DMEs to ask students/trainees about patient care in their feedback sessions and present results to HEB bi-annually.		JL	RA	To be updated in December.	Future date
161	Feedback from training visits	Continue current process for reporting of training visits and wide distribution of results and actions arising. Collate information from visits, survey and medical students to get an overview of		JL	RA	To be updated in December.	Future date

		education quality and include in bi-annual report.					
Theme (recommendation nos.)		**Action/Milestone**	**Date of delivery**	**Exec. Lead**	**Service Lead**	**Progress as at 08/07/2013**	**RAG rating**
Openness, transparency and candour							
174 175 180	Candour about harm	Review the Trust's Being Open policy to ensure it meets the recommendations from the inquiry and is in line with the NPSA's 'Being open' guidance.	31/05/2013	NC	SB	The Being open policy has been reviewed and is in line with the NPSA and NHSLA guidance.	Green
176	Openness	Ensure that any statement made to a regulator or a commissioner in the course of our statutory duties is completely truthful and not misleading by omission.	N/a	All	All	The Trust provides truthful statements to regulators and commissioners. This is embedded within the NHS Constitution and professional codes of conducts in terms of honesty and integrity.	Green
177		Ensure that any public statement made by the Trust about its performance must be truthful and not misleading by omission.	N/a	All	All		Green
179	Contractual clauses	Carry out a retrospective and current review of contracts to ensure 'gagging' clauses are not in place.	31/05/2013	JM	SG	Completed and no clauses in place. Wording in relation to this area has been reviewed for future contracts.	Green
Nursing							
191	Recruitment for values and commitment	When recruiting nursing staff, whether qualified or unqualified, the recruiting manager should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs.	30/09/2013	JM	DDNs	This will be considered as part of the phase 2 CPG restructure which is currently being worked through.	Amber
195	Nursing leadership	Ensure that ward nurse managers operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward.	30/09/2013	JS	DDNs		Amber
197	Nursing leadership	Include leadership training at every level from student to director as part of continuing professional development for nurses.	31/05/2013	JS	KJ/SG	This remains a key objective in the Nursing and Midwifery Strategy. Plans are overseen by the Nursing and Midwifery Professional Practice committee (NMPPC). Two further cohorts of Band 6 and Band 7 leadership programmes are currently in process and an evaluation will be presented to NMPPC in September.	Green

						The annual N&M conference in October will include a focus on leadership for all bands.	
Theme (recommendation nos.)		**Action/Milestone**	**Date of delivery**	**Exec. Lead**	**Service Lead**	**Progress as at 08/07/2013**	**RAG rating**
Getting the basics right – every time							
199	Named key nurse	Allocate a named key nurse (for each shift) to each patient who is responsible for coordinating the provision of care. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient. Consider this as part of the existing handover project.	31/12/2013	JS	DDNs	Currently in place through the 'shift coordinator' role. In order to strengthen the process and gain assurance of this, it will be taken forward as part of the 'handover project' which is overseen by the Nursing and Midwifery improving practice group. The CERNER handover module has been accelerated and will be piloted in August.	
204	Executive Nurse Director	Have at least one executive director who is a registered nurse.	N/a	MD	AC	Director of Nursing is an Executive Director.	
		Consider recruiting nurses as non-executive directors as part of NED.	N/a	Dir. Of Governance/SGu		All NED posts have been recruited to and the Trust also has 2 Associate NEDs of which one is a Nurse. This action will be considered for future NED appointments.	
236	Identification of who is responsible for the patient	To review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	31/09/2013	NC	SM	In progress	
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	Ongoing	All	All	Effective team work is in place through multi-disciplinary working at a clinical level. Ward staff have strong relationships with cleaning and other contracted services staff.	
238	Communication with patients	Regular interaction and engagement between nurses and patients and those close to them	Monthly (as a	JS/NC	SH/SM	Currently undertaken through monthly leadership walk around and weekly	

		should be systematised through regular ward round.	minimum)			'back to the floor' Friday. Further work to be taken forward as part of patient experience improvement plan, working in partnership with communications.	
Theme (recommendation nos.)		**Action/Milestone**	**Date of delivery**	**Exec. Lead**	**Service Lead**	**Progress as at 08/07/2013**	**RAG rating**
239	Continuing responsibility for care	Review our discharge planning processes to ensure that a patient in need of care will receive it on arrival at the planned destination.	August 2013	SMc	RC	Policy currently being updated and as per annual review and this will include Francis recommendations. Work is underway with community and social services to include lessons learnt from the Winter and to ensure patients receive the appropriate care within the new NHS structures.	
240	Hygiene	All staff and visitors to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	Ongoing	AH	KAW	All medical staff has been trained in A-sceptic non-touch technique. Q1 Hand hygiene audits show compliance rates of 90-100% across areas.	
241	Provision of food and drink	Review the arrangements and best practice for providing food and drink to the elderly.	Monthly	JS	SH	We currently audit patient satisfaction regarding food and drink on a monthly basis at CPG level. The audit results for June show 81% of patients were satisfied and answered 'yes' against a range of questions.	
242	Medicines administration	A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need.	Monthly	JS	SH	Monthly audits are performed and CPG reports are presented to the medication safety review group.	
243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	30/09/2013	JS	LP	In progress. This is being addressed as part of the Failure to Rescue project. The implementation of the National Early Warning Score system (currently in pilot) within this project will ensure that routine observations are recorded reliably. Full roll-out will commence in September.	
Information/Performance/Incidents							

12	Incident reporting	Review current incident reporting system and scope the introduction and roll out of DATIX	August 2013	NC	SB	In progress. Currently looking to roll out the upgraded DATIX system.	
89	Serious incident reporting to the HSE	Report all SIs involving death of or serious injury to patients or employees with the Health and Safety Executive.	Awaiting national guidance	NC	SB	Awaiting national guidance. Currently report these types of SIs to the commissioning support unit.	
Theme (recommendation nos.)		**Action/Milestone**	**Date of delivery**	**Exec. Lead**	**Service Lead**	**Progress as at 08/07/2013**	**RAG rating**
105	Incidents and HSMR	To be aware that considerations being given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio	Ongoing	NC	SM/SB	The Trust has recently established a mortality reporting working group to look at the use of mortality reporting within the Trust. Mortality information will be triangulated with incident reports and other patient safety information as part of our quality metrics going forward.	
114	Complaints and SI triggers	Ensure that our current policy states that when comments/complaints describe events amounting to an adverse or serious untoward incident, it should trigger an investigation.	30/06/2013	NC	SM/KI	In progress	
142	Clear lines of responsibility supported by good information flows	Review our current performance management/information flows and processes to ensure that unambiguous lines of information flows exist.	31/07/2013	KJa	RH/KH	Trust's Business Intelligence Strategy Board has provisionally agreed a roadmap to rationalise existing performance reporting systems into a single portal/framework in QlikView. The Trust's Operational Performance Team and Imperial Business Intelligence Service are currently refreshing Trust scorecards in use for performance improvement and performance management.	
143	Quality metrics	Review our existing metrics to ensure they are fit for purpose	30/06/2013	NC	KH/SM	Trust scorecard currently being refreshed to be in line with national quality metrics and our quality strategy.	
244	Common information practices	Assess the Cerner Millenium function against the requirements set out in this recommendation to ensure they are addressed (where possible)	01/08/2013	KJa	RC	Where functionality exists to implement the requirements, the Cerner@Imperial Programme Roadmap will be developed to incorporate these recommendations	

						and agreed by Cerner@Imperial Programme Board. Cerner@Imperial Programme Business Case for post 2015 to be developed.	
Theme (recommendation nos.)		**Action/Milestone**	**Date of delivery**	**Exec. Lead**	**Service Lead**	**Progress as at 08/07/2013**	**RAG rating**
245	Board accountability	Ensure the Board has a designated member with responsibility for information.	N/A	MD	KJa	Chief Information Officer is the senior responsible officer with responsibility for information, as detailed in the Trust's Information Governance Framework, and attends the Trust Board meetings and meetings of its standing committees as required.	
256	Follow up of discharged patients	Review our post-discharge processes to consider a proactive system for following up patients shortly after discharge to improve patient experience.	TBC	JS	SF	This will be considered as part of the ongoing patient experience work plan.	
262 268	Enhancing the use, analysis and dissemination of healthcare information	Undertake a review of Quality & Safety Reporting to standardise reporting and automate processes where possible.	Post CPG restructure	NC	SB	A review of quality and safety structures and reporting has been undertaken and a revised system will be implemented once the new divisional structure is in place.	
Certification of death, coroner and inquest							
264	Speciality data	In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.	N/a	NC	SM	The Trust has recently established a mortality reporting working group to look at the use of mortality reporting/statistics within the Trust at specialty level. Mortality rates are currently published. CPG quality and safety scorecards also include information on the efficacy of treatment.	
269	Audit of data	Undertake audits of data put into systems in order to ensure accuracy.	Ongoing	SMc	RH	Operational data quality and clinical coding accuracy is audited annually via a rolling programme of internal audit as part of the Trust's Audit Plan. Audit recommendations are reported to and tracked by the Trust's	

						Operational Data Standards Committee, part of the Trust's Information Governance framework.	
Theme (recommendation nos.)		**Action/Milestone**	**Date of delivery**	**Exec. Lead**	**Service Lead**	**Progress as at 08/07/2013**	**RAG rating**
279	Certification of death	Review our current policy to ensure that it states; the Consultant or another senior fully qualified clinician in charge of a patient's case/treatment is responsible for certifying the cause of death.	August 2013	NC	SM	In progress	
280	Contact with bereaved families	Ensure that information for the bereaved family/staff about raising any concerns they may have with the independent medical examiner is provided.	30/06/2013	SMc	JB	Current bereavement leaflet for families outlines how they can raise concerns/questions through the patient affairs officer. Patients affairs advise the most appropriate cause of action based on the nature of the concern e.g. complaint.	
282	Coroners and Rule 43 reports	Agree a process that captures Rule 43 feedback from the CQC.	01/08/2013	CP	SHW/KI	In progress	

Executive Lead		**Service Lead**			
JS	Janice Sisgworth	SG	Sue Grange	SH	Sally Heywood
MD	Mark Davies	SM	Shona Maxwell	KH	Kathryn Hughes
JM	Jayne Mee	SB	Sue Burgis	RH	Ruth Holland
NC	Nick Cheshire	S Gu	Stephen Guile	RC	Robbie Cline
JL	Jeremy Levy	KI	Keith Ingram	SH-W	Stephanie Harrison-White
KJ	Kathryn Jones	SF	Scott Fitzgerald	LP	Lesley Powells
SMc	Steve McManus	CN	Christine Norton	DDNs	Divisional Directors of Nursing
KJa	Kevin Jarrold	JB	Jill Butler	PR	Priya Rathod
CP	Cheryl Plumridge	RA	Rachel Abraham	RC	Rebecca Campbell
AH	Alison Holmes	KWA	Komal Whittaker-Axon		

4. Next Steps

Progress against the plan will be overseen by the Director of Nursing and further updates are scheduled as follows:

- Quality Committee: Autumn 2013
- Management Board: December 2013
- Trust Board: December 2013. An annual report summarising progress against the plan will be shared at the meeting in April 2014.

5. Board Action

The Board is asked to:

- **Review** progress against the actions
- **Agree** to receive an update to the Board in December

Imperial College Healthcare NHS
NHS Trust

Report Title: Medical Director's Trust Board Report Appendix A: Patient Safety, Service Quality and Serious Incident (SI) Report Q4 2012/2013

To be presented by: Professor Nick Cheshire, Medical Director

Executive Summary:
The Quarter (Q) 4 report details Trust progress against a range of quality and safety indicators including incidents, Serious Incidents (SIs), complaints and litigation. Trust historic benchmarking data and where possible external comparators such as National Reporting and Learning System (NRLS) data are included. All data within the Q4 report has been refreshed, therefore data in previous scorecards will be different from this report.

The data for the Q4 report has been taken from the March 2013 scorecard.

The format of the Q4 report includes:
- Headlines
- Performance
-Trends over time using Statistical Process Control (SPC)
- Risk Profile

All key message of this paper are included in the Headlines section of the report and cover the following areas:
- Patient Safety
- Clinical Effectiveness

The clinical incident reporting rate has increased from Q3 (6.7) to Q4 (6.9) compared to an NRLS benchmark of 6.9 incidents reported per 100 admissions across the Acute Teaching Trust cluster (our peers).

For Q4 major incidents remain below the national average (positive) and low harm incidents are above the national average (positive). However, it is important to note that our extreme and moderate incidents were above target (negative) and our no harm incidents were below target (negative). A programme of weekly reviews with CPGs has been introduced to improve reporting and ensure that extreme and moderate incidents are correctly classified in the first instance and ensure that extreme and moderate incidents are correctly classified in the first instance and investigated in a timely manner.

In Q4 there has been a change in the top three categories of incidents reported. The top three themes for this quarter are accident that may result in personal injury, medication and clinical assessment (investigations, images and lab tests). In Q3 the top three themes were accident that may result in personal injury, clinical assessment (investigations, images and lab tests) and access, appointment, admission, transfer, discharge.

Inadequate staffing incidents increased from Q3 (227) to Q4 (231) by 2%. The Trust did not meet its internal target of no more than 78 inadequate staffing incidents per quarter (target based on

previous year's data and set internally). The nursing directorate is working to improve the bank fill rate and improve recruitment to nursing vacancies.

Inadequate response to change in patient status (failure to rescue) incidents have increased from Q3 (21) to Q4 (25). This represents an increase of 19%. Site and CPG variations were noted 13 incidents occurring at CXH, 1 at QCCH, 13 in CPG1, 5 in CPG2, 3 in CPG4, 2 in CPG3 and 2 in CPG5A trust wide Failure to rescue group has been set up to drive improvement in this area with roll out of the new National Early Warning scoring system a priority.

Patient identification incidents have increased by 89% from Q3 (9) to Q4 (17). Site and CPG variations were also noted for Q4 with 7 incidents occurring at CXH, 5 at SMH, 4 at HH, 1 at QCCH, 5 in CPG6, 3 in CPG1, 3 in CPG2, 3 in CPG3, 2 in CPG4 and 1 in CPG5. The Clinical Risk Committee is actively looking at identification incidents to identify themes and trends to inform training and learning needs.

Medication incidents have increased by 38% from Q3 to Q4. From the 436 incidents in Q4 none resulted in either major or extreme harm, 2.5% of incidents resulted in moderate harm, 24.5% in low harm and 72.9% in no harm.

We have one Never event relating to a retained vaginal swab from October 2012. Actions relating to this incident include the introduction of swab counting boards in the maternity department.

The number of complaints formally investigated in Q4 was 212 (1.83 complaints per 1000 occupied bed days and 0.46 complaints per 100 admissions). This compares to 186 complaints in Q3. The response rate was 96%, against an internal target of 90%.

The key themes for complaints Trustwide were: All aspects of clinical treatment (55%), Attitude of staff (10%) and appointment delay/cancellation (outpatients) (9%).

Patient Safety and Service Quality Report Q4 2012/2013

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

(Data extracted as at 3rd April 2013 for incidents, 11th April 2013 for complaints and 18th April 2013 for claims. Please note that the data has been refreshed completely from the beginning of the financial year and matches with the March 2013 scorecard).

1. REGULATORY COMPLIANCE

1.1 Care Quality Commission (CQC)

1.1.1 Registration

The Trust remains 'registered without conditions' across all sites and we had no inspections in Q4.

1.1.2 Whistleblowing

Two whistle blowing alerts were received through CQC regarding the CXH site. The issues highlighted were related to cleanliness in Theatres and staffing levels in ITU.
After a thorough investigation we agreed that the theatres could have been cleaner. An extensive action plan has been put into place and reported to the Management Board. This would have impacted on the QRP and may explain a change in the risk rating for this outcome.
Staffing in ITU and a negative response to a staff member when they tried to raise their concerns was the second whistle blowing alert. We could not uphold the staffing concerns but have taken the staff comments seriously and the CPG are taking forward actions to address them. CQC have confirmed that they are satisfied with our responses but will include the relevant outcomes during their future inspections. These include as a minimum:
Outcome 8 – cleanliness and infection control
Outcome 13 – staffing
Outcome 14- supporting staff

1.1.3 Trust Leadership Walkrounds – Key Themes

Leadership Walkrounds involving a multi – professional team of Trust staff were carried out at WEH and HH with ongoing monitoring of the Renal Satellite Units during Q4. A number of themes were identified where improvements are required including:

- Ongoing estates issues
- Cleanliness of equipment and correct use of green stickers
- Blinds in clinical areas not MDA complaint (i.e. looped blinds still in patient areas)

Improvements have been seen in a number of areas as a result of the Leadership Walkround programme including, improvements to the Renal Satellite Units (still ongoing) and WEH where outpatient areas have been refurbished and theatres updated.

1.1.4 CQC Quality and Risk Profile

There were no red or amber risk ratings for the 16 overall outcomes for essential standards.
Although the Trust remains rated as being at 'low risk of compliance failure', there have been four increases in risk ratings from Q3 to Q4 as a result of the previously described issues. These are as follows:

- Outcome 1 (respecting and involving people who use the services) previously rated as **HIGH GREEN** now **LOW YELLOW**
- Outcome 4 (care and welfare of people who use the services) previously rated as **HIGH GREEN** now rated as **LOW GREEN**
- Outcome 13 (staffing) previously rated as **HIGH GREEN** now rated as **LOW YELLOW**
- Outcome 14 (supporting staff) previously rated as **LOW GREEN** now rated as **LOW YELLOW**

All other outcomes remain unchanged in terms of the QRP assessment.

2. HEADLINES

2.1 Patient safety

- The clinical incident reporting rate has increased from Q3 (6.7) to Q4 (6.9) compared to an NRLS benchmark of 6.9 incidents reported per 100 admissions across the Acute Teaching Trust Cluster (our peers).

- For Q4, major incidents remain below the national average (positive) and low harm incidents are above the national average (positive). However, it is important to note that our extreme and moderate incidents were above target (negative) and our no harm incidents were below target (negative). A programme of weekly reviews with CPGs has been introduced to improve reporting and ensure that extreme and moderate incidents are correctly classified in the first instance and investigated in a timely manner.

- Inadequate staffing incidents increased from Q3 (227) to Q4 (231) by 2%. The Trust did not meet its internal target of no more than 78 inadequate staffing incidents per quarter (target based on previous year's data and set internally). The nursing directorate are working to improve the bank fill rate and improve recruitment to nursing vacancies.

- Falls remain lower than the national average (3.8 Vs. 5.6 falls per 1000 occupied bed days –NRLS data) The falls rate has increased very slightly from Q3 (3.7) to Q4. Falls from height, bed or chair have increased by 19%.

- There have been no reported falls resulting in extreme or major harm this year. In Q4 the majority (65.9%) of falls resulted in no harm to the patient.

- Inadequate response to change in patient status (failure to rescue) incidents have increased from Q3 (21) to Q4 (25). This represents an increase of 19%. Site and CPG variations were noted with 13 incidents occurring at CXH, 1 at QCCH, 13 in CPG1, 5 in CPG2, 3 in CPG4, 2 in CPG3 and 2 in CPG5. A trust wide Failure to rescue group has been set up to drive improvement in this area with roll out of the new National Early Warning scoring system a priority.

- Patient identification incidents have increased by 89% from Q3 (9) to Q4 (17). Site and CPG variations were also noted for Q4 with 7 incidents occurring at CXH, 5 at SMH, 4 at HH, 1 at QCCH, 5 in CPG6, 3 in CPG1, 3 in CPG2, 3 in CPG3, 2 in CPG4 and 1 in CPG5. The clinical risk committee is actively looking at identification incidents to analyse themes and trends to inform training and learning needs.

- Medication incidents have increased by 38% from Q3 to Q4. From the 436 incidents in Q4 none resulted in either major or extreme harm, 2.5% of the incidents resulted in moderate harm, 24.5% in low harm and 72.9% in no harm.

- There has been a reduction in SIs. In Q4 there were 18 SIs. This compares to 20 in Q3. 84% of SIs completed investigations due back to NHSL deadline were submitted on time in Q4. The top themes for SIs Trustwide in Q4 were maternity services (7), pressure ulcer (4) and sub-optimal care of the deteriorating patient (3).

- We have one Never event relating to a retained vaginal swab from October 2012. Actions relating to this incident include the introduction of swab counting boards in the maternity department.

- 47 new claims were opened in Q4. This compares to 51 in Q3 representing a decrease of 8%.

- 22 claims were settled in Q4. This compares to 13 in Q3.

- For the NRLS 355,717 incidents were reported by NHS Organisations in Q4. This shows an increase of 4.3% compared to Q4 of 2011/12.

2.2 Clinical effectiveness

- Trust compliance with NICE guidance for Q4 is 80.5%. This is a very slight improvement on compliance levels seen in Q3.

- In Q4 99.6% of CAS alerts have been closed to deadline. This slight drop on Q3 has resulted from a batch of MDA alerts released in quick succession with short

turnaround timescales for each. These are being addressed by Clinical Engineering.

- In Q4 there was 98% reported participation in National clinical audits listed by the DH as eligible for the Quality Accounts 2012/13.

- 46.7% of priority clinical audits were completed to deadline and 66.7% of actions from priority clinical audits due for completion in Q4 have been completed. All outstanding items have been escalated to the respective CPGs for immediate action. This matter is currently being reviewed with an action plan for improvement.

2.3 Patient experience

- The number of complaints formally investigated in Q4 was 212 (1.83 complaints per 1000 occupied bed days and 0.46 complaints per 100 admissions).This compares to 186 complaints in Q3.

- The response rate was 96%, against an internal target of 90%.

- The key themes for complaints Trustwide were:

1. All aspects of clinical treatment (55%)
2. Attitude of staff (10%)
3. Appointment delay/cancellation (outpatients) (9%)

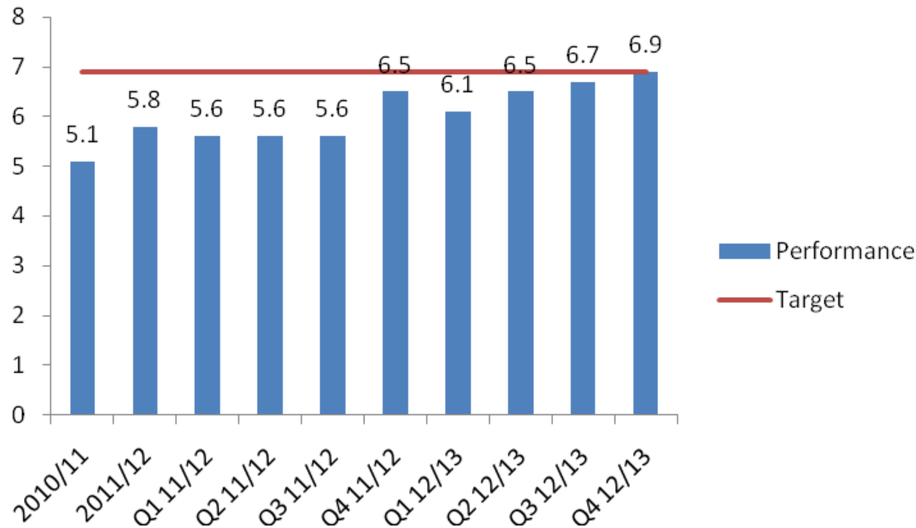
- The number of re-opened complaints was 36. Versus 31 in Q3.

2.4 NRLS: Service Quality

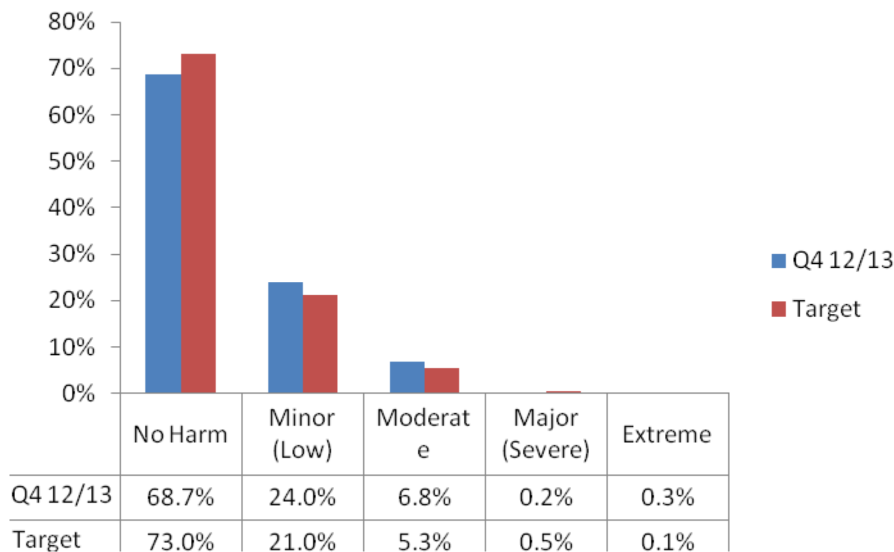
- The NRLS Team has successfully and timely performed, managed and delivered all agreed NRLS functions and outputs for the quarter against the performance schedule proposed in the Memorandum Of Understanding (MOU)

3. PERFORMANCE

Graph 1. Clinical Incident Reporting Rate against NRLS Peer Rate

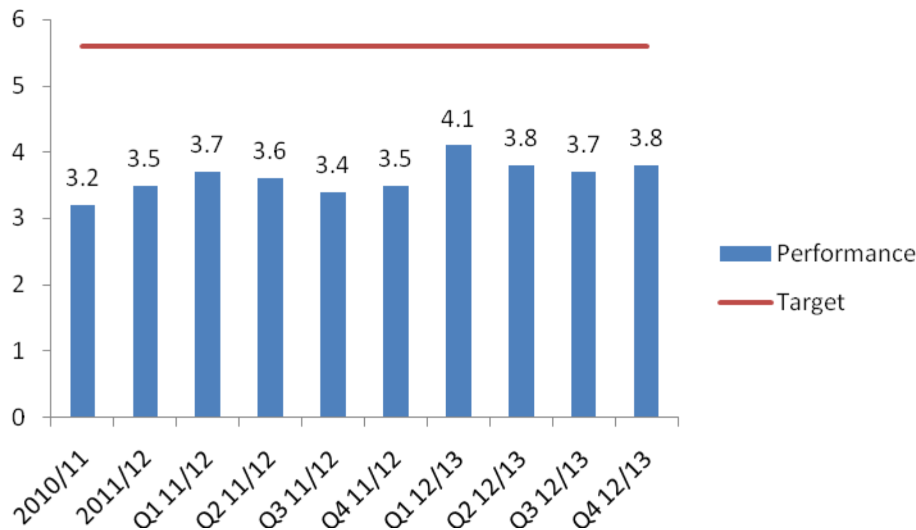


Graph 2. Clinical Incidents by Degree of Harm against NRLS Peers

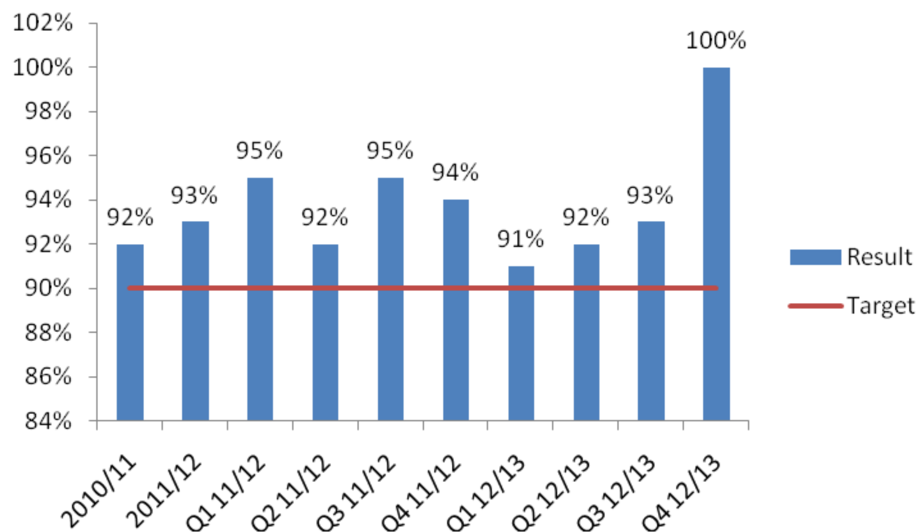


	No Harm	Minor (Low)	Moderate	Major (Severe)	Extreme
Q4 12/13	68.7%	24.0%	6.8%	0.2%	0.3%
Target	73.0%	21.0%	5.3%	0.5%	0.1%

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)

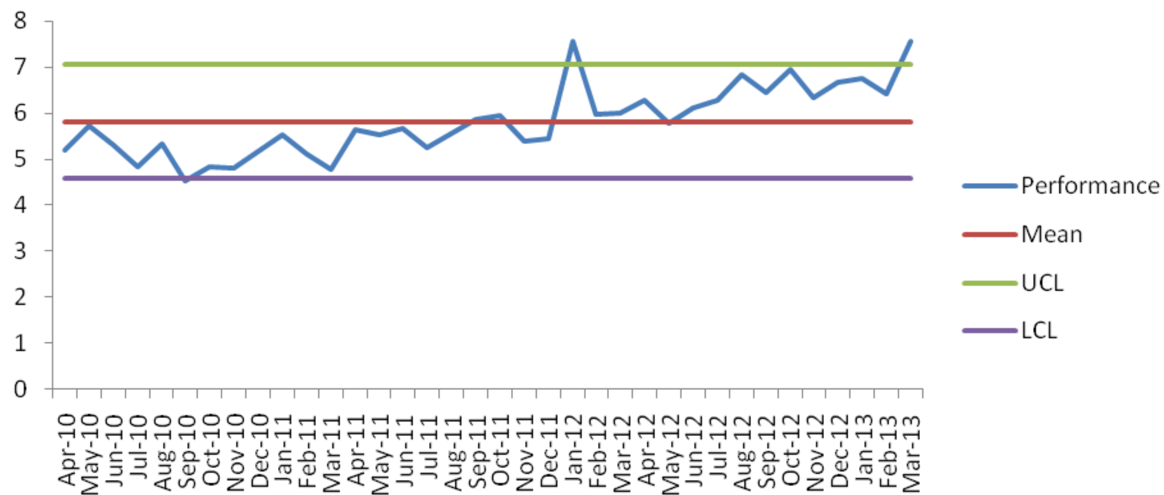
SPC charts were created for each individual indicator to look at variation over a period of 36 months (the data included for analysis is by month for 2010/11, 2011/12 and 2012/13).

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.

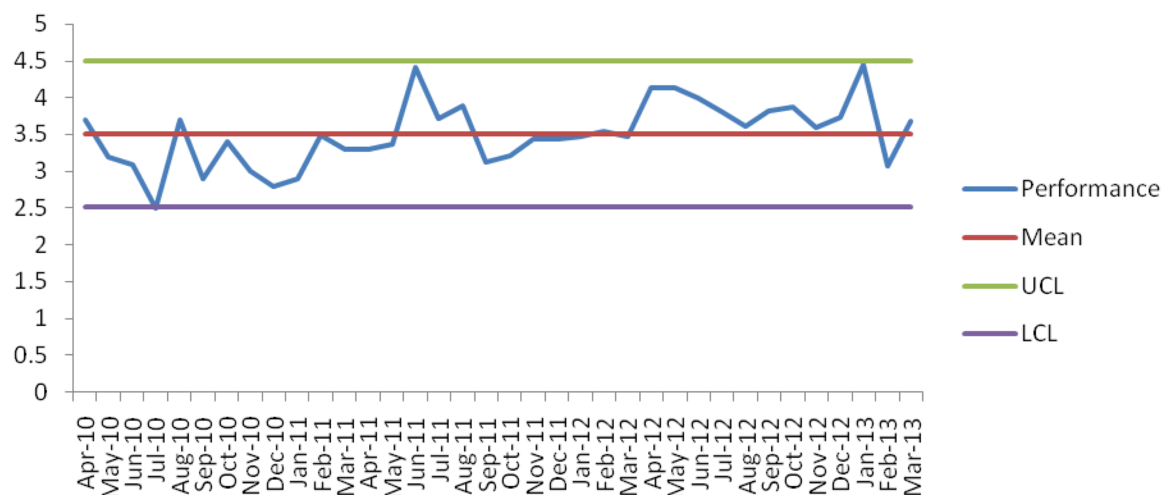
4.2 Patient safety

Graph 5. Clinical Incident Reporting Rate April 2010 – March 2013



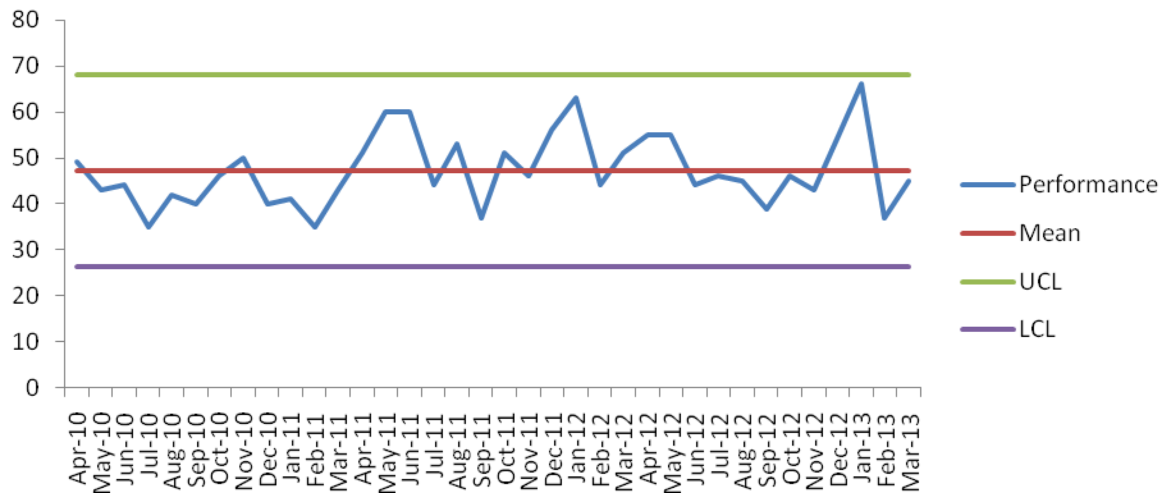
In March 2013 the incident reporting rate exceeded the upper control limit. This can be viewed as positive as it is indicative of an improved safety culture. The reporting rate has now remained above the centre line since May 2012.

Graph 6. Falls per 1000 Occupied Bed Days April 2010 – March 2013



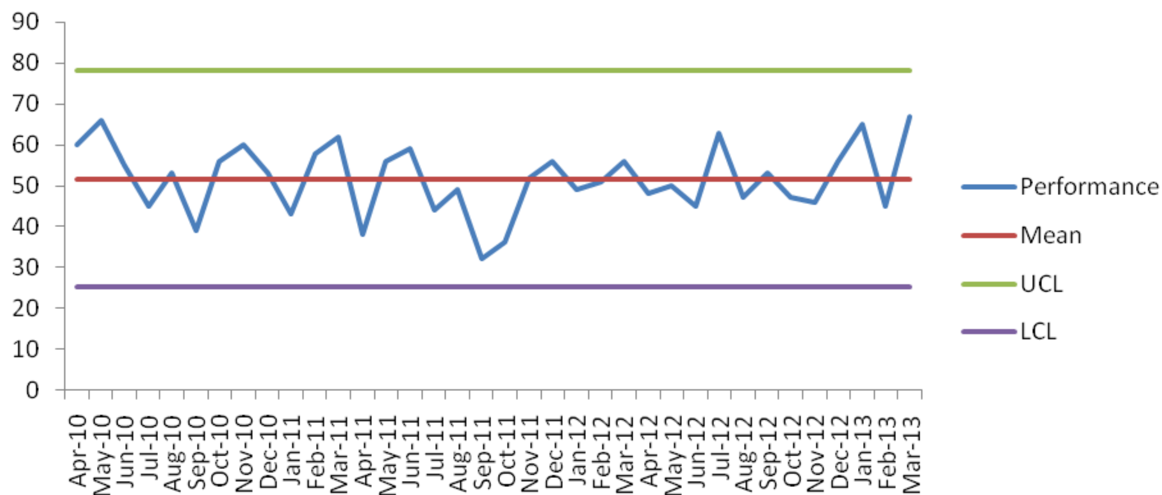
From January to February 2013 falls rate fell from the upper control limit to below the centre line. This was the first time that the indicator fell below the centre line since March 2012. However, from February to March 2013 the indicator has risen above the centre line once again. This should be monitored effectively to ensure that it does not exceed the upper control limit.

Graph 7. Falls with Harm April 2010 – March 2013



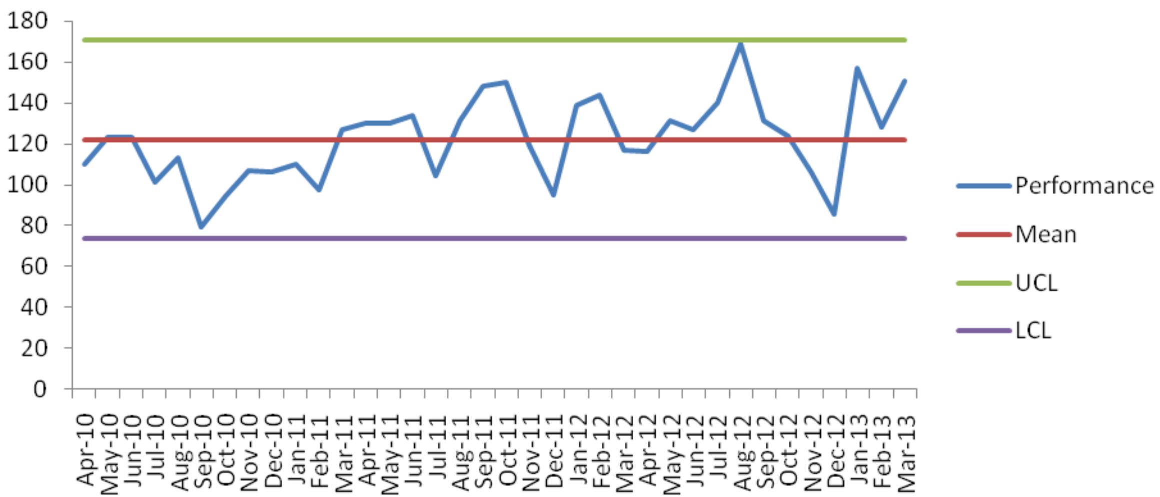
As expected, this indicator shares a similar pattern to falls rate. From January to February 2013 falls with harm fell from just below the upper control limit to below the centre line. However, from February to March we have seen a small increase. This is generally a consistent process and is currently in statistical process control.

Graph 8. Falls from Height, Bed or Chair April 2010 – March 2013



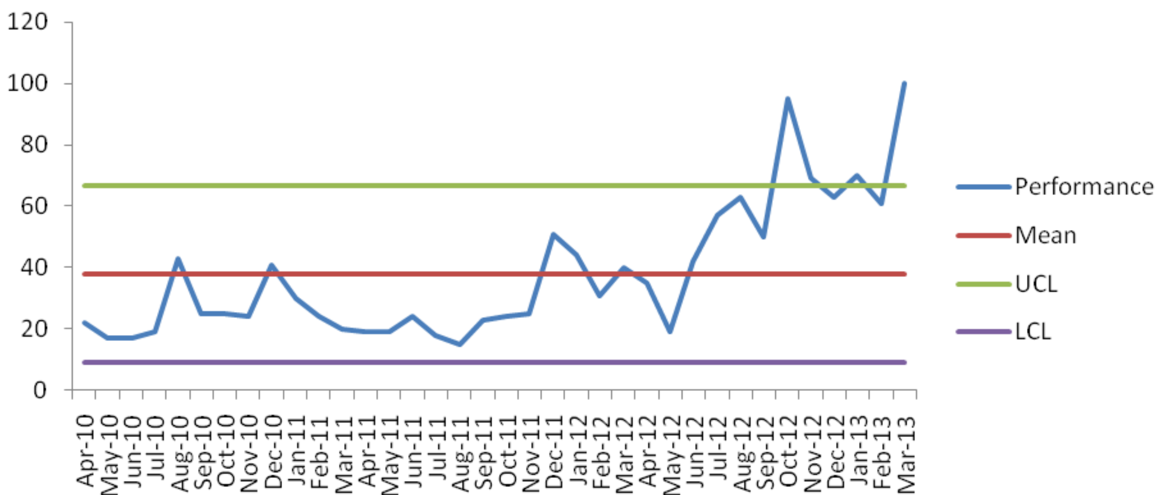
Again, from January to February 2013 this indicator moved from above to below the centre line. However, from February to March it moved back above the centre point. This is generally a consistent process and is currently in statistical process control.

Graph 9. Medication Errors April 2010 – March 2013



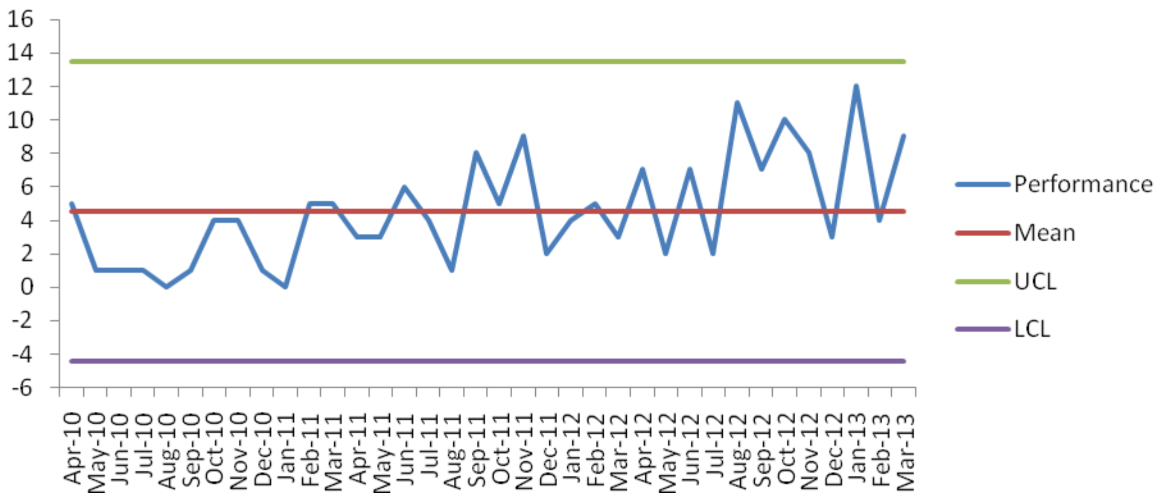
From December 2012 to January 2013 there was a large increase in medication errors moving from below to above the centre line. Throughout the remainder of Q4 this indicator has fluctuated but remained above the centre line.

Graph 10. Inadequate Staffing Incidents April 2010 – March 2013



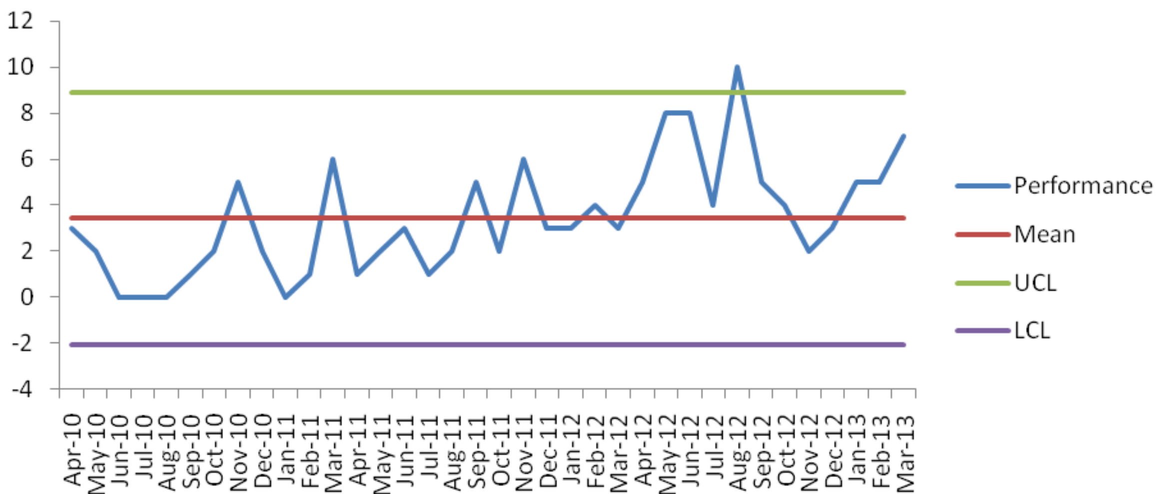
From October 2012 to March 2013 this indicator has exceeded or fallen very close to the upper control limit. In March it reached its highest point so far. This process is out of statistical control and requires attention and improvement actions.

Graph 11. Inadequate Response to Change in Patient Status Incidents April 2010 – March 2013



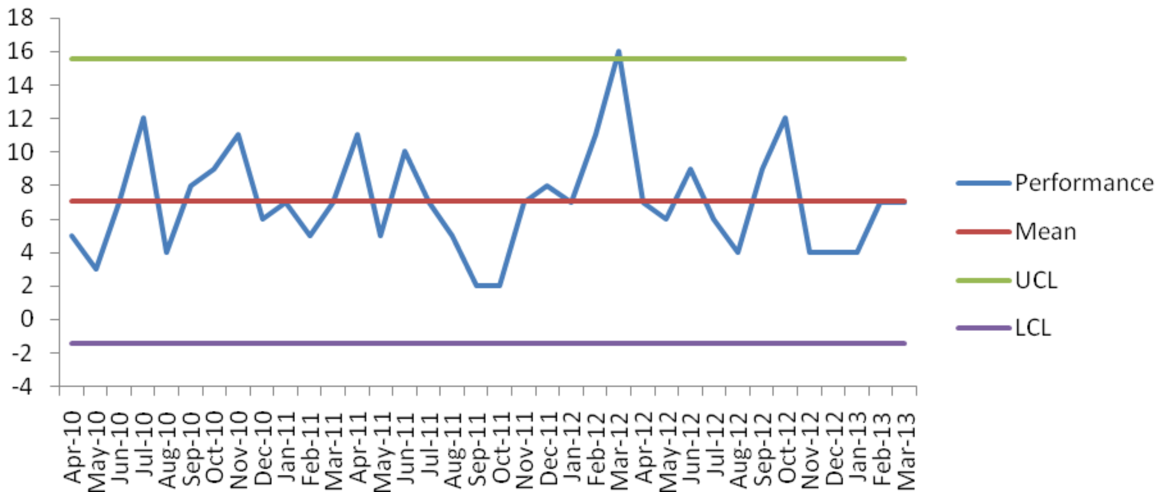
This process has generally remained above the centre line for the majority of Q3 and Q4. However, it continues to fluctuate month on month.

Graph 12. Patient Identification Incidents April 2010 – March 2013



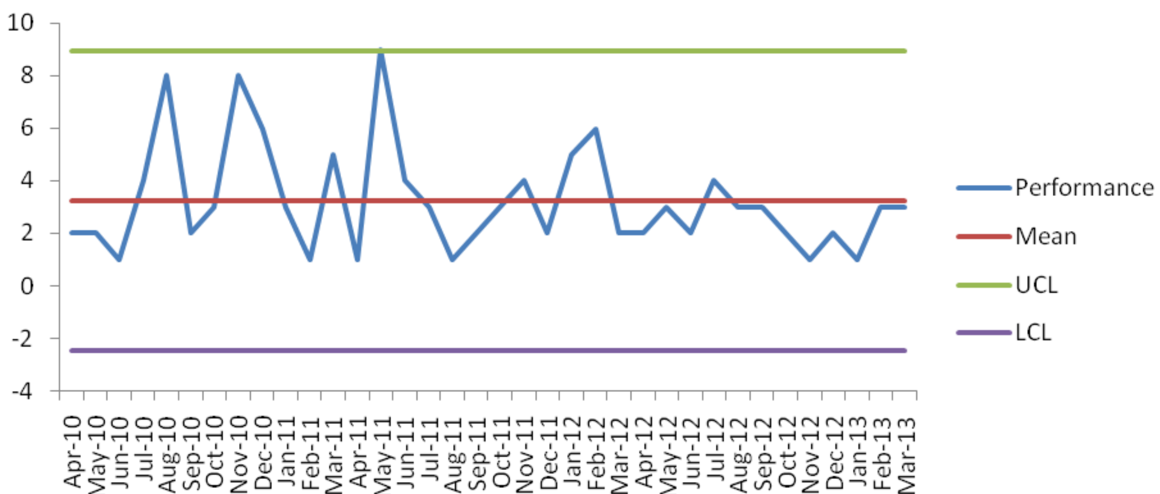
From November 2012 to March 2013 patient identification incidents have steadily increased from below to above the centre line.

Graph 13. SIs April 2010 – March 2013



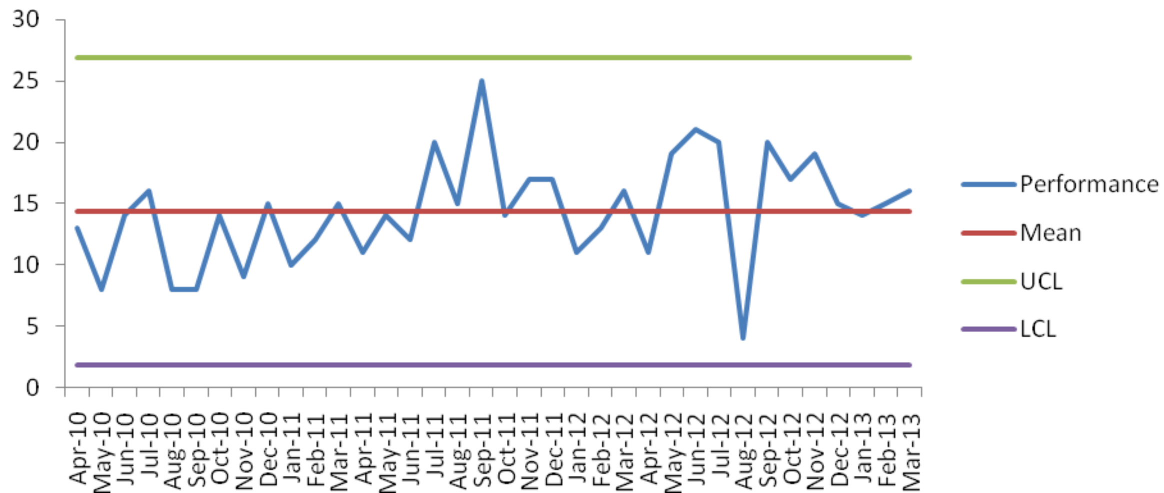
This process has remained below the centre line from November 2012 to January 2013. From January through to March, however, this process has risen to sit directly on the centre line.

Graph 14. Maternity SIs April 2010 – March 2013



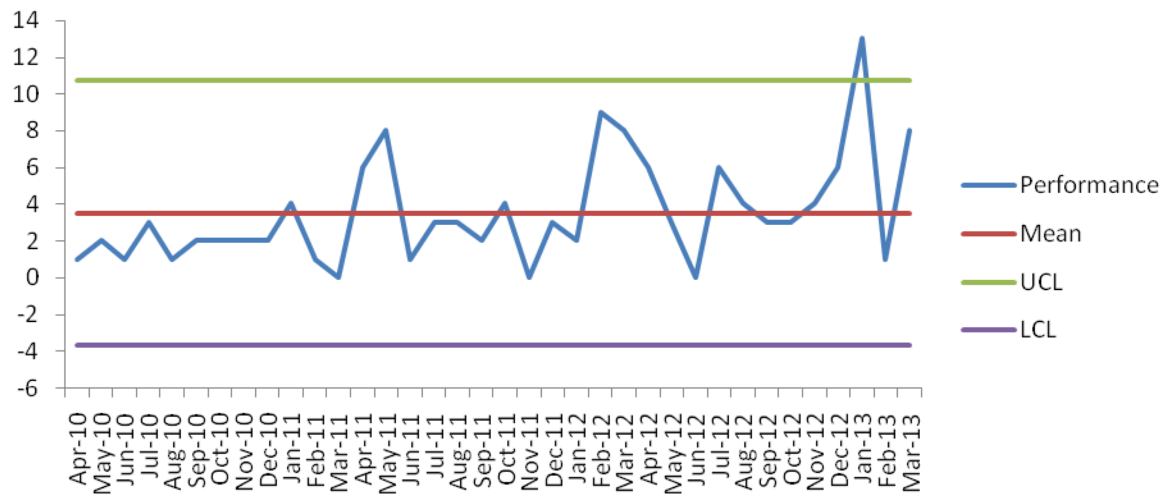
This process has been relatively consistent for the whole of the financial year. It has fallen below the centre line consistently since August 2012.

Graph 15. New Claims April 2010 – March 2013



This process has fallen on or above the centre line since September 2012.

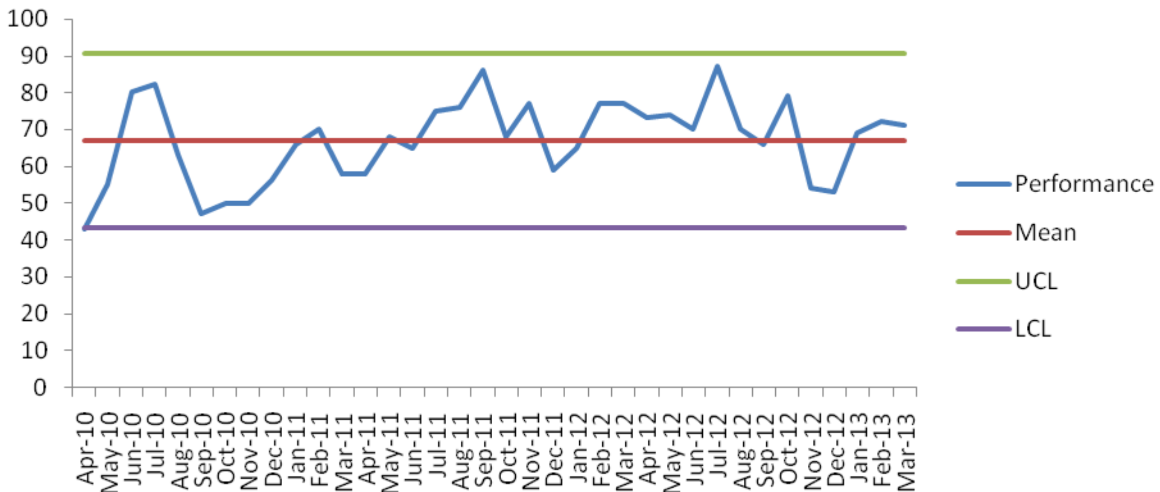
Graph 16. Settled Claims April 2010 – March 2013



The number of settled claims remains highly variable; this is due to the nature of the claims process and the length of time it takes to settle some claims depending on individual circumstances.

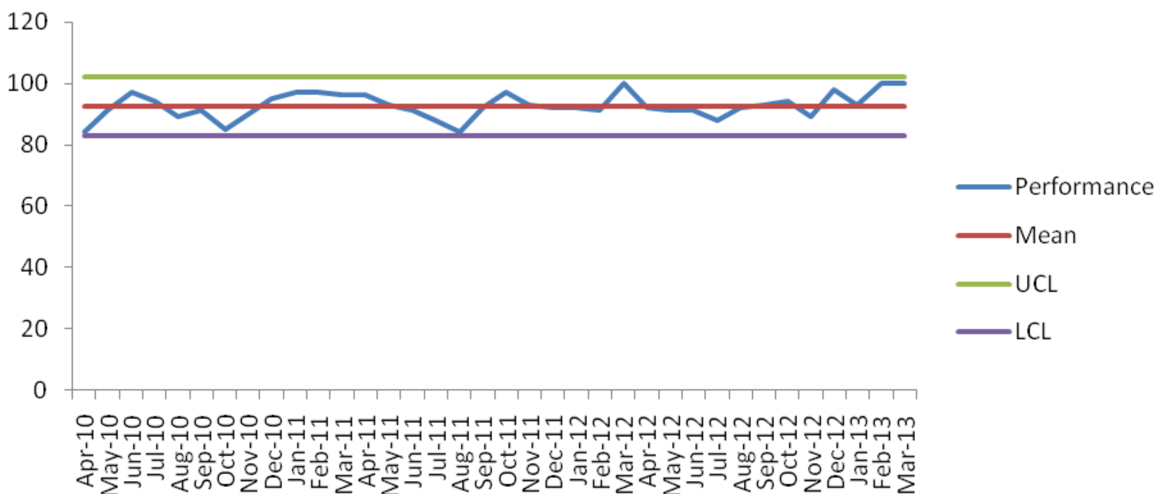
4.3 Patient experience

Graph 17. Complaints April 2010 – March 2013



This process has remained consistent throughout Q4 and falls very close to the centre line.

Graph 18. Complaints Response Time (%) April 2010 – March 2013



Complaint response time have remained consistent throughout Q4 and sits just below the upper control limit (positive).

5. DETAILED ANALYSIS OF Q4 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 Q4 is 6.9 per 100 admissions.

The incident reporting rate has increased from Q3 when it was 6.7 per 100 admissions. Further work in promoting incident reporting is ongoing through the reporting counts 'walkrounds' conducted by the Quality and Safety Team.

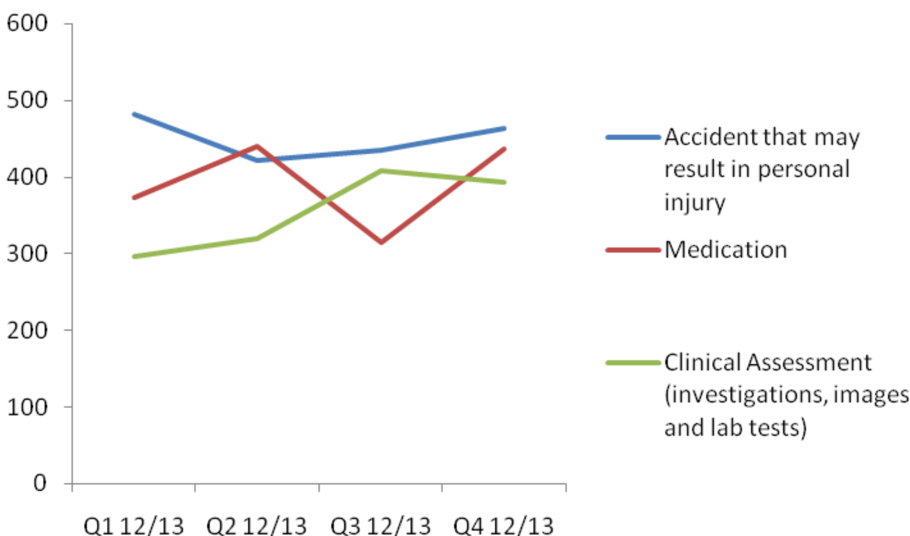
5.1.2 Severity (grade of harm) Reported Incidents

The most frequently reported category of harm for incidents remains 'no harm' at 68.7% for Q4, with minor harm reported in 24% of all incidents, moderate harm at 6.8%, major at 0.2% and extreme at 0.3%.

5.1.3 Incident Themes

In Q4 there has been a change in the top three categories of incidents reported. The top three themes for this quarter are accident that may result in personal injury, medication and clinical assessment (investigations, images and lab tests). In Q3 the top three themes were
accident that may result in personal injury, clinical assessment (investigations, images and lab tests) and access, appointment, admission, transfer, discharge.

Graph 19. Top Three Themes for Clinical Incidents



From Q3 to Q4 incidents categorised as accident that may result in personal injury and medication have increased. Across the same time period incidents categorised as clinical assessment (investigations, images and lab tests) have decreased very slightly.
Table 1. Accident that may result in personal injury top three by sub category

Sub-classification	**Q1 11/12**	**Q2 12/13**	**Q3 12/13**	**Q4 12/13**
Slips, trips, falls and collisions	93.2%	81.7%	82.8%	90.0%
Accident caused by some other means	5.4%	5.0%	5.6%	3.7%
Exposure to electricity, hazardous substance, infection etc	0.6%	0.6%	1.2%	0.8%
Total all incidents in category	16.9%	13.8%	13.8%	14.6%

It is notable that the top sub-theme within this category is consistently slips, trips, falls and collisions.

The most recent NRLS benchmarking data shows that accident that may result in personal injury is also the top theme for our peers (22%).

Table 2. Medication top three by sub-category

Sub-Classification	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Administration or supply of a medicine from a clinical area	52.9%	55.7%	53.0%	49.1%
Medication error during the prescription process	16.3%	20.5%	19.0%	21.3%
Preparation of medicines / dispensing in pharmacy	10.4%	12.7%	12.1%	11.0%
Grand Total	13.1%	14.4%	10.0%	13.8%

The most recent NRLS benchmarking data shows this category to be the third most frequently reported incident type for our peers (11.7%).

Table 3. Clinical assessment (investigations, images and lab tests) top three by sub category

Sub-Classification	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Laboratory investigations	69.3%	88.5%	85.0%	88.0%
Images for diagnosis (scan / x-ray)	12.5%	8.1%	6.9%	4.6%
Assessment - other	12.2%	3.7%	2.5%	2.8%
Grand Total	10.4%	10.5%	12.9%	12.4%

The most recent NRLS benchmarking data shows this category to be the seventh most frequently reported incident type for our peers (6.4%).

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

Site Specific Top Themes for Incidents

SMH: medication; labour or delivery; access, appointment, admission, transfer, discharge.

CXH: accident that may result in personal injury; clinical assessment (investigations, images and lab tests); medication

HH: accident that may result in personal injury; medication; clinical assessment (investigations, images and lab tests)

QCCH: labour or delivery; medication; treatment, procedure

WEH: infrastructure or resources (staffing, facilities and environment); treatment, procedure; patient information (records, documents, test results, scans)

5.1.4 Other Incident Types

Inadequate staffing reports have increased from Q3 (227) to Q4 (231) by 2%.

SMH has reported the most incidents of this type (81, 35.1%), followed by CXH (80, 34.6%). The same pattern was noted in Q3.

CPG1 reported the most incidents in relation to staffing (80, 34.6%). In Q3 CPG2 reported the most incidents of this type.

Slips, trips and falls are the most frequently occurring incident nationally (NPSA, 2011). The Trust has continued to report fewer falls compared to the national average of 5.6 falls per 1,000 occupied bed days. The Q4 rate was 3.8, compared to 3.7 falls per 1000 occupied bed days in Q3.

CPG4 had the highest falls rate of 5.5 for Q4.

In Q4 there were 177 (41%) falls from height. This compares to 149 (37%) in Q3.

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

25 failure to rescue incidents (21 with harm) were reported in Q4. There has been an increase from Q3 (21 incidents) to Q4. Of the 25 incidents, 1 (4%) was graded as extreme, 2 (8%) as major, 10 (40%) as moderate, 8 (32%) as minor and 4 (16%) with no harm to the patient.

Patient Identification:

There were 17 incidents in Q4, an increase of 89% from Q3. None of the incidents in Q4 were categorised as causing extreme or major harm to the patient. 2 incidents were categorised as causing moderate harm and 2 as causing minor harm. The remaining 13 incidents resulted in no harm to the patient.

5.1.5 Serious Incidents (SIs)

In Q4 there were 18 SIs. This is a decrease on the Q3 total of 20. The number of SIs classified under pressure ulcer have also decreased across the two quarters (from 7 to 4). However, SIs classified under maternity services have increased (from 5 to 7).

The top themes for SIs Trustwide in Q4 were maternity services (7), pressure ulcer (4) and sub-optimal care of the deteriorating patient (3).

Data is refreshed monthly, since the Q3 report 2 further SIs have been reported relating to incidents that occurred in Q3. The figure of 18 in the Q3 report has now been updated to 20.

5.1.5.1 Actions arising from investigated Sis

Of the 18 SIs that occurred in Q4 we have achieved 84% compliance with NHS London investigation deadlines.

Please see annex two for a detailed record of all SI actions from Q4.

Compliance with the being open policy in Q4 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. Zero Never Events have been reported at the Trust in 2012/13.

5.1.7 Claims

There were 47 new claims received during Q4 and 22 claims settled. Of the new claims received, 43 relate to alleged clinical negligence while the remaining four relate to personal injury.

Table 4. Top three themes for new clinical claims

	2010/11	2011/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Failure to diagnose/delay in diagnosis	16%	22%	21%	17%	17%	9%	12%
Failure to recognise complication of treatment	13%	11%	15%	11%	9%	9%	7%
Failure/delay in treatment	11%	9%	9%	8%	6%	13%	7%
Totals	118	161	45	36	35	45	43

NB Some claims have multiple themes

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

	2010/11	2011/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Slips, trips, falls and collisions	46%	48%	33%	40%	22%	17%	25%
Lifting accidents	8%	9%	17%	13%	11%	0	25%
Injury caused by physical or mental strain	4%	9%	17%	13%	0	0	25%
Totals:	24	23	6	15	9	6	4

Annex one shows improvement actions from two of the settled claims

5.1.7.1 Risk Management Reports

No risk management reports were received in Q4.
The NHSLA have recently confirmed that they have discontinued the risk management reports as of 01 April 2013. A pilot scheme has been implemented whereby the Trust's claims managers can obtain real-time access to data relating to the Trust from the NHSLA's Claims Management System. This is currently in the trial phase. The claims managers will also continue to provide the CPGs with feedback on their settled claims where required.

5.1.7.2 Report Comparing Trust Data to the NHSLA's 'Ten Years of Maternity Claims Report' (1 April 2000 – 31 March 2010)

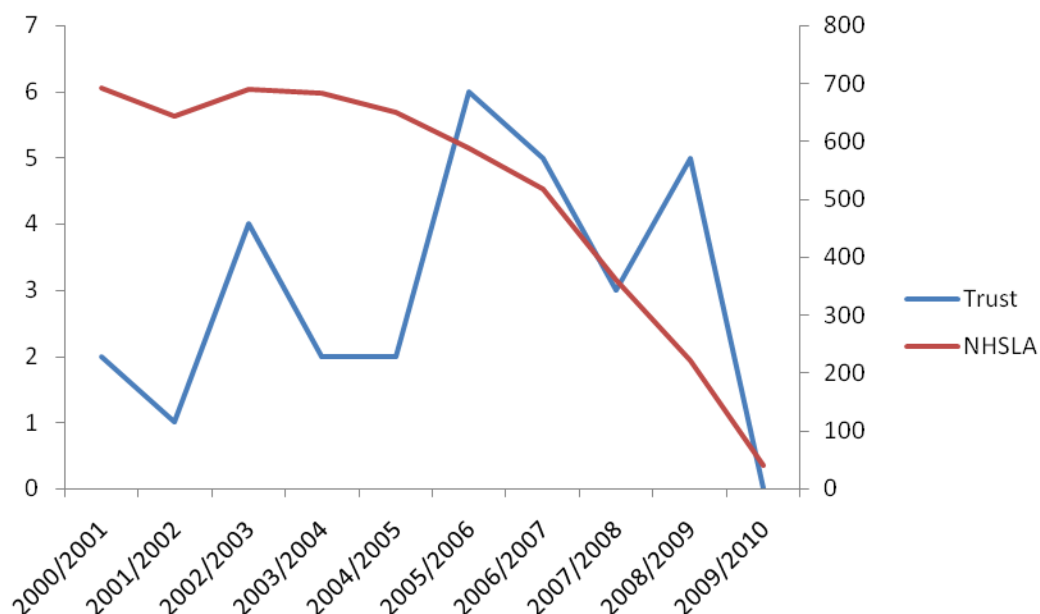
In October 2012, the NHSLA (who cover all clinical negligence claims for the NHS in England and Wales) released a detailed study of maternity claims with an incident date within a ten year period from 1 April 2000 to 31 March 2010. The report provided details on the numbers of, damages awarded as a result of, and key themes arising from, maternity clinical negligence claims. This report compares these figures to those for the Trust to determine potential themes or similarities between the two.

The NHSLA's data includes all claims notified to the NHSLA by defendant Trusts. This includes claims that were either successfully defended by the Trust and NHSLA, or were withdrawn by the Claimant. The NHSLA highlighted that approximately 37% of the total logged with them in the period (5,017) had been closed without any damages paid to the Claimant.

Number of claims received by incident date

The chart below shows the number of claims the Trust reported to the NHSLA during the period, as well as the total number of claims reported to the NHSLA by all member Trusts.

Graph 20. Number of claims received by the Trust and NHSLA



In the case of claims involving children, the Claimant should in most cases have issued Court Proceedings within three years from the child's eighteenth birthday. It is therefore likely that further maternity claims will arise with an incident date after 2005/2006. This accounts for the drop in the number of claims received by the NHSLA with a later incident date, particularly in the financial year 2009/2010 where the number of claims reported by the Trust to the NHSLA dropped to zero. During the period up to 2005/2006, there were on average 670 claims reported to the NHSLA per financial year.

The Trust's data fluctuates far more due to the smaller number of claims received with incident dates in each financial year. On average, there are three maternity related incidents per financial year that lead to clinical negligence claims against the Trust. The highest number of claims reported with an incident date in one financial year was in 2005/2006, when six claims were reported. The incident types of the six reported claims covered several different types, highlighting no theme or trend.

Damages arising from settled claims

The NHSLA's report provided the total agreed level of damages for each settled claim during the period, separated by incident type. The table below outlines these figures against the Trust's own settled claims, and the percentage of the total of agreed damages for each incident type.

Table 6. Damages agreed in settled maternity claims by incident type

Incident Type	Total Value			
	Value		% of Total Value	
	Trust	NHSLA	Trust	NHSLA
Management of Labour	£14,058,116	£424,039,651	26.87%	14.81%
CTG Interpretation	£8,769,858	£466,393,771	16.76%	16.29%
Cerebral Palsy	£7,400,000	£1,263,581,324	14.14%	44.15%

Caesarean Section	£7,163,520	£216,167,223	13.69%	7.55%
Other	£6,504,134	£40,252,783	12.43%	1.41%
Antenatal Investigations	£6,104,500	£144,811,665	11.67%	5.06%
Perineal Trauma	£1,060,657	£31,202,836	2.03%	1.09%
Shoulder Dystocia	£594,887	£103,520,832	1.14%	3.62%
Antenatal care	£384,789	£144,811,665	0.74%	5.06%
Retained Swab	£204,500	£3,021,910	0.39%	0.11%
Bladder	£48,295	£8,824,269	0.09%	0.31%
Stillbirth	£28,257	£15,712,695	0.05%	0.55%
Total	**£52,321,513**	**£2,862,340,624**		

The highest proportion of the damages agreed by the Trust, 27% of the total, related to the management of labour. In the case of the NHSLA, 44% of all damages agreed related to cerebral palsy. The top three incident types in the case of both the Trust and NHSLA related to the management of labour, CTG interpretation and cerebral palsy. These three incident types together represented 57.7% of the total damages agreed for the Trust, and 75.3% in the case of the NHSLA.

The NHSLA's report noted that efforts were made to properly place claims in an appropriate incident type; however, due to the nature of the NHSLA's claims reporting system, certain incident types were more general than others. In particular, the management of labour incident type could potentially cover many different aspects of the labour, while cerebral palsy, the incident type with the highest percentage of settled claims for the NHSLA, is not in itself a type of adverse incident, but rather an outcome arising out of an adverse incident. This may account for the large number of claims allocated to the top three incident types.

This report highlights where the Trust differs from the average of other member Trusts, which will focus our areas of improvement

5.2 Clinical effectiveness

5.2.1 NICE Guidance

Table 7. NICE Guidance Q4

	2011/12 Year end	Q1 2012/13	Q2 2012/13	Q3 2012/13	2012/13 Year end
Number of 'live' NICE guidance	750	759	776	794	817
Not applicable to ICHT	235 (31.3%)	234 (31%)	237 (31%)	244 (31%)	247 (30.2%)
Applicable to ICHT	515	525	539	550	570
Compliant	417 (81.0%)	420 (80%)	431 (80%)	439 (80%)	459 (80.5%)

Partially Compliant	33 (6.4%)	34 (7%)	34 (6%)	33 (6%)	33 (5.8%)
In progress	15 (2.9%)	16 (3%)	18 (3%)	18 (3%)	19 (3.3%)
Blanks (awaiting confirmation of compliance)	50 (9.7%)	55 (11%),	56 (10%)	60 (11%)	59 (10.4%)

NICE compliance activity has maintained the pace of new publications.

5.2.2 CAS alerts (National Safety Alerts)

There have been 960 CAS alerts issued since 2004. 99.6% of these have been closed to deadline. The four alerts overdue for closure are all Medical Devices Alerts awaiting CPG responses. All NPSA and EFA alerts have been closed.

5.2.3 Clinical audit

National Clinical Audits

The National Clinical Audit Programme is administered by HQIP and the DH and is included as an indicator in the Quality Accounts. As at Q3, assurance has been received from the CPGs that the Trust is participating in 47 out of the 48 audits for which the Trust is eligible (98%). The project for which assurance continues to be sought is the National Pain Database. Representations have been made to the National Pain Database organisers (Dr Foster) and a response is awaited from them.

Trust Priority Clinical Audits

The 2012/13 CPG Priority Clinical Audit Programme has commenced. Each project was been given an anticipated date of completion by the respective CPG and as at Q4, 46.7% of priority clinical audits have been completed to deadline This is currently being reviewed to formulate an action plan addressing the shortfalls. Recommendations are monitored for implementation status following audit completion. As at Q4, 66.7% of actions from priority clinical audits due for completion in Q4 have been recorded as being completed. All overdue items have been escalated to the respective CPGs for immediate action. The principle causes are over-ambitious target deadlines being set and unforeseen delays in completion of projects due to competing priorities.

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 149 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 11 April 2013. A total of 258 formal complaints were received in Q4. 212 were formally investigated and 46 low risk grade cases were investigated by PALS. The numbers of formal complaints managed by the Complaints Department in Q4 increased by 14% when compared to Q3 (186 formal complaints). Q3 saw a particularly low amount of new complaints and Q4 is more in line with what we have seen over the rest of the year. Formal complaints have reduced slightly this year when compared to last year by 2.9%.

5.3.1.1 Number of complaints per CPG

The increase in the number of formally investigated complaints reflected an increase in complaints for CPG1 (up 16%), CPG2 (up 12%) and CPG3 (up 64%) and CPG6 (up 57%). Both CPG4 and CPG5 saw reductions in their volume of formal complaints whilst 'others' increased by 18% in Q4. CPG3 saw the largest percentage increase, however, it must be remembered that Q3 saw a reduction in CPG3 complaints of 62%.

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 Q4 96% of all formal complaint responses were completed within the agreed timescale. This compares to 93% in Q3.

5.3.1.3 Top Themes

The top three themes for Q4 were all aspects of clinical treatment (55%), appointments, delays/cancellation (outpatients) (9%) and Attitude of staff (10%), which replaced Communication / Information to patients for the first time this year. As this is the first quarter that staff attitude has become a theme we have not altered the trend tables below to reflect this.

Table 8. Top three themes complaints

Theme	2010/11	2011/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
All aspects of clinical care	46%	46%	38%	57%	43%	51%	57%	55%
Communication / Information to patients	5%	12%	20%	19%	24%	17%	8%	8%
Appointments, delays / cancellation (outpatients)	16%	12%	8%	10%	19%	8%	7%	9%

Table 9. 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 (10)	Poor Nursing Care (6)	Ineffective treatment (4)
CPG2	Poor Clinical Care (11)	Poor Nursing Care (3)	Misdiagnosis (3)
CPG3	Poor Clinical Care (8)	Misdiagnosis (4)	Poor Nursing Care (3)
CPG4	Poor Clinical Care (4)	Poor Nursing Care (3)	Ineffective treatment (4)
CPG5	Poor Clinical Care (8)	Poor Nursing Care (4)	Lack of treatment (3)
CPG6	Results not available (1)	Inadequate Pain Relief (1)	Lack of treatment (1)

Table 10. 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 (16)	Poor Nursing Care (9)	Ineffective treatment (2)
Hammersmith	Poor Clinical Care (6)	Poor Nursing Care (4)	Incorrect Drugs Given (3)
Queen Charlotte	Poor Nursing Care (2)	Poor Clinical Care (2)	Lack of Treatment (1)
Satellite	Poor Clinical Care (1)	Scientific / Technical & Professional (1)	N/A (0)
St Mary's	Poor Clinical Care (15)	Poor Nursing Care (6)	Lack of Treatment (5)
Western Eye	Misdiagnosis (2)	Poor Clinical Care (1)	Consent re procedure (1)

Table 11. Communication/information to patients top three sub-categories

Sub-Category	Q4
Incorrect information given to patient	25%
Other information	25%
Information not given to patient	19%

Table 12. Appointments, delays/cancellation (outpatients) top three sub-categories

Sub-Category	Q4
Delay in follow up appointment	44%
Delay in first appointment	22%
Wait	17%

5.3.1.4 Severe Complaints

There were four high risk grade complaints in Q4:

CPG4 Alleged bowel perforation (currently under investigation)
CPG3 Failure to review patient (currently being investigated as an SI)
CPG1 Misdiagnosed aortic dissection (currently being investigated as an SI)
CPG1 Alleged poor clinical and nursing care (Please note following the complaints investigation this complaint has been downgraded to medium risk)

5.3.1.5 Second Stage Reviews

Complainants can request 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 Q4 for CPG5 regarding our decision not to continue with treatment.

5.3.1.6 Inquests

In Q4 there were no inquests which produced significant learning for the Trust.

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 top themes for incidents and complaints have not changed from those identified in Q3. For new claims the top theme has changed from failure/delay in treatment to failure to recognise complication of treatment and for settled claims the top theme has changed from failure of follow up arrangements to failure to diagnose/delay in diagnosis.
Incidents top themes vary slightly from Q3 to Q4. CPG3 has changed from treatment, procedure to medication, SMH has changed from access, appointment, admission, transfer, discharge to medication and WEH has changed from access, appointment, admission, transfer, discharge to infrastructure or resources (staffing, facilities, environment). All other sites and CPGs have remained the same over the two quarters.
Complaints top themes are entirely consistent with the results for Q3. At every level of analysis all aspects of clinical treatment was the top theme.
New Claims top theme The top theme across the Trust was a failure to recognise a complication of treatment with five new claims received. CPG1 received three new claims relating to an alleged failure to diagnose/delay in diagnosis.
Settled Claims top theme A significant percentage of claims settled in Q4 involved a failure to diagnose/delay in diagnosis and failure to provide informed consent across the Trust. The numbers for these themes were cumulative across the different sites and CPGs. No single site or CPG had a high number of claims settled in this period.
Improvement actions are to be agreed at the Clinical Risk Committee. The full risk profile can be found in annex three.

7. QUALITY ACCOUNTS

Annex four presents the Trust Quality Accounts scorecard. The Q4 scorecard contains performance against all agreed targets excluding those where the data is annual or bi annual.
In Q4 a number of priorities are on or above target including VTE, falls, C-difficile rates, MRSA rates, pressure ulcers and incidents graded as major and extreme.
There are a number of priorities which are not meeting targets.
Indicator 1: The Trust is above its quarterly and annual target for the total number of failure to rescue incidents. At present our annual target was <52 and we are currently at 82. This may continue to rise at present due to the focused work that is ongoing but it is anticipated to improve practice and reduce these incidents in the longer term.
Indicator 2: The Trust has not met its target to reduce delays in outpatients by year end. A number of initiatives are being introduced including reviewing capacity issues in OPD and piloting new ways of delivering routine information to patients other than having to attend an outpatients appointment. This includes using technology such as telecommunications and email to deliver routine results.

Indicator 3: The Trust has not met its target of being 75% compliant with specific aspects of the Discharge Policy. There have however been improvements in this indicator since last year, with the 88% of patients now having an anticipated date of discharge.
The PROMs data is not complete for Q4 yet as March data has not yet been uploaded. It is anticipated that we will meet this target.
The Annual Quality Accounts Report is currently being collated with the inclusion of three new quality indicators for 2013/14. These are:

- Dementia CQUIN
- Caring & Compassionate staff
- Family & Friends Test

8. NRLS SERVICE QUALITY REPORT

From April 2012 The Trust took over the operational management of the NRLS for a two year period. The NRLS team is based within the Governance department.
The following reflects NRLS Team's performance during the period between 01/01/2013 and 31/03/2013 against agreed performance targets with the NHS England.

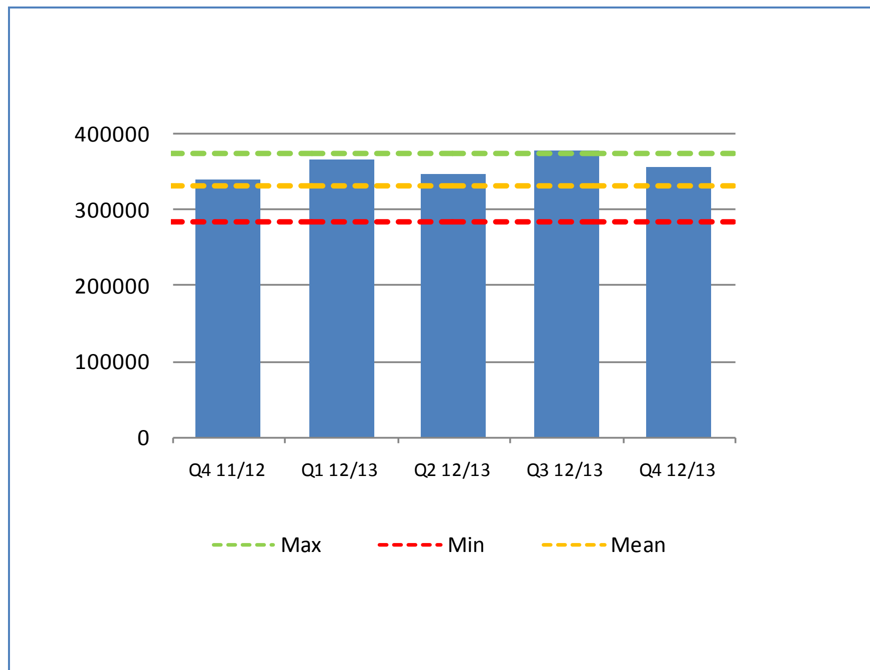
8.1 Key Updates

- During Q4 of 2012/13 NHS organisations reported 355,717 incidents to the NRLS; It is an increase of 4.3% above 2011/12 Q4;
- 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)
- Enhancing flexibility and promoting use of NRLS data: Organisation Patient Safety Reports Explorer Tool – Launched in March 2013.
- Informing to support improvement: Monthly Organisation Provisional Data – new version launched in March 2013.

8.2 National Incident Reporting

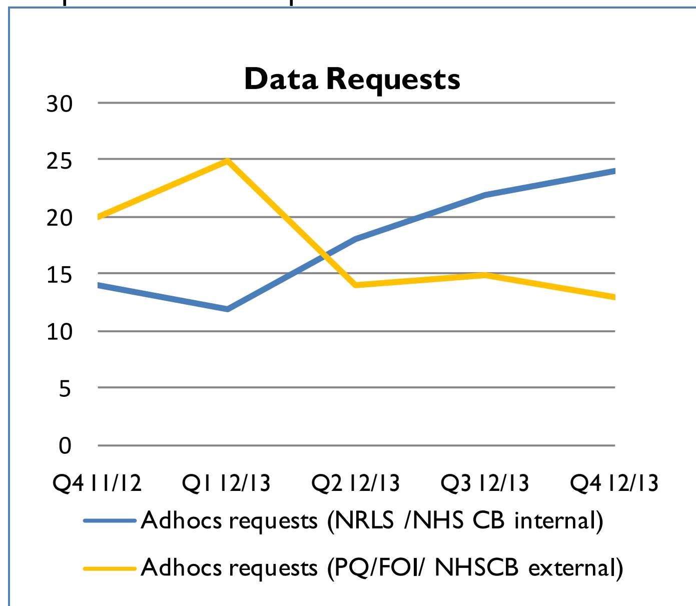
During Q4 of 2012/13 NHS Organisations reported 355,717 incidents to the NRLS. This shows an increase of 4.3% compared to Q4 of 2011/12, and a decrease of 5.9% compared to Q3 of 2012/13.

Graph 21. NRLS Incident Reporting Levels



8.3 Delivery against Agreement

Graph 22. Data Requests



All NRLS outputs agreed on the MOU were delivered on time and to expected quality. The number of ad hoc requests has fluctuated within the capacity predicted in the MOU. Since Q1 of 2012/13 the number of FOIs remains around 5 per quarter.

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

Example improvement actions from reported incidents linked to top three themes

Accident that may result in personal injury

- To identify if the right equipment is available for staff to use to assist with correct manual handling techniques.
- Falls screen done on readmission from CXH and reviewed after fall. Some documentation a little unclear. Highlighted at ward meeting.
- Extensive and continued use of behavioural charts
- Auditing of risk assessments and care plans (ongoing in certain areas)
- Physio-led exercise classes on the 8th Floor (8 West ChX)

Medication

A monthly Medication Safety Monitoring Audit has been implemented, where two or three wards are assessed each month by the Associate Director of Nursing, Patient Safety and Lead Pharmacist, Clinical Services. This audit focuses on a range of medication safety related issues, such as security of medication, availability of oral syringes, VTE risk assessments as well as evidence of pharmacy endorsements on all prescriptions on a drug chart.

Work has continued focusing on ensuring that medication stored on wards and clinics is kept secure. This work has led to an improvement in the number of wards and clinics which are secure, with the December 2012 Audit of Security and Safety of Ward and Clinic Drug Stocks showing that 99% of all areas were secure.

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 confusion regarding the term 'near miss' in relation to medication incidents, a number of other Trusts were contacted to find out if they had a definition for near miss, which they did not. The latest Organisation Patient Safety Incident Report (March 2013) was reviewed, which shows that 89.4% incidents reported in this Trust are graded as causing no harm, compared to 74% for all acute teaching organisations, which indicates that near misses are being reported throughout the Trust.

To prevent missed doses after haemodialysis, guidelines for medicines administration of hospitalised haemodialysis patients have been produced, which details the preferred administration for a range of medication.

In response to chemotherapy delays where nursing staff have not been administering the shortest expiry of a drug first, pharmacy have implemented a number of changes such as the use of coloured labels and putting chemotherapy in separate boxes labelled with the correct date.

Following a previous incident with potassium permanganate soaks, further actions that have been implemented are the wording on the label produced by pharmacy have been amended and patients are now given a British Association of Dermatology patient information leaflet when supplied with this medication. These patient

information leaflets are in full colour and contain pictures to aid patient understanding.

Other actions that have been implemented include an automatic warning has been added to the pharmacy labelling system highlighting that a certain brand of cholecalciferol contains peanut oil; the Trust IV guide has been added to the quick links on the intranet to help staff easily find this information; and the medication that can be stored in bedside lockers has been amended to aid the administration of medication and maximise the use of patient bedside lockers.

Work that is currently on-going includes reviewing the barriers to self-administration on wards, adding an alert onto the EDC system so that when a drug on the North West London Red List is prescribed, this is highlighted to the prescriber and reviewing the storage of IV fluids on wards throughout the Trust.

Clinical Assessment (investigations, images and lab tests)

- The referral of samples from Special haematology at SMH to the HH has been discussed and a new SOP activated December 2012.
- The current lack of commonality in hospital numbers across the Trust can lead to issues with acceptance of samples. This should be addressed after the implementation of Cerner PAS in July 2013.
- Ensure all new staff aware how to transport all specimens safely to the correct labs.
- There has been a full review and restructure of the clinic 8 area at CXH and the staff are all undergoing training. The way bloods are taken has been changed with request etc coming only from the clinicians. All phlebotomists have had an update in training and there is much more collaborative working with CPG 6 to review and laboratory investigation incidents with both CPG investigating and completing the datix.
- Double bagging of samples in certain areas
- Where samples are received at ChX for process at Chelsea and Westminster, there is a new protocol in place
- Audit of pod times and purchase of coloured pods
- Sample checking and labelling in front of patient
- Use of red labels and highlighting to make additional lab requests more noticeable.

Example improvement actions from complaints linked to top three themes

All Aspects of Clinical Care

- CPG4 has reviewed how consultant cover is organised to help ensure their procedures do not allow for operations to be cancelled due to holiday requests. In rare cases where cover cannot be provided patients will be informed as soon as possible
- Nursing staff on wards 11 South and 6 North have been reminded of the importance of undertaking a complete and through hand over. Patient transfer and falls documentation is now in place to ensure falls are discussed when a patient is transferred between areas
- The nursing team on & North Ward will attend pain study sessions to help improve their pain management skills. Nurses have also been reminded of the importance of responding to call bells in a timely fashion

- The Clinical Haematology Department have now reviewed their procedures for booking blood tests for patients who have not had a medical review to ensure the phlebotomist has the appropriate information to hand before the patient attends their appointment
- A weekly family stroke consultant liaison session has now been introduced so that families can raise concerns and obtain advice
- CPG2 oncology consultants now ensure x-rays are reviewed on the patients return to the ward
- The Imaging Department and the oncology teams will review the patient sedation / general anaesthesia pathway
- The appropriate staff have been reminded how the BCG vaccination should be given
- The process of reviewing radiology reports in A&E has occurred to ensure they are reviewed daily
- The Urology Clinic has reminded their staff that even when clinics are fully booked and an appointment cannot be made due to the clinical demand and lack of capacity, this must be escalated to the management team to see what further options may be available. This can include arranging an out of hours or weekend clinic and overbooking clinics to ensure patients are appropriately seen
- Midwives have been reminded to ensure that women either in a delivery room or in the Recovery Area are given and shown how to use the call bell
- Nursing staff on Peters Ward have been reminded that they must ensure all bed bound patients are checked hourly and of the importance of keeping property with the patient at all times, but especially before and after renal dialysis
- In future if Western Eye Hospital is contacted about a patient's referral not being received by their GP it will be faxed immediately to the appropriate practice and followed up with a telephone call to confirm safe receipt.

Communication/Information to Patients

- Admission lounge staff have been reminded to regularly update patients on the progress of the operating list. All updates are now recorded in a log so that it can be reviewed to ensure updates are provided
- Midwives have been reminded of the importance of checking the spelling of a patients name on forms / documentation. This issue has also been highlighted with the maternity clinical team via the staff newsletter
- The Endoscopy Department have reviewed how general instructions for patients are made available and are in the course of making them available on the Trust's website
- The electronic prescription template will be updated to include an area that reflects verbal intrusions given to patients by their clinician
- Individual and group sessions have occurred with clinicians so that they can reflect how their communication and interaction with patients are perceived
- We have invited a local school to contact us so that our clinicians can assist with the medical management of one of their pupils
- A notice board will be displayed informing patients about the details of staff members working regularly in the outpatient unit

Attitude of staff

- A nurse told a patient to urine in her bed. This matter has been handled appropriately to ensure this does not happen again. Additionally, the importance of treating patients with dignity and respect has been discussed and reiterated with the whole nursing ward team
- A senior midwife will be discussing with her team how poor attitude and lack of thought of some of her staff has marred a patient's whole experience of her care. The importance of clear and polite communication with women at all times will be highlighted
- The member of the catering team concerned has had appropriate disciplinary sanctions made against them and will continue to be monitored with regard to their performance and appropriate training provided where necessary
- A&E Minors reception staff will be annually reviewed against their customer care standards to help improve their customer care skills

Two settled claims had improvement actions in Q4:

- Consider protocols or in-house training to remind staff of the importance of documenting all manoeuvres and how they are performed, and the reason and type of traction used.
- Consider reminding staff of ambiguous phrases in medical records, by providing examples of phrases could be misconstrued.

Actions from completed SIs

STEIS ID	CPG	Site	Quarter	Description	Action	Lead	Deadline	Progress
2012_15394	3	SMH	Q1	Hypoxic Brain Injury post arrest during surgery	Feedback the events and learning of this case to anaesthetic and intensive care departments	CoS, Anaesthetics	31st October 2012	Complete
2012_15394	3	SMH	Q1	Hypoxic Brain Injury post arrest during surgery	All central lines(whether placed with ultrasound guidance or using landmark techniques) to be confirmed by blood gas analysis and/or transduction	CoS, Anaesthetics	31st October 2012	Complete
2012_15394	3	SMH	Q1	Hypoxic Brain Injury post arrest during surgery	Review induction of temporary staff in theatres	Lead Nurse, theatres	31st October 2012	Complete
2012_15394	3	SMH	Q1	Hypoxic Brain Injury post arrest during surgery	Confirm follow up of patient with GP	Medical Director	31st October 2012	Complete
2012_15394	3	SMH	Q1	Hypoxic Brain Injury post arrest during surgery	Ensure that the national standard “Checking Anaesthetic Equipment – 2012” by the AAGBI is used in all anaesthetic areas	CoS, Anaesthetics, Lead Nurse, theatres	31st October 2012	Complete
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Formal quorate MDT to be implemented for this group of patients	Chief of Service	Complete	Complete
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Local training regarding standards of nursing documentation	Head of Education CPG4	28th February 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Review documentation standards training for medical staff, including SpR and consultant refresher training	Director of Medical Education	31st March 2013	Outstanding

2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Implement National Early Warning charts and process across the Trust	Critical Care Outreach Team	31st July 2013	Within timeframe
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	To develop guidance on the management of patients undergoing deep venous bypass to be included in the junior doctors handbook	Vascular Consultant 1	31st March 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Review staffing requirements for HDU	General Manager and Head of Nursing CPG4	28th February 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Review and standardise the HDU chart across the surgical areas at SMH	Critical Care Outreach Team	30th September 2013	Within timeframe
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Develop a standardised protocol for the management and review of patients in HDU, to include daily consultant review	Chief of Service and Head of Nursing	28th February 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Include use of inotropes in the junior doctors handbook	Rick Gibbs	1st April 2013	Within timeframe
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Outcomes and benefits of the procedure to be audited and feedback to MDTs	Vascular Consultant 1	31st March 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Ensure central monitoring is available in HDU	General Manager and Head of Nursing CPG4	31st March 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure	Relaunch the policy for management of IV heparin	Lead pharmacist	31st January 2013	Outstanding

				to recongnise and escalate				
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Include adherence to heparin policy in annual audit cycle	Quality and Safety Coordinator CPG6	1st April 2013	Within timeframe
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Review vascular IV heparin protocol	Vascular Consultants	31st March 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Review this case and other SI cases at March CPG4 M&M and audit meeting	CPGD 4	31st March 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Feedback the learning from this case to CPGDs to highlight the issues relating to consent and documentation	Medical Director	31st January 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Request that all CPGs review SI reports and learning at a local forum quarterly	Medical Director	31st January 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Discuss the outcome of the investigation with vascular consultant 1	CPGD 4	28th February 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Review handover documentation in theatres, and ensure training	HON CPG3	28th February 2013	Outstanding
2012_29229	4	SMH	Q2	Patient deteriorated post surgery. Failure to recongnise and escalate	Local training for nursing staff to ensure that the name of the ward is written in the notes on admission and transfer	HON CPG4	31st March 2013	Outstanding

2013_809	3	SMH	Q2	Trust grade 3	Daily Nursing Ward Rounds emcompaasing nursing documentation and pressure areas being one of the topics.	Ward manger	30th September 2012	Complete
2013_809	3	SMH	Q2	Trust grade 3	All patients with a high risk of develping a pressure sore are placed on a pressure relieving mattress and turning chart where appropriate.	Ward manger	30th September 2012	Complete
2013_809	3	SMH	Q2	Trust grade 3	Refresher Training for all members of staff on Valentine Ellis regarding pressure area care.	Ward manger	30th September 2012	Complete
2012_12960	5	SMH	Q3	Child death, transfer from WMUH with endocarditis	Development of an SOP for tertiary referral patients to include: • All patients need baseline bloods on admission • All patients are to be reviewed by a Consutlant paediatrician within 12 hours of admission • All patients cared for by nursing staff with the appropriate level of experience for the first 48 hours of their admission	Chief of Service, Paediatrics	28th February 2013	Outstanding
2012_12960	5	SMH	Q3	Child death, transfer from WMUH with endocarditis	Communicate to Paediatric consultants that patients with acute complex cardiac problems are generally not to be accepted for admission.	Chief of Service, Paediatrics	28th February 2013	Outstanding
2012_12960	5	SMH	Q3	Child death, transfer from WMUH with endocarditis	Introduce training on observations and identifying abnormal readings	Head of Nursing, Paediatrics	28th February 2013	Outstanding
2012_12960	5	SMH	Q3	Child death, transfer from WMUH with endocarditis	Introduce training on escalating an abnormal observation	Head of Nursing, Paediatrics	28th February 2013	Outstanding
2012_12960	5	SMH	Q3	Child death, transfer from WMUH with endocarditis	Implement a new Paediatric Early Warning Score trigger chart	Head of Nursing, Paediatrics	1st March 2013	Outstanding

2012_12960	5	SMH	Q3	Child death, transfer from WMUH with endocarditis	Nurse-in-charge quality round weekly sheets to be completed by the ward managers, ward managers to wear the red nurse-in-charge badge.	Head of Nursing, Paediatrics	28th February 2013	Outstanding
2012_12960	5	SMH	Q3	Child death, transfer from WMUH with endocarditis	Reinforce the twice daily consultant led ward round with the clinical team caring for the patient	Chief of Service, Paediatrics	28th February 2013	Outstanding
2012_26847	5	QCH	Q3	Maternal death	No actions	No actions	No Actions	No actions
2012_30235	1	SMH	Q3	3 patients waited >1hour	Ambulatory Care Pathways – The Trust is proceeding to completion of a business case for an ambulatory care service across all three sites.	Ambulatory Care Operational and clinical group	31st May 2013	Within timeframe
2012_30235	1	SMH	Q3	3 patients waited >1hour	Local escalation policies to be re-circulated and staff to confirm they have read the policy.	Service Manager/ Senior Nurse	31st January 2013	Outstanding
2012_30235	1	SMH	Q3	3 patients waited >1hour	Care management system compliance and use to be an agenda item on department meetings.	Service Manager/Lead Clinician	28th February 2013	Outstanding
2012_30235	1	SMH	Q3	3 patients waited >1hour	Use of the hospital alert system to plan for forthcoming arrivals to be discussed at next department meeting.	Service Manager/lead Clinician	28th February 2013	Outstanding
2012_30235	1	SMH	Q3	3 patients waited >1hour	Reinforce A&E Nurse in Charge attends 22.00 site call to update on activity/acuity in the department.	Service Manager/ Senior Nurse	31st January 2013	Outstanding
2012_30235	1	SMH	Q3	3 patients waited >1hour	Implement new staffing structure that matches nursing numbers to activity.	General Manager	Complete	Complete
2012_30235	1	SMH	Q3	3 patients waited >1hour	Establish LAS and Emergency Department working group.	Service Manager	28th February 2013	Outstanding
2012_32887	4	SMH	Q3	Trust grade 3	Continue on-going notes audit to ensure all pressure ulcer, assessments re-assessments, and maintenance of support documentation are carried out per trust policy and as part of the improvement plan.	Lead Nurse/ Band 6 Senior Staff Nurse	1st April 2013	Outstanding

2012_32887	4	SMH	Q3	Trust grade 3	For all staff to attend the Tissue Viability Study Days in 2013 on pressure ulcer prevention assessment and treatment with priority given to band 6 staff	Tissue viability nurses	31st Ocober 2013	Within timeframe
2012_32887	4	SMH	Q3	Trust grade 3	Teaching programme for Z cope staff with emphasis on correct grading of Pressure Ulcers	Tissue viability nurses	30th April 2013	Within timeframe
2012_32887	4	SMH	Q3	Trust grade 3	Re launch of the TVN link nurses and regular updates at team meetings	Tissue viability nurses	30th April 2013	Within timeframe
2012_32887	4	SMH	Q3	Trust grade 3	Development of a laminated poster in relevant clinical areas to guide staff in accurate grading of pressure ulcers	Lead Nurse	31st march 2013	Complete
2012_32887	4	SMH	Q3	Trust grade 3	Mini Root cause analysis to be undertaken for all Grade 2 PU and themes to be reviewed as part of the trustwide improvement plan	Band 6 Senior Staff Nurse	31st march 2013	Complete
2012_32887	4	SMH	Q3	Trust grade 3	Liaise with ITU in improving communication of Pressure ulcer risk, documentation and action to be implemented prior to transfer to HDU/Ward	Lead Nurse/ ITU lead	30th April 2013	Within timeframe
2012_32887	4	SMH	Q3	Trust grade 3	Review mattress supply for double amputee patients	Head of Facilities	31st march 2013	Outstanding
2013_3074	5	SMH	Q3	Unexpected admission to NNU	Amend the Midwifery Led Care guidelines in terms of management of significant ketonuria and fluid intake	Consultant Midwife	31st May 2013	Within timeframe
2013_3074	5	SMH	Q3	Unexpected admission to NNU	Education for all midwives in terms of fluid management	Practice Development Midwife	To begin 1st May 2013	Within timeframe
2013_3074	5	SMH	Q3	Unexpected admission to NNU	Reiterate recommendation in the maternity risk newsletter.	Risk Management Midwife	31st May 2013	Within timeframe
2013_3083	5	SMH	Q3	Unexpected maternal admission to ITU	Amend the Midwifery Led Care guidelines in terms of management of significant ketonuria and fluid intake	Consultant Midwife	31st May 2013	Within timeframe

2013_3083	5	SMH	Q3	Unexpected maternal admission to ITU	Education for all midwives in terms of fluid management	Practice Development Midwife	To begin 1st May 2013	Within timeframe
2013_3083	5	SMH	Q3	Unexpected maternal admission to ITU	Reiterate recommendation in the maternity risk newsletter.	Risk Management Midwife	31st May 2013	Within timeframe
2013_3086	1	CXH	Q3	C-Diff on part 1a of death cert	No actions	No actions	No Actions	No actions
2013_826	1	CXH	Q3	Trust grade 3	Review of current guidance in terms of blister management to be ratified at evidence based practice group and published at back to the floor Fridays	-TVNs	31/03/2013	Outstanding
2013_826	1	CXH	Q3	Trust grade 3	Take photographs as per trust policy.	Ward Managers	31/03/2013	Outstanding
2013_826	1	CXH	Q3	Trust grade 3	Ward based education/update re: grading and referral to TVN	Tissue Viability Nurse	31/03/2013	Outstanding
2013_5148	5	QCH	Q4	Unexpected maternal admission to ITU	Focussed reflective session for the midwife involved.	Consultant Midwife	31/03/2013	Complete
2013_5148	5	QCH	Q4	Unexpected maternal admission to ITU	Wider learning by presenting this case at a development day	Midwife involved in case	31/03/2013	Complete
2013_5148	5	QCH	Q4	Unexpected maternal admission to ITU	Hold a teaching session on the use of terbutaline in septic patients for the Obstetric Registrars	Consultant Obstetrician – Clinical Risk	31/03/2013	Complete
2013_5148	5	QCH	Q4	Unexpected maternal admission to ITU	Explore the feasibility of relocating the maternity triage service to the birth centre overnight.	Lead Midwife, Maternity Triage and Head of Midwifery	30th June 2013	Within timeframe
2013_97	Estates	Sat	N/A	Death of patient following RTA on-route to dialysis	All actions DHL - complete (see excel document in folder)	DHL		Complete
2012_10134	5	QCH	Q1	Maternal admission to ITU	Feedback to clinical staff regarding the documentation of a plan of care	Clinical lead	30th June 2012	Complete
2012_10134	5	QCH	Q1	Maternal admission to ITU	Ensure all staff are aware of the procedure to contact interpreters as per policy	Clinical lead / Midwifery lead	30th June 2012	Complete

2012_11642	3	SMH	Q1	Unexpected death	Implement updated Trust tracheostomy guidelines in ITU SMH	Critical Care Nurse Consultant	31st August 2012	Complete
2012_11642	3	SMH	Q1	Unexpected death	Roll out an education for all of July with the aim to have 75% of ITU nursing and physiotherapy staff educated before implantation in the change of practice (the use of inner cannulas for all tracheostomies) is commenced.	Clinical educators Senior ITU physiotherapist	Teaching: July 1st - July 31st New practice: August onwards	Complete
2012_11642	3	SMH	Q1	Unexpected death	ITU physiotherapists will change their Trust teaching information to reflect and incorporate the use of inner cannulas.	Senior ITU physiotherapist	31st July 2012 - Ongoing	Complete
2012_11642	3	SMH	Q1	Unexpected death	Remind staff on the unit about the importance of accurate documentation	Senior Nurse ITU	31st July 2012	Complete
2012_11655	5	SMH	Q1	Unexpected admission to NNU	No actions	No actions	No Actions	No actions
2012_11664	1, 4	CXH/SMH	Q1	TB lookback	Communicate with medical staff in respiratory medicine and emergency services that if TB is suspected, the patient needs to be investigated and isolated until the diagnosis is proven	Chief of Service, Clinical Infection and Respiratory Medicine and Chief of Service for Emergency Services	31st July 2012	Complete
2012_11664	1, 4	CXH/SMH	Q1	TB lookback	Explore with Medical Records the feasibility and timeframe for patients at Imperial College Healthcare to have a single set of health records.	Patient Safety Manager	31st July 2012	Complete
2012_11664	1, 4	CXH/SMH	Q1	TB lookback	Ensure the Trust is aware of all the results from the 27 people identified as requiring screening	TB lead consultant and Consultant Infectious Diseases	31st August 2012	Complete
2012_11664	1, 4	CXH/SMH	Q1	TB lookback	Ensure the staff who have tested positive have been offered appropriate support	Occupational Health and Heads of Nursing, CPG 1 and 4	31st July 2012	Complete

2012_11664	1, 4	CXH/SMH	Q1	TB lookback	Ensure communications department are aware of this incident.	TB lead consultant and Consultant Infectious Diseases	05/04/2012	Complete
2012_12836	5	QCH	Q1	Unexpected admission to NNU	Discussion with SHO involved in resuscitating the baby.	Consultant Neonatologist investigating this case.	15th August 2012.	Complete
2012_12961	3	CXH	Q1	Tracheostomy	Local training and induction of ITU staff regarding available equipment	Senior Nurse, ITU	31st August 2012	Complete
2012_12961	3	CXH	Q1	Tracheostomy	All equipment to be tested regularly (monthly)	Clinical Technologist	31st July 2012	Complete
2012_12961	3	CXH	Q1	Tracheostomy	ITU monitors to be updated to ensure all have capnography available	Clinical Technologist	31st August 2012	Complete
2012_12961	3	CXH	Q1	Tracheostomy	Report the incident to the company who produce Dolphin sets	ITU lead consultant	Complete, MDA issued	Complete
2012_12961	3	CXH	Q1	Tracheostomy	Develop a standard operating procedure for the insertion of tracheostomies in ITU	ITU lead consultant	31st August 2012	Complete
2012_12961	3	CXH	Q1	Tracheostomy	Review of options within the bed contract to change the bed type in ICU	Associate Director, Quality and Safety	31st August 2012	Complete
2012_12961	3	CXH	Q1	Tracheostomy	Feedback the learning and recommendations to staff involved in the incident	ITU lead consultant	31st July 2012	Complete
2012_12961	3	CXH	Q1	Tracheostomy	Review of ICUs for compliance with the recommendations from NAP4	ITU lead consultants	31st August 2012	Complete
2012_13029	4	HH	Q1	C-Diff on part 1a of death cert	No actions	No actions	No actions	No actions
2012_13033	4	HH	Q1	Disconnected	All dialysis connections to be	Head of Nursing	30th September	complete

				Tesio line - patient bled and could not be resuscitated	double checked by Auchi dialysis registered nurses and signed on the dialysis chart	(CPG4)	2012	
2012_13033	4	HH	Q1	Disconnected Tesio line - patient bled and could not be resuscitated	Audit of double signatures on dialysis chart by Auchi dialysis staff	Head of Nursing (CPG4)	31st October 2012	complete
2012_13033	4	HH	Q1	Disconnected Tesio line - patient bled and could not be resuscitated	Venous disconnection to be discussed by ward managers with all staff at staff meeting and process of double checking re-iterated	Head of Nursing (CPG4)	Completed	Complete
2012_13033	4	HH	Q1	Disconnected Tesio line - patient bled and could not be resuscitated	Morbidity and mortality meeting addressing the need for directly observed inpatient dialysis (including satellite units)	Renal Governance Lead	Completed	Complete
2012_13033	4	HH	Q1	Disconnected Tesio line - patient bled and could not be resuscitated	To carry out a formal risk assessment regarding the management of 'eliminating mixed sex accommodation' requirements, and formalise a process for the effective monitoring of patients receiving dialysis	Head of Nursing (CPG4) and the Renal team	30th September 2012	complete
2012_13033	4	HH	Q1	Disconnected Tesio line - patient bled and could not be resuscitated	A supportive conversation regarding compliance of Trust policy regarding double checking dialysis with staff nurse 1	Head of Nursing (CPG4)	31st August 2012	complete
2012_13033	4	HH	Q1	Disconnected Tesio line - patient bled and could not be resuscitated	All renal staff to be reminded of compliance with the Trust policy regarding double checking dialysis machines	Head of Nursing (CPG4)	31st August 2012	complete
2012_13033	4	HH	Q1	Disconnected Tesio line - patient bled and could not be resuscitated	Staff involved to be given feedback following investigation and subsequent learning discussed	Head of Nursing (CPG4)	31st August 2012	Complete

2012_13033	4	HH	Q1	Disconnected Tesio line - patient bled and could not be resuscitated	Consider feedback from the investigation to be given to the patient or her family	Consultant lead for SI	30th September 2012	complete
2012_13055	1	SMH	Q1	Grade 3 ulcer	Raise the profile of skin assessment daily at ward handover. Emphasize in bed side handover if any documentation/ assessments have not been completed	Ward Manager and Lead Nurse	31st August 2012	Complete
2012_13055	1	SMH	Q1	Grade 3 ulcer	Stress the importance of assessment within 6 hours of arrival on to each ward area, during handover and ward meetings.	Ward Manager and Lead Nurse	31st August 2012	Complete
2012_13055	1	SMH	Q1	Grade 3 ulcer	Undertake a local audit of completion of risk assessments and make recommendations based on the outcome	Ward Managers and Lead Nurses	31st August 2012	Complete
2012_13055	1	SMH	Q1	Grade 3 ulcer	TVN will include importance of how to grade/ identify pressure damage in the pressure ulcer study day	TVN	31st October 2012	Complete
2012_13055	1	SMH	Q1	Grade 3 ulcer	Senior sister/charge nurse to feed back to clinical area the importance of grading/properly identifying	Ward Managers	31st August 2012	Complete
2012_13055	1	SMH	Q1	Grade 3 ulcer	Staff to be reminded to document care at times using the appropriate documentation tools.	Ward Managers and Lead Nurses	31st August 2012	Complete
2012_13266	5	QCH	Q1	Unexpected admission to NNU	No actions	No actions	No Actions	No actions
2012_15394	3	SMH	Q1	Anaeshetic issue	Feedback the events and learning of this case to anaesthetic and intensive care departments	CoS, Anaesthetics	31st October 2012	Complete
2012_15394	3	SMH	Q1	Anaeshetic issue	All central lines(whether placed with ultrasound guidance or using landmark techniques) to be confirmed by blood gas analysis and/or transduction	CoS, Anaesthetics	31st October 2012	Complete
2012_15394	3	SMH	Q1	Anaeshetic issue	Review induction of temporary staff	Lead Nurse, theatres	31st October 2012	Complete

					in theatres			
2012_15394	3	SMH	Q1	Anaeshetic issue	Confirm follow up of patient with GP	Medical Director	31st October 2012	Outstanding
2012_15394	3	SMH	Q1	Anaeshetic issue	Ensure that the national standard “Checking Anaesthetic Equipment – 2012” by the AAGBI is used in all anaesthetic areas	CoS, Anaesthetics, Lead Nurse, theatres	31st October 2012	Complete
2012_15642	Trust	Trust	Q1	Breach				
2012_17057	5	QCH	Q1	Unexpected admission to NNU	Case to be discussed at monthly maternity/obstetric meeting	Chief of Service	Completed	Complete
2012_17057	5	QCH	Q1	Unexpected admission to NNU	Case to be discussed at weekly birth centre meeting	Birth Centre Midwifery Consultant	Completed	Complete
2012_17057	5	QCH	Q1	Unexpected admission to NNU	Midwife 1 to reflect on the case with her Supervisor of Midwives	Supervisor of Midwives	Completed	Complete
2012_17057	5	QCH	Q1	Unexpected admission to NNU	Registrar 1 to reflect on the case with Chief of service Obstetrics	Chief of service	Completed	Complete
2012_17057	5	QCH	Q1	Unexpected admission to NNU	Lead midwife to ensure and discuss at next caseload meeting that two midwives should be present at labour when an alternative birth plan is made	Lead midwife	30th September 2012	Complete
2012_17057	5	QCH	Q1	Unexpected admission to NNU	Review of patient’s declining care guidance to include escalation when patients refuse medical advice	Consutlant Obstetrician	31st October 2012	Outstanding
2012_17507	5	QCCH	Q1	Unexpected admission to NNU	Case to be discussed at monthly maternity/obstetric meeting	Chief of Service	Completed	Complete
2012_17507	5	QCCH	Q1	Unexpected admission to NNU	Case to be discussed at weekly birth centre meeting	Birth Centre Midwifery Consultant	Completed	Complete
2012_17507	5	QCCH	Q1	Unexpected admission to NNU	Midwife 1 to reflect on the case with her Supervisor of Midwives	Supervisor of Midwives	Completed	Complete

2012_17507	5	QCCH	Q1	Unexpected admission to NNU	Registrar 1 to reflect on the case with Chief of service Obstetrics	Chief of service	Completed	Complete
2012_17507	5	QCCH	Q1	Unexpected admission to NNU	Review of patient's declining care guidance to include escalation when patients refuse medical advice	Jenny Loudon?	31st October 2012	Complete
2012_18146	5	SMH	Q1	Biopsy without consent	Feedback the findings and learning from this investigation to the teams involved – to specifically include the completion of WHO checklist	Chief of Service, Paediatrics	31st October 2012	Outstanding
2012_18146	5	SMH	Q1	Biopsy without consent	Review checking process for procedures agreed against procedures booked	MDT lead	31st October 2012	Outstanding
2012_18432	1	SMH	Q1	Outbreak C-Diff	Local training on appropriate isolation on the ward	Infection prevention and control team	30th November 2012	Complete
2012_18432	1	SMH	Q1	Outbreak C-Diff	Continued liaison between the ward and the infection prevention and control team	Ward managers and infection prevention and control team	Ongoing	Complete
2012_18433	1	CXH	Q1	Member of staff with TB	No actions	No actions	No Actions	No actions
2012_18435	1	HH	Q1	Patient with TB	Infection Prevention and Control Team to work with the ward to ensure learning is delivered on isolation precautions	Senior Infection Control Nurse HH Site	Complete at time of writing report	Complete
2012_18435	1	HH	Q1	Patient with TB	Feedback the findings of this SI investigation to the teams involved in her care regarding: 1. Radiological evidence of TB. 2. Use of PCR in patients who are likely to have TB medications resistance.	Consultant in Infection Prevention and Control, Senior Nurse for CPG1 wards at Hammersmith Hospital	31st October 2012	Outstanding
2012_18507	5	SMH	Q1	Unexpected maternal admission to ITU	No actions	No actions	No Actions	No actions
2012_18521	5		Q1	Unexpected admission to NNU	To feedback to the doctors involved regarding their interpretation of the CTG in context	Maternity Clinical lead,	31st October 2012	Outstanding
2012_18521	5	SMH	Q1	Unexpected admission to NNU	To reinforce the need for escalation when appropriate at the next labour ward meeting	Head of Midwifery	31st October 2012	Complete

2012_18521	5	SMH	Q1	Unexpected admission to NNU	To review the guidelines for Persistent Pulmonary Hypertension of the Newborn (PPHN) and share the revision with all staff	Neonatal lead	31st December 2012	Complete
2012_25239	3	HH	Q1	Trust grade 3	Create a tissue Viability group locally	Senior Nurse ITU	Completed	Complete
2012_25239	3	HH	Q1	Trust grade 3	Discuss training and education required with TVN	Senior Nurse ITU	Completed	Complete
2012_25239	3	HH	Q1	Trust grade 3	Educate staff according to policy and follow and use correct documentation	Link Nurse ITU	31st March 2013	Outstanding
2012_25239	3	HH	Q1	Trust grade 3	For staff in GICU to receive further training and education regarding the grading of pressure ulcers and completing assessment documentation including 1:1 Coaching for staff caring with for patients with who have wounds/ PU's, including pre- discharge	Clinical Education Team	28th February 2013	Outstanding
2012_25239	3	HH	Q1	Trust grade 3	To create a unit quick reference guide/flowchart for staff for the identification and treatment of pressure ulcers	Senior Nurse ITU	28th February 2013	Outstanding
2012_25239	3	HH	Q1	Trust grade 3	Feedback the learning and recommendations from this report to the staff within ITU at Senior Nurse meeting, and unit meetings, then reminders at staff team days.	Senior Nurse ITU	31st January 2013	Complete
2012_25239	3	HH	Q1	Trust grade 3	Update Trust pressure ulcer policy to include photographing pressure ulcers on discharge	Head of IPCT	Jun-13	Within timeframe
2012_25239	3	HH	Q1	Trust grade 3	Communication relating to the change in the pressure ulcer policy	Head of IPCT	Jun-13	Within timeframe
2012_9839	5	SMH	Q1	Retained swab	New maternity adapted Count policy to be implemented and include instructions for tampon use	Midwifery lead	10/07/2012	Complete
2012_9839	5	SMH	Q1	Retained swab	All midwifery staff required to complete and return an assessment of the maternity count policy to ensure that they have knowledge and understanding of the policy	Midwifery lead	10/07/2012	Complete

2012_9839	5	SMH	Q1	Retained swab	All tampons and small swabs (10x10) removed from the delivery and suture packs	Ward manager	10/07/2012	Complete
2012_9839	5	SMH	Q1	Retained swab	Midwifery lead to discuss the findings of the investigation and reflection of involvement	Ward manager	20th July 2012	Complete
2012_9839	5	SMH	Q1	Retained swab	Chief of service to discuss performance, accountability and reflection with registrar 1, and for the incident to be discussed with the registrar's supervisor so that it can be recorded at their end of year review	Chief of Service	20th July 2012	Complete
2012_9839	5	SMH	Q1	Retained swab	Format of the 'Record of Perineal Repair/Trauma' proforma documentation to be amended to highlight tampon use	Midwifery Lead	10 July 2012	Complete
2012_9839	5	SMH	Q1	Retained swab	Instrumental delivery proforma to include information on the use of tampons	Midwifery lead	10 July 2012	Complete
2012_9839	5	SMH	Q1	Retained swab	Perineal Trauma and Repair guidelines to be updated to reflect changes to the proforma	Midwifery lead	10/07/2012	Complete
2012_9839	5	SMH	Q1	Retained swab	Include swab count policy in mandatory training for all staff	Midwifery lead	30th April 2013	Complete
2012_9839	5	SMH	Q1	Retained swab	Audit of maternity documentation regarding swab count	Risk lead	30th November 2012	Complete

2012_18599	PP	SMH	Q2	Unexpected maternal admission to ITU	Midwifery lead to discuss with midwife 1 the importance of appropriate documentation each time the patients are reviewed	Arona Ahmed	Completed	Complete
2012_18599	PP	SMH	Q2	Unexpected maternal admission to ITU	Discussion with midwives on the unit regarding the mechanisms and importance of sending blood to the laboratory	Arona Ahmed	31st October 2012	Complete
2012_18602	5	QCH	Q2	Unexpected admission to NNU	Midwife 1 to discuss her practice with her supervisor of midwives.	Midwife 1 and her SOM	Complete at time of writing report	Complete
2012_18602	5	QCH	Q2	Unexpected admission to NNU	Labour ward coordinators should be supernummary on a shift in order to allow them to manage effectively.	Head of Midwifery	1st October 2012	Complete
2012_18602	5	QCH	Q2	Unexpected admission to NNU	The maternity unit should implement the findings of the review of labour ward staffing to try and ensure that 1:1 care for labouring women can be undertaken.	Head of Midwifery	30th April 2013 - Date revised to June 2013	Within timeframe
2012_18602	5	QCH	Q2	Unexpected admission to NNU	The Trust should be moving towards the recommended ratio of 1 midwife to 30 deliveries in order to improve 1 to 1 care ratios on labour ward.	Head of Midwifery	30th April 2013 - Date revised to June 2013	Within timeframe
2012_18659	5	SMH	Q2	Unexpected maternal admission to ITU	To document in the maternal notes total fluid consumption at least every 4 hours unless clinically indicated (appropriate amount is approximately 200 mls per hr)	Consultant midwife/LW managers	31st October 2012	Outstanding
2012_18659	5	SMH	Q2	Unexpected maternal admission to ITU	To educate staff on fluid balance and ketonuria by holding a multi disciplinary seminar and review of the evidence.	Head of Midwifery	31st October 2012	Complete
2012_18659	5	SMH	Q2	Unexpected maternal admission to ITU	To conduct an RCT investigating appropriate fluids for latent phase/early labour	Midwifery research fellow	31st Ocotober 2013	Within timeframe

2012_18659	5	SMH	Q2	Unexpected maternal admission to ITU	Patient's with unresponsive ketonuria to be escalated and reviewed by the medical team	Lorna Phelan/Pauline Cooke	31st October 2012	Outstanding
2012_19685	5	SMH	Q2	Unexpected neonatal death	Individual learning for Midwife 5 in terms of checking handover sheet for babies on transitional care observations	Supervisor of Midwives.	31 October 2012	Complete
2012_22622	5	QCCH	Q2	Unexpected neonatal death	No actions	No actions	No Actions	No actions
2012_22626	5	Qcch	Q2	Unexpected admission to NNU	Include in Risky Business Newsletter that when your plan is to reassess a woman you ensure you do this.	Risk Management Midwife	31st December 2012	Complete
2012_22626	5	Qcch	Q2	Unexpected admission to NNU	Refer case to Supervisor of Midwives for review of management and take action as appropriate.	Lead Midwife	Case referred at time of writing report. Complete review and Action plan – 31st December 2012	Complete
2012_22626	5	Qcch	Q2	Unexpected admission to NNU	Individual learning to be undertaken by registrar involved regarding following planned reviews.	Consultant Obstetrician, Risk Lead QCCH	Complete at time of writing report.	Complete

2012_22626	5	Qcch	Q2	Unexpected admission to NNU	Individual learning to be undertaken by Midwife in terms of escalation of an abnormal CTG.	Lead midwife	As part of supervisory investigation – 31st December 2012	Complete
2012_23997	3	SMH	Q2	Unexpected death	Review current provision of the outreach service. In the interim, introduce an outreach ward round on a Friday evening.	Head of Nursing CPG 3	31st December 2012	Complete

2012_23997	3	SMH	Q2	Unexpected death	Training team to review the working patterns of the FY1s and their areas of responsibilities	Karen Frame	31st January 2013	Outstanding
2012_23997	3	SMH	Q2	Unexpected death	Liaise with FY1 induction co-ordinator to ensire the Medical Director has a slot on induction to discuss failure to escalate	Patient Safety Manager	31st December 2012	Complete
2012_23997	3	SMH	Q2	Unexpected death	Director of Nursing to brief nursing population that if they are concerned they should escalate above the FY1. Out of hours, if an FY1 is called to review a patient, then the site management team must also be called.	Director of Nursing	31st December 2012	Complete
2012_23997	3	SMH	Q2	Unexpected death	Medical Director to inform all consultants Trustwide that a daily registrar ward round to review all patients must take place at weekends.	Medical Director	31st December 2012	Outstanding
2012_23997	3	SMH	Q2	Unexpected death	Senior Nurse to conduct twice daily ward rounds at weekend	Lead Nurse Orthopaedics	31st December 2012	Complete
2012_23997	3	SMH	Q2	Unexpected death	Increase the number of senior nursing (Band 6) out of hours on the orthopaedic unit.	Lead Nurse Orthopaedics	31st December 2012	Complete
2012_23997	3	SMH	Q2	Unexpected death	Design and implement a handover proforma for the FY1s	Karen Frame	31st December 2012	Outstanding
2012_23997	3	SMH	Q2	Unexpected death	Nurse-in-charge to be supernumerary	Ward Manager	Complete at time of writing report	Complete
2012_23997	3	SMH	Q2	Unexpected death	Write a guidance document in addition to the induction session for FY1s on recognising the deteriorating patient and when to escalate.	Karen Frame	31st December 2012	Outstanding

2012_23997	3	SMH	Q2	Unexpected death	In orthopaedics, initiate weekend consultant ward rounds to review all patients.	Chief of Service, Orthopaedics	Complete at time of writing report	Complete
2012_23997	3	SMH	Q2	Unexpected death	Ward manager to ensure all nursing staff are ILS trained.	Ward manager	30th June 2013	Within timeframe
2012_23997	3	SMH	Q2	Unexpected death	Clinical educator from ICU to spend time on the ward educating staff on early warning scores, triggering and how to pre-empt problems.	Lead Nurse Orthopaedics	Complete at time of writing report	Complete
2012_23997	3	SMH	Q2	Unexpected death	Refer the staff involved for a review of their practice in terms of the care provided to this patient.	Senior Nurse and Karen Frame	15th December 2012	Complete
2012_23997	3	SMH	Q2	Unexpected death	Ensure there is individual learning for the staff involved in this case.	Senior Nurse and Karen Frame	15th December 2012	Complete
2012_23997	3	SMH	Q2	Unexpected death	Liaise with the communications team regarding launching screensavers in terms of escalation	Patient Safety Manager	31st December 2012	Complete
2012_24437	5	SMH	Q2	Unexpected admission to NNU	No actions	No actions	No Actions	No actions
2012_24722	5	SMH	Q2	Unexpected maternal admission to ITU	Midwife educator and HDU midwifery lead to continue mandatory sessions on the use of the MEWS chart for all midwifery staff.	Midwife Educator and HDU midwifery lead	Ongoing	Complete
2012_24722	5	SMH	Q2	Unexpected maternal admission to ITU	Section in Risky Business regarding the MEWS chart and escalation	Risk Management Midwife	28th February 2013	Complete
2012_24722	5	SMH	Q2	Unexpected maternal admission to ITU	Refer case to Supervisor of Midwives for review.	Lead Midwife	31st December 2012	Complete

2012_24722	5	SMH	Q2	Unexpected maternal admission to ITU	Refer to midwifery management for developmental support period.	Head of Midwifery	30th September 2012	Complete
2012_24722	5	SMH	Q2	Unexpected maternal admission to ITU	Monthly audit of maternity recovery health records	HDU midwifery lead	Ongoing	Complete
2012_25175	1	CXH	Q2	MRSA death	No actions	No actions	No Actions	No actions
2012_25272	1	SMH	Q2	Trust grade 3	All staff on DAAU have been informed of the importance of this, and they will have individual discussions with ther tem leaders regarding this. An email setting out a ward action plan has been sent to all staff, and we are planning to do spotcheck the next coming weeks to check compliance.	Senior Nurse	31st October 2012	Complete
2012_25272	1	SMH	Q2	Trust grade 3	All staff on DAAU have been informed of the importance of this, and they will have individual discussions with ther tem leaders regarding this. An email setting out a ward action plan has been sent to all staff, and we are planning to do spotcheck the next coming weeks to check compliance.	Senior Nurse	31st October 2012	Complete
2012_25272	1	SMH	Q2	Trust grade 3	All staff on DAAU have been informed of the importance of this, and they will have individual discussions with ther tem leaders regarding this. An email setting out a ward action plan has been sent to all staff, and we are planning to do spotcheck the next coming weeks to check compliance.	Senior Nurse	31st October 2012	Complete

2012_25272	1	SMH	Q2	Trust grade 3	All staff on DAAU have been informed of the importance of this, and they will have individual discussions with ther tem leaders regarding this. An email setting out a ward action plan has been sent to all staff, and we are planning to do spotcheck the next coming weeks to check compliance. War resource files have been ordered, and in the mean time all staff have received guidance online for equipment. Key trainers are awaiting training dates	Senior Nurse	31st December 2012	Complete
2012_25272	1	SMH	Q2	Trust grade 3	All staff on DAAU have been informed of the importance of this, and they will have individual discussions with ther tem leaders regarding this. An email setting out a ward action plan has been sent to all staff, and we are planning to do spotcheck the nex	Senior Nurse	31st December 2012	Complete
2012_25272	1	SMH	Q2	Trust grade 3	Email willl be sent to all staff as a reminder. This will be raised as an issue in the next ward emeting.	Senior Nurse	31st October 2012	Complete
2012_25272	1	SMH	Q2	Trust grade 3	Re- introduction of I care through a band 5 who is doing this as part of her internship project	Senior Nurse	31st October 2012	Complete
2012_25272	1	SMH	Q2	Trust grade 3	Recruitment into vacant posts	Senior Nurse	30th November 2012	Complete
2012_25278	3	SMH	Q2	Unexpected death	Review the Patient Transfer Policy	Lead Nurse Practice Development and Innovation	31st December 2012	Outstanding
2012_25278	3	SMH	Q2	Unexpected death	Design and implement a medical staff handover proforma	FY1 training lead	31st December 2012	Outstanding
2012_25278	3	SMH	Q2	Unexpected death	Write a guidance document in addition to the induction session for FY!s on recognising the deteriorating patient and when to escalate	FY1 training lead	31st December 2012	Outstanding

2012_25278	3	SMH	Q2	Unexpected death	Initiate weekend consultant ward rounds to review all patients	Chief of Service Orthopaedics	Complete at time of writing the report	Complete
2012_25278	3	SMH	Q2	Unexpected death	Clinical educator to spend time with ward staff educating them on the use of the early warning system, triggering and escalation actions	Lead Nurse, Orthopaedics	Complete at time of writing the report	Complete
2012_25278	3	SMH	Q2	Unexpected death	Senior Nurse to conduct twice daily ward rounds at weekend	Lead Nurse Orthopaedics	Complete at time of writing the report	Complete
2012_25278	3	SMH	Q2	Unexpected death	Increase the number of senior nursing (Band 6) out of hours on the orthopaedic unit.	Lead Nurse Orthopaedics	Complete at time of writing the report	Complete
2012_25278	3	SMH	Q2	Unexpected death	Liaise with FY1 induction co-ordinator to ensure the Medical Director has a slot on induction to discuss failure to escalate	Patient Safety Manager	31st December 2012	Complete
2012_25278	3	SMH	Q2	Unexpected death	Director of Nursing to brief nursing population that if they are concerned they should escalate above the FY1. Out of hours, if an FY1 is called to review a patient, then the site management team must also be called.	Director of Nursing	31st December 2012	Complete
2012_25278	3	SMH	Q2	Unexpected death	Liaise with the communications team regarding launching screensavers in terms of escalation	Patient Safety Manager	31st December 2012	Complete
2012_22641	5	SMH	Q3	Unexpected admission to NNU	No actions	No actions	No Actions	No actions
2012_24727	5	QCCH	Q3	Unexpected neonatal death	No actions	No actions	No Actions	No actions
2012_25176	1	SMH	Q3	C-Diff on part 1a of death cert	Clinical Director to circulate the current Clostridium Difficile policy to all medics within the CPG.	Clinical Director CPG 1	31st January 2013	Outstanding
2012_25176	1	SMH	Q3	C-Diff on part 1a of death cert	Reminder to all clinical teams that when a patient is positive for clostridium difficile a senior review should be initiated.	Clinical Directors all CPGs	31st January 2013	Outstanding
2012_25236	3	HH	Q3	Trust grade 3	Create a tissue Viability group locally	Senior Nurse ITU	Completed	Complete
2012_25236	3	HH	Q3	Trust grade 3	Discuss training and education	Senior Nurse ITU	Completed	Complete

					required with TVN			
2012_25236	3	HH	Q3	Trust grade 3	Educate staff according to policy and follow and use correct documentation	Link Nurse ITU	31st March 2013	Outstanding
2012_25236	3	HH	Q3	Trust grade 3	For staff in GICU to receive further training and education regarding the grading of pressure ulcers and completing assessment documentation including 1:1 Coaching for staff caring with for patients with who have wounds/ PU's, including pre- discharge	Clinical Education Team	28th February 2013	Outstanding
2012_25236	3	HH	Q3	Trust grade 3	To create a unit quick reference guide/flowchart for staff for the identification and treatment of pressure ulcers	Senior Nurse ITU	28th February 2013	Outstanding
2012_25236	3	HH	Q3	Trust grade 3	Feedback the learning and recommendations from this report to the staff within ITU at Senior Nurse meeting, and unit meetings, then reminders at staff team days.	Senior Nurse ITU	31st January 2013	Complete
2012_25236	3	HH	Q3	Trust grade 3	Update Trust pressure ulcer policy to include photographing pressure ulcers on discharge	Head of IPCT	31st June 2013	Within timeframe
2012_25236	3	HH	Q3	Trust grade 3	Communication relating to the change in the pressure ulcer policy	Head of IPCT	31st June 2013	Within timeframe
2012_25236	3	HH	Q3	Trust grade 3	Review process for the transfer of patients from ITU who require a pressure relieving mattress, and devise local guidelines	Head of IPCT	28th February 2013	Outstanding
2012_25544	1	SMH	Q3	Trust grade 3	All staff to be assessed in Accident and Emergency and Acute Medical Unit	Senior Nurse Emergency Services	31st March 2013	Outstanding
2012_25544	1	SMH	Q3	Trust grade 3	All staff to be assessed /documentary evidence that information disseminated to social services.	Senior Nurse Emergency Services and Lead Nurse Unplanned Care SMH	31st March 2013	Outstanding
2012_25544	1	SMH	Q3	Trust grade 3	Discussion with staff in terms of delayed referral to dietician	Lead Nurse Unplanned Care SMH and Ward Manager Witherow Ward	31st March 2013	Outstanding

2012_25937	5	QCH	Q3	Retained swab	All staff regardless of start date to attend local induction that includes education regarding the swab count policy and to sign local induction checklist re understanding an complying with Trust policies	Practice development midwives	Jan-13	Complete
2012_25937	5	QCH	Q3	Retained swab	A4 sized white boards to be purchased for all delivery rooms on delivery suite	Labour ward matrons	Jan-13	Complete
2012_25937	5	QCH	Q3	Retained swab	Swab counts performed in delivery rooms to be recorded pre-procedure on new A4 white boards by individual who opens swabs. Post-procedure swab counts to be performed by surgeon and witness, ensuring consistent with documented swab count on white board. Confirmation of number of swabs used in procedure and accuracy of final count to be recorded in maternity notes.	Head of Midwifery, Chief of Service Obstertrics	on arrival, by end Februarys 2013	Outstanding
2012_25937	5	QCH	Q3	Retained swab	All used swabs to be placed in a disposable kidney dish in delivery rooms from where they will be counted post-procedure	All staff performing perineal repair	Jan-13	Outstanding
2012_25937	5	QCH	Q3	Retained swab	Inform all staff that person performing suturing is responsible and accountable for all swabs before, during and after the procedure	Head of Midwifery, Chief of Service Obstertrics	Jan-13	Outstanding
2012_25937	5	QCH	Q3	Retained swab	Develop structured handover guidance in the revised maternity swab count policy re patients who requires transfer to theatre and with heavy bleeding from local vaginal trauma, a vaginal pack can be used for haemostasis and needs to be handed over to theatre team. Swabs not to be inserted in vagina during transfer to theatre	Head of Midwifery, Chief of Service Obstertrics	Revised to April-13 from Feb-13	Outstanding
2012_25937	5	QCH	Q3	Retained swab	Adapt and then relaunch WHO checklist used in theatre. Final sign out to be confirmed by scrub nurse	Chief of Service Obstetrics	Revised to April-13 from Feb-13	Outstanding

					and surgeon			
2012_25937	5	QCH	Q3	Retained swab	Revise swab counting policy and swab counting booklet with above amendments and then relaunch policy. All staff to confirm policy has been read and understood and complie with, develop an audit programme and feedback mechanism to staff	Lead Midwife	Revised to April-13 from Feb-13	Outstanding
2012_25937	5	QCH	Q3	Retained swab	Clarify and communicate across both sites clinical indicators for the use of tampons	Chief of Service Obstetrics	Feb-13	Complete
2012_25937	5	QCH	Q3	Retained swab	Refer staff involved in the care to line managers/supervisors to identify and address any HR issues related to non-compliance	Director of Midwifery, Chief of Service Obstetrics	Feb-13	Complete
2012_25937	5	QCH	Q3	Retained swab	Review case, prior cases and research articles as a thematic analysis at the post graduate forum and include in maternity staff newsletter	Director of Midwifery, Chief of Service Obstetrics	Feb-13	Complete
2012_26227	5	HH	Q3	Management of suspected ectopic pregnancy	Discussion with Chief of Service Anaesthetics regarding emergency access to theatre at night.	Clinical Director CPG 5	31st December 2012	Outstanding
2012_26227	5	HH	Q3	Management of suspected ectopic pregnancy	Produce guidelines on expectations of out of hours ultrasound scanning.	Chief of Service Gynaecology	31st December 2012	Outstanding
2012_26227	5	HH	Q3	Management of suspected ectopic pregnancy	Update the administration of Methotrexate guideline to reflect: • Prescription for Methotrexate must be agreed with Gynaecology Emergency Room / Early Pregnancy Assessment Unit Consultant only • Methotrexate is not to be given “out of hours” • Gynaecology Emergency Room / Early Pregnancy Assessment Unit nursing staff to be trained to	Chief of Service Gynaecology	31st December 2012	Outstanding

					administer Methotrexate.			
2012_26335	5	SMH	Q3	Unexpected admission to NNU	Training in CTG interpretation for junior doctors to continue in accordance with the education programme	Consultant Obstetrician	Complete and Ongoing	Complete
2012_26335	5	SMH	Q3	Unexpected admission to NNU	Practice Development Midwife and Supervisor of Midwives to discuss the escalation policy with Midwife 3	Practice development midwife	31st January 2013	Complete
2012_29224	5	QCH	Q3	Unexpected admission to NNU	No actions	No actions	No Actions	No actions

Appendix Three: Risk Profile Q4 2012-13

The 2012/13 key areas of focus were developed in the annual report through the use of a risk profile. The top theme for incidents, complaints and claims is now analysed at Trust level, at individual CPG level and at individual site level every quarter. The outcomes are aggregated to provide a risk profile as shown below.

Trustwide top themes for incidents and complaints have not changed from those identified in Q3. For new claims the top theme has changed from failure/delay in treatment to failure to recognise complication of treatment and for settled claims the top theme has changed from failure of follow up arrangements to failure to diagnose/delay in diagnosis.

Incidents top themes vary slightly from Q3 to Q4. CPG3 has changed from treatment, procedure to medication, SMH has changed from access, appointment, admission, transfer, discharge to medication and WEH has changed from access, appointment, admission, transfer, discharge to infrastructure or resources (staffing, facilities, environment). All other sites and CPGs have remained the same over the two quarters.

Complaints top themes are entirely consistent with the results for Q3. At every level of analysis all aspects of clinical treatment was the top theme.

New Claims top theme The top theme across the Trust was a failure to recognise a complication of treatment with five new claims received. CPG1 received three new claims relating to an alleged failure to diagnose/delay in diagnosis.

Settled Claims top theme A significant percentage of claims settled in Q4 involved a failure to diagnose/delay in diagnosis and failure to provide informed consent across the Trust. The numbers for these themes were cumulative across the different sites and CPGs. No single site or CPG had a high number of claims settled in this period.

Trust Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury 15%	All aspects of clinical treatment 60%	**NEW:** Failure to recognise complication of treatment 12% **SETTLED:** Failure to diagnose/delay in diagnosis 25%

CPG 1 Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury 30%	All aspects of clinical treatment 60%	**NEW:** Failure to diagnose/delay in diagnosis 100% **SETTLED:** No theme

CPG 2 Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Infrastructure or resources (staffing, facilities, environment) 17%	All aspects of clinical treatment 55%	**NEW:** Failure to recognise complication of treatment 20% **SETTLED:** Failure to diagnose/delay in diagnosis 20%

CPG 3 Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Medication 21%	All aspects of clinical treatment 47%	**NEW:** No theme **SETTLED:** Failure to recognise complication of treatment 25%

CPG 4 Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury 27%	All aspects of clinical treatment 75%	**NEW:** No theme **SETTLED:** Failure to provide informed consent 22%

CPG 5 Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Labour or delivery 40%	All aspects of clinical treatment 64%	**NEW:** No theme **SETTLED:** No theme

CPG 6 Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Clinical assessment (investigations, images and lab tests) 52%	All aspects of clinical treatment 44%	**NEW:** No theme **SETTLED:** No claims settled

SMH Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Medication 14%	All aspects of clinical treatment 52%	**NEW:** Lack of assistance/care 16% **SETTLED:** No theme

HH Risk Profile Q4

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury	All aspects of clinical treatment 71%	**NEW:** Failure to recognise complication of treatment

	21%		25% **SETTLED:** No claims settled

CXH Risk Profile Q4

	Incidents	Complaints	Claims
Theme	Accident that may result in personal injury 20%	All aspects of clinical treatment 52%	**NEW:** Wrong diagnosis made 17% **SETTLED:** Failure to diagnose/delay in diagnosis 31%

QCCH Risk Profile Q4

	Incidents	Complaints	Claims
Theme	Labour or delivery 48%	All aspects of clinical treatment 56%	**NEW:** No theme **SETTLED:** No theme

WEH Risk Profile Q4

	Incidents	Complaints	Claims
Theme	Infrastructure or resources (staffing, facilities, environment) 18%	All aspects of clinical treatment 58%	**NEW:** No claims opened **SETTLED:** No claims settled

NB – Some claims have multiple themes.

Action plan – to be discussed at Clinical Risk Committee

Issue	Action	Lead	Deadline	Monitoring forum

Quality Accounts 2012/13
Quarter 2 Trustwide Performance

Trust Board: 24 July 2013 Agenda Number: 2.2, Appendix A – Annex 4

Quality Account Priorities

Ref	Measures	Freq	Target	Q4 target	Q1 total	Q2 total	Q3 total	Q4 total	Year Total	Year End Target/Comparative Comparative	Status	
Patient Safety												
PS1	Safety Thermometer - 90% of all inpatients assessed for VTE Risk	Q	90%	90%	91.10%	91.11%	91.13%	91.13%		90% of all inpatients risk assessed		
PS2	Safety Thermometer - remain below the national average rate of reported falls	Q	<5.6	<5.6	4.09	3.75	3.74	3.75	3.83	Below 5.6		
PS3	Safety Thermometer - reduce the number of patient falls that result in severe harm	Q	<9	<2.25	0	0	0	0	0	Less than 9 cases		
PS4	Safety Thermometer - To reduce the number of pressure ulcers	Q	<22	5.5	3	4	7	4	18	Less than 22		
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	23	20	86	Less than 110 cases		* Data is refreshed each month and due to additional reporting and re-classificaiton of some incidents the data is a moving total and the year end will be the final.
PS7	To reduce cases of MRSA (less than 9 cases)	Q	<9	<2.25	1	1	2	4	8	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	88%	85%	Bi-annual audit		1. Falls previously Q1 was 3.7% and Q2 was 3.47% - 30th October 2012
PS9	Remain above the peer average for patient safety reporting rates	Q	>6.8	>6.8	6.05	6.52	6.66	6.91	6.53	Equal/ Above 6.9		2. Severe harm comprises NRLS graded incidents extreme and major
PS10	Remain below the peer average for incidents graded extreme	Q	<0.1%	<0.1%	0%	0.10%	0.20%	0.30%	0.10%	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	<0.2	<0.2	0.20%	0.10%	0%	0.20%	0.10%	Less than 0.5%		4. Incidents graded major for Q1 was previously 0.18%
PS12	Failure to rescue total incidents (improving recognition of deterioriation)	Q	<52	<13	16	20	21	25	82	Less than 52		5. Incidents graded extreme for Q1 was previously 0.15%
Clinical Effectiveness												
CE1	Below the national average for mortality rates SHMI	Q		100		76				Awaiting confirmation of national average		Data only available for October 2011- September 2012
CE2	To reduce the number of emergency readmissions to hospital within 28 days of discharge	Q	6.53%		6.68%	6.57%	6.71%	6.59%	6.66%	Awaiting confirmation of national average		
CE3	To increase patient satisfaction as measured by PROMs and increase participation rate to 80% and above (Her	Q	80%	80%	53.33%	140%	121%	*41%*		80% and above		*Q4 data provisional and low as not all March figures included until 16th working day of the month*
	To increase patient satisfaction as measured by PROMs and increase participation rate to 80% and above (Hip)	Q	80%	80%	111.00%	120%	151%	*91%*		80% and above		*Q4 data provisional and low as not all March figures included until 16th working day of the month*
	To increase patient satisfaction as measured by PROMs and increase participation rate to 80% and above (Kne	Q	80%	80%	177.00%	246%	186%	*167%*		80% and above		*Q4 data provisional and low as not all March figures included until 16th working day of the month*
	To increase patient satisfaction as measured by PROMs and increase participation rate to 80% and above (Vein	Q	80%	80%	54.00%	75%*	64%*	*33%*		80% and above		*Q4 data provisional and low as not all March figures included until 16th working day of the month*
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%	SMH - 70.19%	SMH - 81.2%	78.07%	85%		
			85%	85%	CXH - 69.76%	CXH - 69.08%	CXH - 69.90%	CXH - 67.5%	69.06%	85%		
			85%	85%	HH - 55.87%	HH - 68.1%	HH - 69.67%	HH - 59.3%	63.23%	85%		
	To improve the patient experience related to discharge 75% compliance with each apsect of the policy measured											
	All patients have an anticipated date of discharge (ADD)		75%	75%	88%					75%		
	Patients informed of their ADD		75%	75%	57%					75%		
	Patient centred discharge plan in patient records		75%	75%	65%					75%		
	Approporiate discharge plan followed		75%	75%	74%					75%		
	Copy of electronic discharge communication (EDC) to patient		75%	75%	79%					75%		
	Copy of EDC to GP		75%	75%	81%					75%		
PE3	To improve the responsiveness to inpatients needs - 1. Involvement in care	Q	>87.13	>87.13	87.56	88.31	89.26	88.48	88.40	Above 87.13		
	To improve the responsiveness to inpatients needs - 2. Worries and Fears	Q	>80.30	>80.30	80.11	81.46	82.67	81.67	81.47	Above 80.30		
	To improve the responsiveness to inpatients needs - 3. Privacy	Q	>91.86	>91.86	92.15	92.38	93.19	92.78	92.63	Above 91.86		
	To improve the responsiveness to inpatients needs - 4. Medication side effects	A	National average comparison		5.2 (national average 5.1)					Above the national average		
	To improve the responsiveness to inpatients needs - 5. Contact information	A	National average comparison		7.5 (national average 7.6)					Above the national average		
PE4	To remain above the national average for staff who would recommend the Trust to friends/family needing care	A	Annual	Annual	3.69 (national average 3.57)					Above the national average		

* Data is refreshed each month and due to additional reporting and re-classificaiton of some incidents the data is a moving total and the year end will be the final.

Above totals are data as of 16th April 2013

<5.6%	<5.6%	4.09%	3.75%	3.74%	3.75	3.83	Below 5.6%

<5.6%	<5.6%	0.0	3.75%	3.74%	3.75	3.83	Below 5.6%

<5.6	<5.6	4.09	3.75	3.74	3.75	3.83	Below 5.6

>6.9%	>6.9%	6.05%	6.52%	6.66%	6.91	6.53

>6.9	>6.9	6.05	6.52	6.66	6.91	6.53

<0.1%	<0.1%	0.0%	0.1%	0.2%	0.3	0.1

<0.1	<0.1	0.00	0.10	0.20	0.30	0.10

<0.5%	<0.5%	0.2%	0.1%	0%	0.2	0.1
<0.5	<0.5	0.2	0.1	0.0	0.2	0.1

0.0	0.1	0.2	0.3	0.1

0%	0.10%	0.20%	0.30%	0.10%

0.2	0.1	0.0	0.2	0.1
0.18%	0.10%	0%	0.20%	0.10%

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Bill Shields
Acting CEO
On behalf of Mark Davies (in his absence)
St Mary's Hospital
Praed Street
London W2 1NY

2nd July 2013

Dear Chris,

Re: Care Quality Commission maternity outlier alert for elective caesarean section rates at Imperial College Healthcare NHS Trust

Thank you for the notification of the fact that analysis of maternity indicators undertaken by the Care Quality Commission has indicated significantly high rates of elective caesarean sections at Imperial College Healthcare Trust. The response to this alert is detailed below. If you would like to discuss the content of this response in more detail, please do not hesitate to contact me.

Yours sincerely

Bill Shields
Acting CEO
On behalf of Mark Davies (in his absence)

Response to the Care Quality Commission maternity outlier alert for elective caesarean section rates at Imperial College Healthcare NHS Trust

Having thoroughly investigated this alert, it is apparent that the high elective caesarean section rates apply to the St Mary's Hospital site only, as the elective caesarean section rates on the Queen Charlottes site have been in line with national figures, before, during and following the period of your alert (July-December 2012). In view of this, we have restricted the investigation, to the St Mary's site only.

For ease of comparison, we have mirrored the data tables that you sent to us (from HES data) and we have removed the Queen Charlottes data so that the analysis of the St Mary's data is clear.

All data that we have pulled has been generated via CMIS (St Mary's information system) which is the standard data collection system used on the St Mary's site. This system, long in use, is known to be a valid and accurate source of maternity statistics. Standardized reports are generated on a monthly, quarterly and yearly basis and

further data can be easily and reliably produced via ad hoc enquires to investigate trends and themes or for routine audit purposes.

As you are aware, there is a private facility within the St Mary's site campus and the private maternity statistics are collected and retrieved using the same CMIS system. As in our previous report (ref: CQC Alert 2011), we have removed all private data from our analysis as the elective caesarean section rates in this particular group of women is well above the national figures and as such inclusion would skew our data significantly.

Our report includes a review of the maternity statistics on the St Mary's site and a detailed case note review. All elective caesarean sections during the alert period (July-December 2012) were identified on CMIS and a random sample (n=100) was chosen (via Excel spreadsheet). All notes were requested and 85 sets were available for review (5 sets missing and 10 excluded as the reviewing clinician had been involved in the decision for caesarean section). All sets of notes were reviewed by a Consultant Obstetrician and data recorded on a previously used database. The findings of the case note review are detailed in the report.

Delivery methods

- In excluding the QCCH data, Table one shows that the elective caesarean section rate during the alert period was indeed significantly higher than national figures.) The ventouse rate on CMIS data was in fact 9.0% and the forceps rate was lower than national figures (4.8% versus 6.8%) reflecting the preference for this type of instrument within our unit.
- The normal delivery rate at SMH was lower than nationally (55% compared with 60.9%) although our CMIS data at 55% is higher than your HES data suggests.

Table 1: Proportion of deliveries by recorded delivery method (July to December 2012)

	England	Imperial College Healthcare NHS Trust- SMH Site	
	Deliveries (%)	Deliveries (n)	Deliveries (%)
Elective caesarean delivery	10.6%	746	15.1%
Other/Emergency caesarean delivery	14.5%	719	15.0%
Breech Extraction delivery	0.0%	*	*
Other Breech delivery	0.4%	*	*
Low Forceps cephalic delivery	3.1%	257	3.0%
Other Forceps Delivery	3.7%	8	1.8%
Ventouse (Vacuum) delivery	5.9%	560	9.0%
Spontaneous other delivery	0.4%	*	*
Normal delivery (Spontaneous vertex)	60.9%	2,424	55.0%
Other/unrecorded delivery method	0.5%	14	0.3%
Total deliveries	334,581	4,740	100%

Source CMIS

Notes: Delivery methods are derived from primary procedure. For reasons of confidentiality, numbers below 6 have been replaced with *.

Profile of all deliveries at the trust

- Analysis showed that SMH has an older profile of deliveries compared to nationally as well as a significantly higher rate of multiple deliveries (see Table 2). We are overrepresented in the 35-39-age range (24.3% cf 15.4%) and underrepresented in the 20-34-age range (64% cf 76.1%). In addition, our women aged 40 and over are higher than national figures and we know that our elective and emergency caesarean section rate is higher in this group of women due to increased co-morbidities and less favorable pregnancy and intrapartum outcomes.
- Of note, the percentage of multiple births using CMIS SMH data was actually 3.4% during the alert period and as our elective caesarean section rate in this group was 50% during the alert period, this would have contributed to the high overall elective CS rate.

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Table 2: Profile of all deliveries (July to December 2012)			
	England	**Imperial College Healthcare NHS Trust- SMH site**	
	Deliveries (%)	**Deliveries (n)**	**Deliveries (%)**
Gestation period			
Under 24 weeks	0.8%	*	*
Pre term 24-36 weeks	7.3%	160	8.3%
Term 37-42 weeks	91.6%	1797	94.0%
Post Term >42 weeks	0.3%	1	0.0%
Single or multiple births			
Single	98.5%	1844	96.6%
Multiple	1.5%	66	3.4%
Mother's age			
Under 20	4.6%	45	2.3%
20-34	76.1%	1197	64.0%
35-39	15.4%	191	24.3%
40+	3.9%	170	6.9%
NHS or privately funded patient			
NHS patient	99.4%	1910	85.0%
Private patient	0.5%	327	14.6%
Length of stay			
Median length of stay	2 days	2 days	
Total number of deliveries			
Total number of deliveries	334,581	2,237	

Source: CMIS

Notes: A single birth includes any delivery where there is no indication of a multiple birth; analysis of gestation periods excludes deliveries where this information was unrecorded (16.8% nationally compared to 3.1% at the trust). For reasons of confidentiality, numbers below 6 have been replaced with *

2.5% of maternal age data was missing on this CMIS enquiry.

Caesarean section rates (January to December 2012)

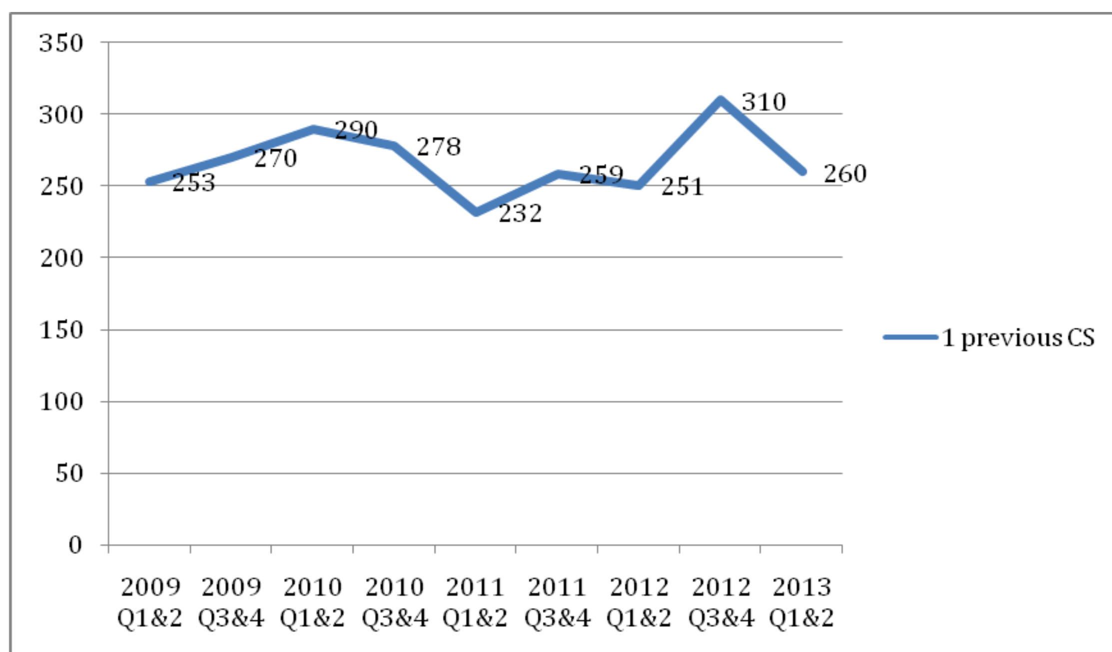
- Table 3 shows the elective caesarean rate and the comparable emergency caesarean rate at SMH for two time periods; January to June 2012 and July to December 2012.
- We agree that cross sectional analysis of standardized elective caesarean rates showed the trust's rates to be significantly higher than expected (see Table 4 and Figure 4) between July and December 2012. This was a significant increase from the previous six-month period (January to June 2012), when the rate at the trust had been well within expected limits.
- Both the emergency and overall caesarean rates at the trust were found to be within expected limits for both time periods.
-

- **Table 3: Caesarean rates (January to December 2012)**

	England	Imperial College Healthcare NHS Trust- SMH site		
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardized Ratio
January to June 2012				
Elective caesareans	10.4%	332	14.0%	101.5 (z = 0.1)
Emergency caesareans	14.5%	355	17.0%	109.7 (z = 0.7)
Total caesarean rate	24.9%	687	31.0%	106.1 (z = 0.8)
July to December 2012				
Elective caesareans	10.6%	309	16.0%	124.4 (z = 2.0)
Emergency caesareans	14.5%	294	15.0%	99.3 (z = -0.1)
Total caesarean rate	25.1%	603	31.0%	110.7 (z = 1.2)

Source: CMIS Data

Figure1: Number of women with one previous CS delivering at SMH (Jan 2009-June 2013)



- As we can see from the above chart, we delivered a peak number of women who had one previous caesarean section in the last 2 quarters of 2012. It is of note that there was a similar peak in the first 2 quarters of 2010 (during our last CQC elective caesarean section alert.).

- This group of women, constitute the highest contributors to our elective caesarean section rate overall. We know from analysis using Robson criteria, that our elective caesarean section rate in this group of women was 57% during the recent alert period; therefore, if we are booking and delivering more women in this category, then inevitably it will affect our overall elective caesarean section rate.

- During the 3rd and 4th quarters of 2012, we delivered 310 women who had one previous caesarean section, representing a 24% increase in numbers compared to the 1st and 2nd quarters of 2012.

- Obviously, we recognize that our primip emergency section rate will have an impact on the number of subsequent multiparous women booking a second time at Mary's for their delivery. During the alert period (July-Dec 2012), our primip emergency caesarean section rate was 14%, which is similar to our figure in the 2010 alert (14.7%) and in line with national figures.

- For comparison, we also reviewed the number of women who delivered in our unit over the same time period that had a history of 2 or more caesarean sections. As one can see from the chart below (Figure 2), those figures have been fairly static over the past 3 years and therefore would not have influenced the elective caesarean rate during the alert period.

Figure 2: Number of women with one previous CS delivering at SMH (Jan 2010-Dec 2012)

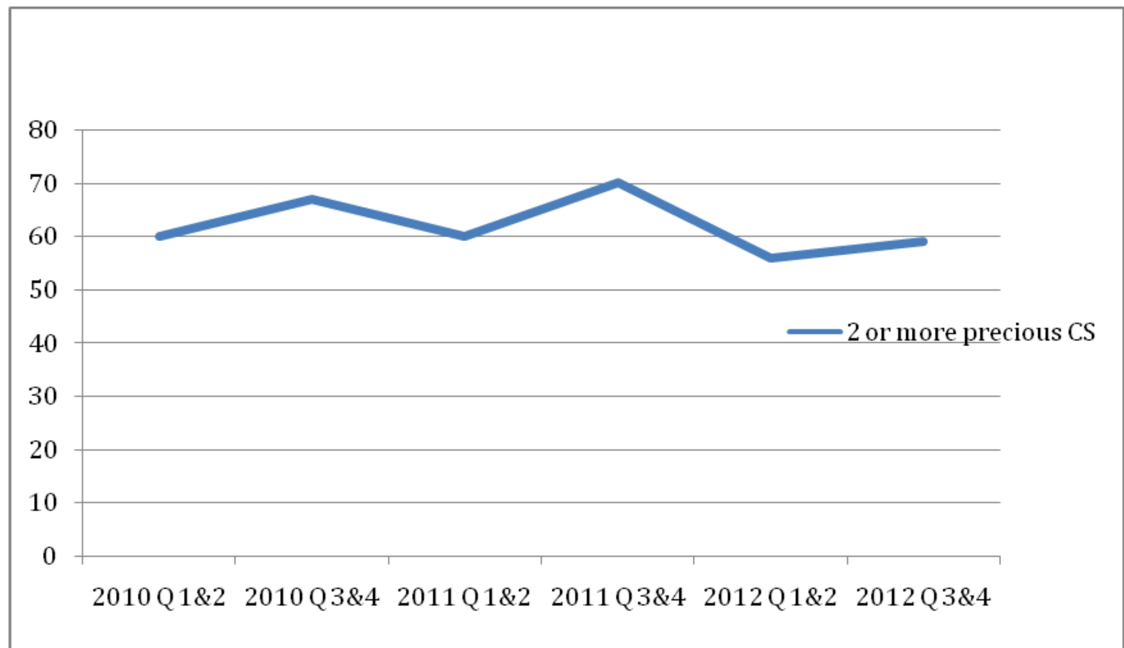
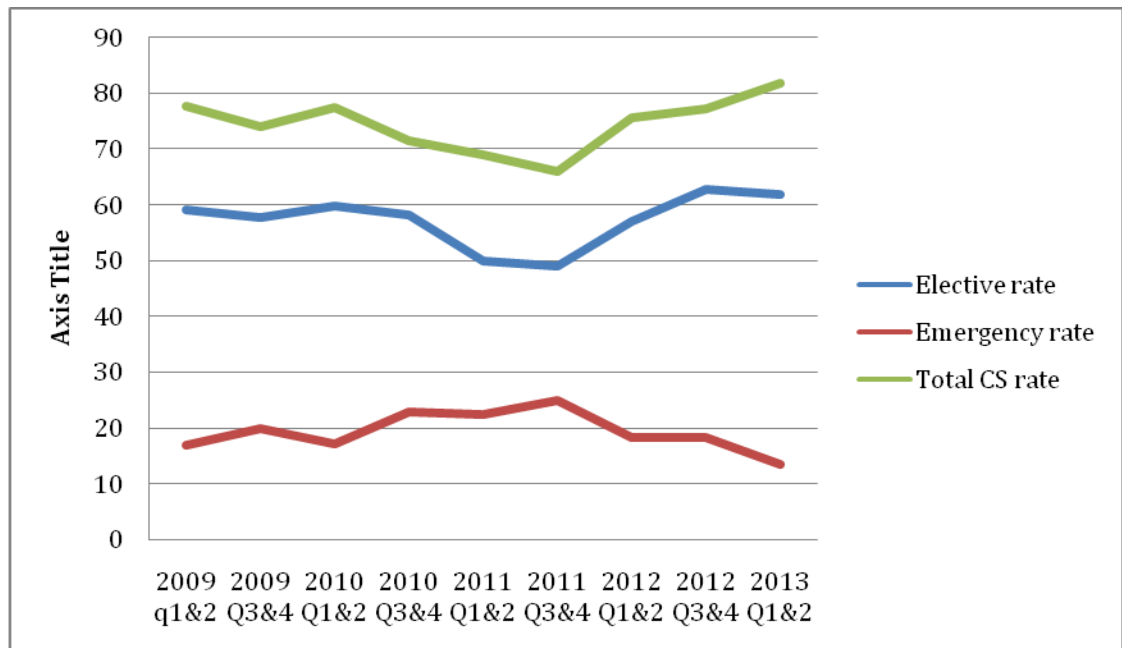


Figure 3: Elective, emergency and total CS rates in women at SMH with one previous CS (Jan 2009-June 2013)



- As we can see from the above chart, the emergency caesarean section rate in this group of women has remained relatively constant over the past 3 years and appears to be on a current downward trend.
- The elective caesarean section rate is the lead contributor to the overall caesarean section rate in this group, and again with the highest numbers ever of women booking and delivering in this category during the alert period, we can interpret and justify our data.

Elective Caesarean rates by NHS or private funding

- Table 4 shows that the national elective caesarean rate among private patients is around three times higher than the rate among NHS patients.
- Between July and December 2012, the SMH elective caesarean rates were higher than the national rates both for NHS and private patients. When compared to the previous six months, rates increased on the SMH site across both groups of patients.

Table 4: Elective caesarean rates (January to December 2012)			
	England	**Imperial College Healthcare NHS Trust- SMH Site**	
	Elective Caesarean rate	**Elective Caesareans (n)**	**Elective Caesarean rate**
January to June 2012			
NHS patients	10.3%	285	14.0%
Private patients	31.8%	200	34.0%
July to December 2012			
NHS patients	10.5%	309	16.0%
Private patients	33.2%	140	41.0%

Source: CMIS data

Elective Caesarean rates by delivery characteristics

The following analysis looks at elective caesarean rates among categories of women for whom the likelihood of having a caesarean differs.

At SMH, 2.7% of deliveries did not have enough information to be given one of these categories, compared to 15.5% in England. Therefore, the proportion of women who could be categorized was better at SMH than nationally.

The data that we have used from CMIS for the Robson groupings at the SMH site is more favorable than that suggested by the HES data that you have used.

For example, in delivery category 1, our figures compare favorably with national figures. In category 2, we are almost identical to national figures.

In category 4, we are significantly higher than national figures but the number in our group was so small (n=1) that it would not have influenced the overall elective caesarean section rate during the alert period.

We do have a significantly higher rate of elective caesarean sections in multiple pregnancies. All of our multiple pregnancies now have their management streamlined in a team of Consultants with Fetal Medicine expertise. Many of these pregnancies are high risk, decisions regarding mode of delivery are made at consultant level in the fetal medicine setting, and as such, the decisions for elective delivery in these cases would be justified.

We note a higher than anticipated rate of elective caesarean sections in category 6. The national figure is 8.2% and our figure of 19% is significantly higher than our previous figures (i.e. 6.25% at the last alert in 2011). This will be the subject of a further case note review of all of the sample size, but given that the actual numbers involved were relatively small (n=20), we would not anticipate that this has contributed to the overall high elective section rate during the alert period.

Table 5: Elective caesarean section rates by delivery characteristics (July to December 2012)- SMH Site

Delivery characteristics	England	Imperial College Healthcare NHS Trust	
	Elective Caesarean rate	Elective Caesareans (n)	Elective Caesarean rate
1. Single pregnancy, head down, 37 weeks or more	2.8%	10	2.5%
2. Women who had a previous C/S, single pregnancy, head down, 37 weeks or more	58.6%	132	57%
3. Single pregnancy, feet-first (breech)	51.2%	28	62.0%
4. Single pregnancy, presentations other than feet-first or head-first (e.g. shoulder)	5.8%	1	20.0%
5. Multiple pregnancy	35.3%	18	50.0%
6. Single pregnancy, head-first, premature birth (less than 37 weeks)	8.2%	20	19.0%

Source: CMIS Data

Notes:

a) Single pregnancy means no information was available to suggest a multiple pregnancy (using 'numbaby' and a diagnosis code in any position of O30 'Multiple gestation' or Z37.2 to Z37.7 'Outcome of delivery – twins or other multiple births').

b) Marker for a previous caesarean section was a diagnosis code (in any position) of O34.2 'Maternal care due to uterine scar from previous surgery', or O75.7 'Vaginal delivery following previous caesarean section'.

c) Marker for breech presentation was a diagnosis code (in any position) of O32.1 'Maternal care for breech presentation', O32.2 ' Maternal care for transverse and oblique lie', O64.1 'Obstructed labour due to breech presentation', or a delivery method (derived from primary procedure) of 'Breech Extraction delivery' or 'Other Breech delivery'.

d) Marker for unusual presentation was a diagnosis code (in any position) of O32 'Maternal care for known or suspected malpresentation of fetus' (excluding O32.1 and O32.2), or O64 'Obstructed labour due to malposition and malpresentation of fetus' (excluding O64.1).

Case note review:

As mentioned previously, CMIS generated all women who delivered by elective caesarean section during the alert period (July 2012- December 2012). From the hospital numbers generated a random sample of 100 notes was requested.
Five of these notes were missing and ten sets were removed from the analysis due to potential bias as the Consultant performing the case note review had made the decision for the elective caesarean section.

The remaining 85 sets of notes were thoroughly reviewed and the results detailed below under headings of the indication for the elective caesarean section.

1. One previous caesarean section (n=37)

This was the largest single group in the case note review, as we would expect.
In 9 of the cases, other medical factors existed which supported the decision for an elective caesarean section and thus were deemed "appropriate'. Contributing factors were for example, insulin dependent diabetes with severe fetal macrosomia and suboptimal glycaemic control.

The remaining 28 women in this group had no other contributory factors necessitating an elective caesarean section, as such were 'suitable' for an attempt at vaginal delivery, and thus were deemed 'inappropriate'. However, all the women in this group following counseling on mode of delivery, requested delivery by caesarean section.

It is of note that in this group of women overall, all 37 were eligible for referral to the Birth s Clinic (BOC) (even the ones whose elective caesarean section was appropriate as their other complicating factors did not develop until the very end of pregnancy). So, of the 37 women eligible for referral, only 12 were actually referred and only 9 were seen in the clinic. Of the 3 that were referred and did not have an appointment, 2 'could not get an appointment on time' and so were counseled by the Consultant in the antenatal clinic and the other women did not attend her booked appointment.

From the above review, it is clear that only 30% of women eligible for referral to the Birth Options Clinic are actually being referred and this is a significant under usage of this valuable resource. Of course, all of these women reviewed ended up having an elective caesarean section and requested one from the outset. Many of them were 'adamant' that they wanted an elective caesarean and so many might have declined the offer of a Birth Options Clinic referral, although this was only documented in one set of notes.

Following the CQC alert in 2011, we actioned setting up a Birth Options Clinic to address specifically our elective caesarean section rate in this group. This clinic is indeed 'up and running' and provides a very valuable service but we have recognized the need to increase referrals and staff to support it. In advance of this CQC alert, we had instigated changes to the clinic structure in March 2013 to improve throughput to the clinic and as such we would be optimistic that we have already made changes that will address this and pending the audit following these changes, we will be able to assess clinic uptake further.
However, following this alert and especially following this detailed case note review, it may be prudent for us to make more radical changes to organizational structure of the clinic. We will therefore take the following steps:

- We will second the lead midwife for the VBAC clinic on our sister site (which has been successful in reducing the elective caesarean section rate in this group of women). We will utilize her expertise to ensure the organization of the clinic mirrors that on the QCCH site and we will ensure the ongoing training and support of staff to optimally deliver this service.
- We will refer ALL eligible at booking to the Birth Options Clinic for their antenatal counseling and ensure that unless medically indicated, they do NOT need to see an obstetrician again regarding their mode of delivery and if necessary, they can return to the BOC for a second appointment.
- We will audit the clinic activity and also agreed mode of delivery (MOD) for all women attending and shall of course interpret this data in the context of our elective caesarean section rate in this group overall.
- These changes will be instituted from 01.08.13 and the first audit cycle will be completed by 31.01.14.

2. Breech (n=16)

This was the third largest group in the case note review. All of these women were seen and assessed for external cephalic version (ECV). 8 women had an ECV performed by a Consultant Obstetrician in the setting of the Breech Clinic. For the remaining 8 women, 2 declined an attempt at ECV and the other 6 had additional factors, which precluded an ECV attempt (previous caesarean section, IUGR, hypertension).
We were satisfied that the elective caesareans performed in this group were all appropriate.

3. Multiple pregnancy (n=6)

We know from studying our maternity statistics that we have higher numbers of multiple pregnancies compared to national figures (3.4% vs. 1.5%). We have streamlined the management of our multiple pregnancies so that they are looked after by a team lead by Fetal Medicine specialists who are best placed to make the decisions on mode of delivery following review of antenatal serial ultrasound scanning.
In his group of women (n=6), due to other co morbidities and growth concerns, only one woman was suitable for attempt at a vaginal delivery, she was counseled at Consultant level and requested a caesarean section which was agreed (although she was not referred to the birth options clinic). We are satisfied that all of the elective caesarean section in this group were appropriate.

4. Two or more previous caesareans. (n=13)

This was the second largest group of women in the review. 10 women had 2 previous caesarean sections and 3 women had 3 previous caesarean sections. Whilst we recognized that 2 previous caesarean sections is not a contraindication to an attempt at vaginal delivery, all of the women in this group requested an elective caesarean and as such we are satisfied that all caesarean sections in this group were appropriate.

5. Primip caesarean section (n=5)

Of the 5 notes reviewed all but 1 were ‘appropriate’ (previous myomectomy, pelvic fracture, hip dysplasia etc.). Only one woman had no ‘medical indication’ and requested an elective caesarean section on the basis of maternal anxiety. Whilst she was counseled extensively at Consultant level, she was not referred to the BOC at any stage.

6. Multips, without previous caesarean section. (n=6)

This group included 3 women whose pregnancies were implicated by placenta praevias, 2 third degree tears (seen in perineal clinic and caesarean section advised and one severe IUGR. We were satisfied that all of these were appropriate.

7. **Coding issues: (n=2)**
   In 2 cases, the caesareans were recorded as 'elective' by the doctors in the notes but were actually 'emergencies'. This amounts to a scribing error.

Action plan update from 2011 CQC Alert:

On careful review of our maternity statistics, the only 'obvious' anomaly during the alert period was a significant increase in the number of women who delivered in our unit with one previous caesarean section. Indeed, this was the highest number of women in that category that we have delivered in the past five years and as such, I am confident this has generated the alert. However, we have and do recognize that our section rate in women with one previous caesarean section remains higher than national figures and we feel this is largely due to the under utilization of our Birth Options Service.

Our action plans from 2011 are clearly outlined in Appendix 1.
Whist we have undertaken and completed all of the actions in the timeframe stated, it is clear we are still under-utilizing this service. The evidence from our case note review during the alert period, showed only 30% of women eligible for referral were seen.

Whilst we had already recognized this deficiency and had made changes to the clinic organization in March of this year, we do now need to be more radical in the clinic re-organization in order to address our elective caesarean section rate in this group.

We have put forward an action plan following this CQC alert (Appendix 2) with time frames and relevant personnel to be involved.

We will be happy to discuss any areas of our report and would welcome any feedback.

Theme	Detail/Action	Responsible	Progress/deadline
Overall caesarean section rate	Consolidate a 29% combined caesarean section rate, moving to 28% combined caesarean section rate within 6 months	All	28% by end 2011
Vaginal delivery after caesarean section	Establish consultant midwife-led VBAC clinic that all relevant women attend	Pauline Cooke (consultant midwife) Jenny Smith-lead midwife	Complete Oct-11

Appendix 1: Action Plan following CQC Alert 2011

	Continue development and audit of established VBAC clinic for all women with one previous caesarean section	Mandish Dhanjal Pauline Cooke (consultant midwife) Jenny Smith-lead midwife	Complete Clinic now running twice weekly
	Establish dedicated birth options clinic	Lorna Phelan (consultant Obstetricians) Pauline Cooke(consultant midwife)	Complete
	Review and update of birth options patient information leaflet Improvement and harmonisation of information given to women across sites	Maternity information steering group	Complete
Induction of labour	Delay IOL to no earlier than term +12 low risk primips and multips in line with NICE guidance	Mandish Dhanjal TG Teoh (consultant Obstetricians) Pippa Nightingale (Head of Midwifery)	Complete Sep-11
	Commence weekly consultant-led CTG and caesarean section education sessions to discuss cases from previous week	TG Teoh/Lorna Phelan Sara (Patterson-Brown (consultant Obstetricians)	Complete Aug-11
	Implement IOL using Propess for primip women	Serap Akmal Lorna Phelan (consultant Obstetricians)	Complete Nov-11

Appendix 2: Action Plan following CQC Alert 2013

Theme	Detail/Action	Responsible/	Completion date &/Report Lines
Overall caesarean section rate	Consolidate a 28% combined rate (St Mary's (SMH) and Queen Charlottes & Chelsea Hospitals(QCCH), moving to 27% combined caesarean section rate within 6 months	All	**Completion-** 31st December 2013 **Report to -** CPG Quality & Safety Board 16th -01-2014
Vaginal delivery after caesarean section	Review the VBAC process and patient pathway at SMH & QCCH and standardise the pathways	Pauline Cooke (Consultant midwife) Jenny Smith (Midwife)	**Completed-** 01.August 2013 **Report to -** CPG Quality & Safety Board 17-10-13-
	Further increase training and availability of midwives to staff the Birth Options Clinic and ensure all relevant women are referred at booking.	Pauline Cooke (Consultant midwife) Jenny Smith (Midwife)	**Completion** 1st Jan 2014 **Report to** CPG Quality & Safety Board 16th -01-2014
	Ensure ALL women with one previous caesarean section are NOT referred back to Obstetricians following attendance at the Birth Options Clinic unless medically indicated On-going 6 monthly audit to ensure that referrals are increasing and that DNA's are minimal.	All Team Lead Midwives, Lead is Pauline Cooke (Consultant midwife)	**Completion:** 1st Jan 2014 **Report to** CPG Quality & Safety Board 16th -01-2014. **Present** audit at postgraduate forum (Jan-June 2014, date to be confirmed)
	Routine postnatal ward round by Consultants to debrief women who have had an emergency caesarean section and counsel for VBAC in subsequent pregnancies Evidenced by documentation in patient notes- 6 monthly notes audit	Christina Yu Etienne Horner Lorna Phelan (Consultant obstetricians) Audit by Supervisors of midwives	**Completed**– ward rounds Audit completion 1st February 2014 **Report to** CPG Quality & Safety Board 10th April 2014 **Present** audit at postgraduate forum (Jan-June 2014, date to be confirmed)
	Discharge letter that includes a plan for the next birth to be given to all women following emergency caesarean section. Evidenced by a copy of the letter in the maternal notes-6 monthly notes audit	Christina Yu (Consultant obstetrician)	**Completed**- discharge letter- Audit completion 1st February 2014 **Report to** CPG Quality & Safety Board 10th April 2014 **Present** audit at postgraduate forum (Jan-June 2014, date to be confirmed)
	Weekly review of caesarean sections that occurred in the preceding week to ensure appropriateness and enhance learning	TG Teoh (Consultant obstetrician)	**Completed-** **Report to** CPG Quality & Safety Board 17-10-13-
	Ensure compliance with unit policy regarding the use of syntocinon for VBAC women.	Christina Yu Lorna Phelan (Consultant obstetricians)	**Completed** **Report to-** CPG Quality & Safety Board 17-10-13-

40, RESTRICTED

Care Quality Commission
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Mark Davies, Chief Executive
Imperial College Healthcare NHS Trust
The Bays, South Wharf Road
St Mary's Hospital
London
W2 1NY

05 June 2013

Our reference: C120/AH

Dear Mr Davies

Re: Care Quality Commission maternity outlier alert for elective caesarean section rates at Imperial College Healthcare NHS Trust

We are writing to notify you of the fact that analysis of maternity indicators undertaken by the Care Quality Commission has indicated significantly high rates of elective caesarean sections at your trust.

The Care Quality Commission has conducted its own analysis of this alert and considered the results alongside other relevant information held internally, including that provided by the trust in relation to a previous alert for this indicator (see Appendix 1). Based on the findings of this analysis, we would like to request information from the trust to enable us to review the matter further. In particular:

1. Any explanation you may have for the increased rates of elective caesarean sections at your trust in 2012 quarters 3 and 4, following a period of similar to expected rates, as indicated in our analysis (shown in Figures 1 and 2 of Appendix 1). Please provide us with your understanding of this and also an update on your progress with the work you had been undertaking to reduce your elective caesarean rate, as outlined in your previous response to us from 27 April 2011.

2. Evidence of any analysis you have undertaken to assess this alert. We expect this to include the details and findings of a case note review. We recommend that a random sample of at least 30 women who had an elective caesarean section from July 2012 onwards are included. Please refer to Appendix 3 for further guidance on the information we expect to be included in your review, and the level of detail we would like to see.

3. Please could you let us know details of any additional activity for this service that you have taken or are planning in response to this alert or your own performance monitoring. Please include details of how these actions will be implemented, and provide timescales for completion and the names or roles of the personnel

responsible for each of the actions planned. Can you also ensure that the actions address all areas where a need for improvement was highlighted by the review.

We would be grateful if you could provide this information by 2 July 2013. If you foresee any difficulty in complying with this request, please contact me to discuss the matter.

We do not necessarily expect you to have determined the cause of this alert. However, we would expect to see the evidence that assured you that either there were no concerns regarding the clinical care of these patients and/or, if you have identified areas where quality of care could be improved, that you have plans in place to address each of these areas, with clear timescales for completion and names of lead personnel.

We anticipate that the findings from your review will be incorporated into your clinical governance arrangements so that any learning points are disseminated within the trust, and we would like to have some assurance from you that this has happened or is planned.

If you have difficulty in identifying the relevant patients, please contact us as soon as possible on receiving this letter and we will able to provide further detail.

Please continue to communicate with your regular Care Quality Commission regional contacts with regards to general trust matters, but liaise directly with me with regards to these specific enquiries.

We look forward to receiving the information requested and anything additional you would like to provide.

This letter will be shared with your Care Quality Commission regional contacts and the Trust Development Authority for their information. We would also like to share this information with your local Clinical Commissioning Group(s) and Area Team and are aiming to have a list of the relevant bodies and named contacts to use for this purpose in future. However, as an interim measure, we would be grateful if you could let us know who the appropriate contacts would be in your case (including names, job titles and email addresses if possible), so that we can forward this letter to them.

If you would like to discuss the content of this letter in more detail, please do not hesitate to contact me.

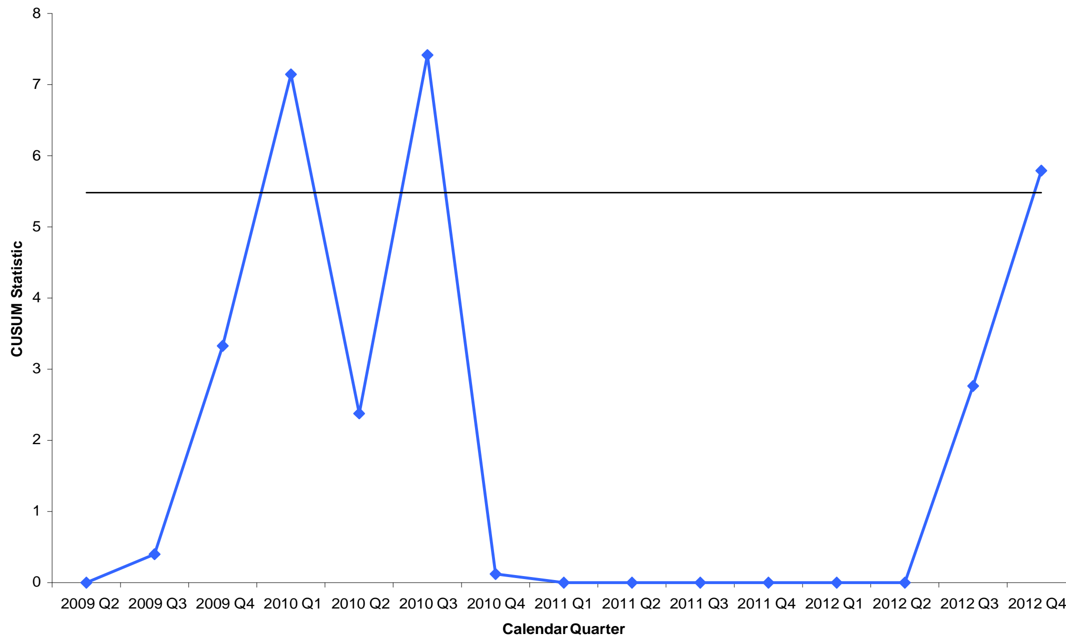
Yours sincerely

Mr Chris Sherlaw-Johnson
Surveillance Manager
020 7448 4547
outliers@cqc.org.uk

cc: Anne Farley – Compliance Inspector – Care Quality Commission
Gale Stirling – Compliance Manager – Care Quality Commission
Michele Golden – Compliance Manager – Care Quality Commission
Sarah Seaholme – Head of Regional Compliance – Care Quality Commission
Alwen Williams – Directory of Delivery & Development (London) – Trust Development Authority

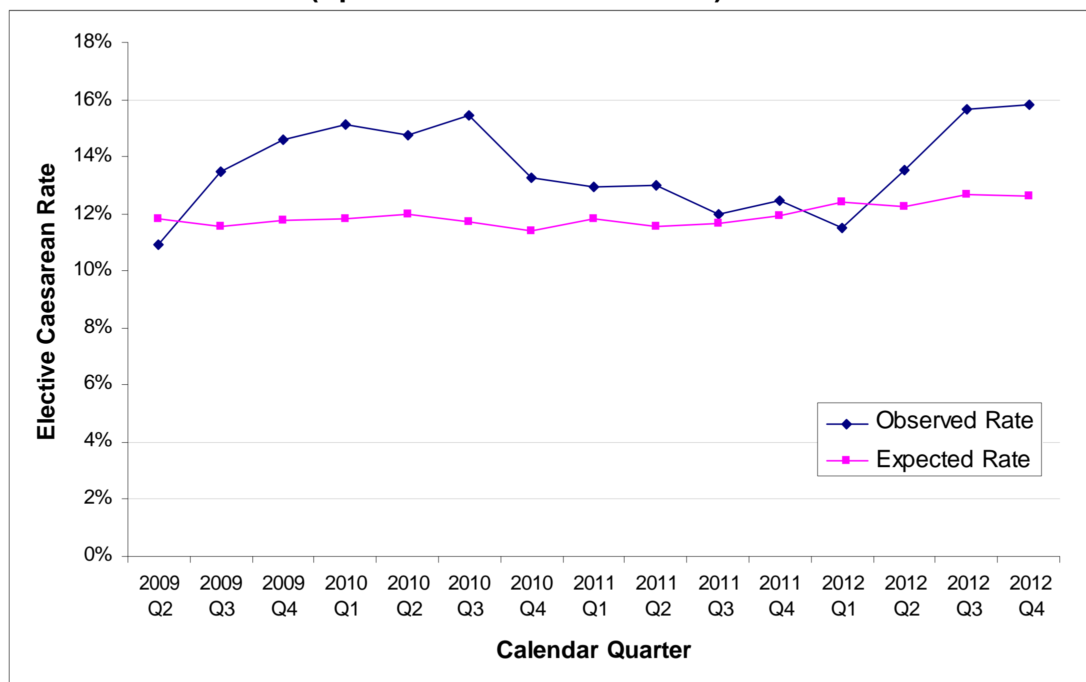
Trust **Imperial College Healthcare NHS Trust (RYJ)**	**Maternity Alert** **Elective Caesareans**

Figure 1: CUSUM statistical process control chart: standardised elective caesarean rates at Imperial College Healthcare NHS Trust (April 2009 to December 2012)



Source: Hospital Episode Statistics
Note: see Appendix 2 for information regarding CUSUM methodology; rates are indirectly standardised for the age profile of women delivering at the trust.

Figure 2: Observed and expected elective caesarean rates at Imperial College Healthcare NHS Trust (April 2009 to December 2012)



Source: Hospital Episode Statistics
Note: See Appendix 2 for information regarding the ‘expected rate’.

Summary

- This is the second elective caesarean outlier alert for the trust. Following the first alert in 2010 a notable decrease in rates was seen. However, during 2012 quarters 3 and 4 the rates have increased to previous levels.
- In the response to the previous outlier alert, the trust informed us about measures they had been taking to reduce their elective caesarean rate.
- The trust is a tertiary referral centre and has a significantly older profile of deliveries compared to nationally (*note that this indicator is indirectly standardised to adjust for the age profile of women delivering at the trust*).
- 9.3% of deliveries at the trust were among private patients, compared to 0.5% nationally. The trust's elective caesarean rate is higher than nationally among both NHS and private patients, and the rates among both groups have increased at the trust between July and December 2012 when compared to the previous six month period.
- Analysis by delivery characteristics showed that elective caesarean rates were higher than expected across all categories of women.
- The trust has recently achieved Level 3 on CNST Maternity Risk Management Standards.

1. Introduction

Imperial College Healthcare NHS Trust alerted, using the CUSUM time series technique (see Appendix 2 for method), for significantly high rates of elective caesarean sections, signalling in 2012 quarter 4 (see Figure 1). Figure 2 shows how the rates at the trust have compared to the expected rates since 2009 Q2.

Elective caesareans are identified by a primary procedure code of R17 (elective caesarean delivery) within a delivery episode. Standardisation is carried out to adjust for the age profile of women delivering at the trust.

The indicator detailed above, and the analysis within this report, are based on deliveries that took place in-hospital. Home deliveries are excluded, as the level of information recorded in HES for these deliveries is not detailed enough to be used in our analysis.

2. Previous elective caesarean section outlier case

This is the second time the trust has had an alert relating to elective caesarean section rates. The first alert signalled in 2010 quarter 2 (April to June 2010). Based on our analysis of HES we wrote to the trust, asking them to focus on elective caesareans among mothers aged 35 and over, as this was where the rate appeared to be significantly raised when compared to nationally.

In their response, the trust stated that the HES data used in the CQC analysis included private deliveries across both sites. At the St Mary's site, 804 of the 4,801 (16.7%) deliveries from October 2009 to September 2010 were private deliveries. Although they were in a separate location from the NHS patients, they were clinically governed by the NHS maternity division. The trust found that these deliveries skewed their caesarean section rate as the elective caesarean section rate for the 804 private deliveries alone was 38%. In contrast, the elective caesarean section rate for NHS deliveries only at St Mary's was 11.9%.

The number of private deliveries (250) at the Queen Charlotte's site was lower and did not skew the caesarean section rate. However, the total number of private deliveries across both sites totalled 1,054 and accounted for over 10% of the trust's deliveries. If these were excluded from the HES data, the trust felt their caesarean section rate (14.6%), while still high, would not have triggered the CUSUM alert signal.

The trust stated that the patient population for both sites is diverse and includes tertiary referrals to its specialist maternal and fetal medicine service.

The trust response included the results of the audit of elective caesarean sections on women aged 35 and over and for the period July to September 2010. This was individually reported by the Queen Charlotte's and St Mary's sites with a sub-analysis of the private patients delivered at the Lindo Wing, and included details of why each woman required a caesarean. The trust found valid reasons for all but four of the elective caesareans, which were at the request of the mother. All four of these women were private patients.

The trust stated that they provided 2 VBAC clinics. The one at Queen Charlotte's site has been open since January 2008 and is staffed by 2 midwives and a consultant obstetrician. The VBAC clinic at St Mary's started in July 2010 and this 'Birth Options' clinic is staffed by a consultant midwife with a consultant obstetrician available for advice when necessary. The trust did not believe the new clinic would have had a significant impact on the women who had previous caesarean sections during the time period covered by our analysis, but they were hopeful that women on both sites would benefit from this service.

The trust stated that they had been aware of their high caesarean section rate and had been introducing measures to improve the situation:

- Both maternity sites have monthly, quarterly and annual review of their clinical practice in the labour ward and produce reports. These reports raise awareness about clinical performance and they also address and highlight the caesarean section rates for the respective hospitals.
- Queen Charlotte's produces annual reports. The 2010 annual report showed that 70% of women who had a scar and laboured had a successful vaginal delivery. This improved performance was attributed to the VBAC clinic. This service was also introduced to the St Mary's site in July 2010.
- Since the merger of the two hospitals, there are now common clinical guidelines which are applicable to both sites. Those focussing on lowering the caesarean section rate were included in the response. However, most of these guidelines were written in 2010 Q3 and would not have been in place in sufficient time to influence the outcome of caesarean sections at the time of the alert.
- The Robson's 10 groupings for maternal characteristics have been used to differentiate the reasons for caesarean and has proven to be useful in reducing the rate in some categories by changing clinical practice, for example, intrapartum care, timing of examinations, use of syntocinon and CS at full dilatation, a consultant led outpatient induction programme and using propess for all the nulliparous women.
- Queen Charlotte's was used as a pilot site to change the prostaglandin induction agent and also introduce a consultant led outpatient induction programme. They have managed to decrease the caesarean rate from induction of labour from 39% to 34% in 2 years and so this practice will now be introduced to the St Mary's site.
- Once work on a multi-centre randomised controlled trial comparing the mode of delivery for multiple pregnancies is completed and published, the trust will convene a multi-disciplinary team to propose the optimal management of the delivery of multiple pregnancies.

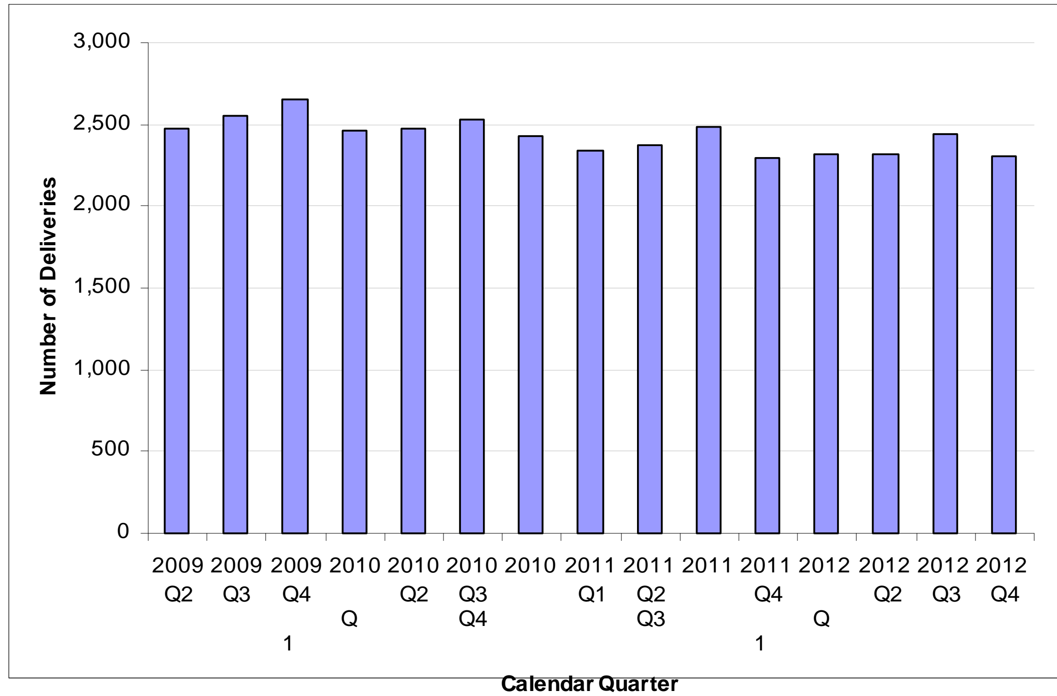
The case was closed in June 2011 with regional follow up on the trust action plan.

3. Deliveries at the trust

Volumes of deliveries

- Figure 3 shows the quarterly volumes of deliveries at the trust since 2009 quarter 2.

Figure 3: Quarterly numbers of deliveries at Imperial College Healthcare NHS Trust (April 2009 to December 2012)



Source: Hospital Episode Statistics

Delivery methods

- Table 1 shows that, in addition to a significantly high elective caesarean rate, the trust had a notably high ventouse delivery rate (11.8% compared with 5.9% nationally).
- The normal delivery rate at the trust was lower than nationally (51.1% compared with 60.9%).

Table 1: Proportion of deliveries by recorded delivery method (July to December 2012)

	England	Imperial College Healthcare NHS Trust	
	Deliveries (%)	**Deliveries (n)**	**Deliveries (%)**
Elective caesarean delivery	10.6%	746	15.7%
Other/Emergency caesarean delivery	14.5%	719	15.2%
Breech Extraction delivery	0.0%	3	0.1%
Other Breech delivery	0.4%	4	0.1%
Low Forceps cephalic delivery	3.1%	257	5.4%
Other Forceps Delivery	3.7%	8	0.2%
Ventouse (Vacuum) delivery	5.9%	560	11.8%
Spontaneous other delivery	0.4%	5	0.1%
Normal delivery (Spontaneous vertex)	60.9%	2,424	51.1%
Other/unrecorded delivery method	0.5%	14	0.3%
Total deliveries	334,581	4,740	100%

Source: Hospital Episode Statistics
Notes: Delivery methods are derived from primary procedure.

Profile of all deliveries at the trust

- Analysis showed that the trust had an older profile of deliveries compared to nationally as well as a significantly high rate of multiple deliveries (see Table 2). This fits with the information previously supplied by the trust about their complex casemix, which includes tertiary referrals to its specialist maternal and fetal medicine service.
- In their response to a previous alert relating to elective caesarean section rates in 2010, the trust stated their high proportion of private patients was skewing their overall elective caesarean rate. Table 2 shows that, between July and December 2012, 9.3% of the trust's deliveries were privately funded, a much higher proportion than nationally (0.5%)

Table 2: Profile of all deliveries (July to December 2012)

	England	Imperial College Healthcare NHS Trust	
	Deliveries (%)	Deliveries (n)	Deliveries (%)
Gestation period			
Under 24 weeks	0.8%	3	0.1%
Pre term 24-36 weeks	7.3%	339	7.4%
Term 37-42 weeks	91.6%	4,240	92.4%
Post Term >42 weeks	0.3%	9	0.2%
Single or multiple births			
Single	98.5%	4,642	97.9%
Multiple	1.5%	98	2.1%
Mother's age			
Under 20	4.6%	70	1.5%
20-34	76.1%	3,116	65.7%
35-39	15.4%	1,154	24.3%
40+	3.9%	400	8.4%
NHS or privately funded patient			
NHS patient	99.4%	4,299	90.7%
Private patient	0.5%	441	9.3%
Length of stay			
Median length of stay	2 days	2 days	
Total number of deliveries			
Total number of deliveries	334,581	4,740	

Source: Hospital Episode Statistics

Notes: A single birth includes any delivery where there is no indication of a multiple birth; analysis of gestation periods excludes deliveries where this information was unrecorded (16.8% nationally compared to 3.1% at the trust).

4. Triggering Indicator: Elective caesarean section rate

Quarterly deliveries and elective caesareans

- Table 3 shows quarterly numbers of elective caesareans at the trust compared to the expected numbers.
- Across the end of 2009 and throughout 2010 the trust had higher than expected numbers of elective caesarean sections, which led to their first outlier alert for this indicator (which we have previously followed up with the trust, see section 2). The trust's standardised ratio started to decrease following the previous alert, down to a low of 92.7 in 2012 quarter 1.
- However, the standardised ratio has shown a notable increase in 2012 quarter 3 which was sustained in 2012 quarter 4, leading to the CUSUM signal (see Figure 1).

Table 3: Quarterly elective caesarean sections at Imperial College Healthcare NHS Trust (April 2009 to December 2012)

Quarter	Deliveries	Elective caesareans	Expected elective caesareans	Standardised Ratio (SR)
2009 Quarter 2	2,478	271	293.3	92.4
2009 Quarter 3	2,549	344	294.9	116.7
2009 Quarter 4	2,655	387	312.0	124.0
2010 Quarter 1	2,464	373	291.8	127.8
2010 Quarter 2	2,471	364	296.1	122.9
2010 Quarter 3	2,529	390	296.3	131.6
2010 Quarter 4	2,432	323	277.8	116.3
2011 Quarter 1	2,342	303	276.5	109.6
2011 Quarter 2	2,373	308	274.5	112.2
2011 Quarter 3	2,484	298	290.2	102.7
2011 Quarter 4	2,297	286	273.5	104.6
2012 Quarter 1	2,320	267	288.0	92.7
2012 Quarter 2	2,312	313	283.5	110.4
2012 Quarter 3	2,439	382	309.0	123.6
2012 Quarter 4	2,301	364	290.6	125.3

Source: Hospital Episode Statistics

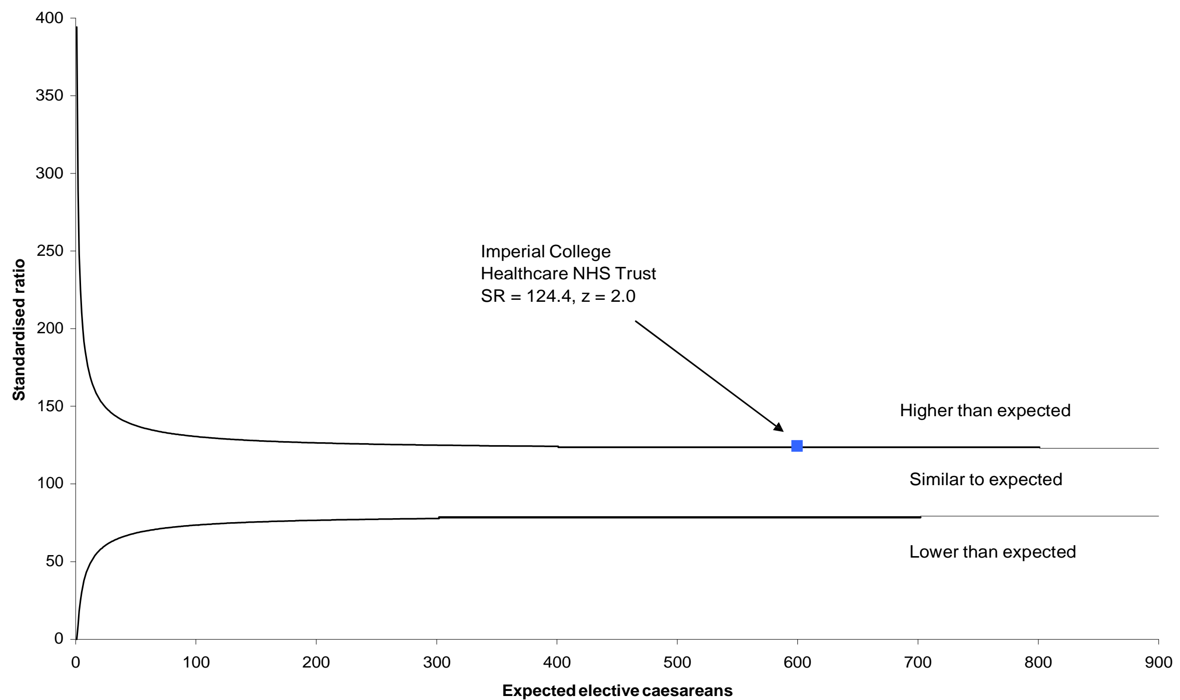
Caesarean section rates (January to December 2012)

- Table 4 shows the elective caesarean rate and the comparable emergency caesarean rate at the trust for two time periods; January to June 2012 and July to December 2012.
- Cross sectional analysis of standardised elective caesarean rates showed the trust's rates to be significantly higher than expected (see Table 4 and Figure 4) between July and December 2012. This was a significant increase from the previous six month period (January to June 2012), when the rate at the trust had been well within expected limits.
- Both the emergency and overall caesarean rates at the trust were found to be within expected limits for both time periods.
- In addition, analysis was carried out to compare the elective caesarean rate at the trust to other trusts within London. This found a rate of 11.0% from July to December 2012, which was still much lower than the trust's rate of 15.7%.

Table 4: Caesarean rates (January to December 2012)				
	England	Imperial College Healthcare NHS Trust		
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio
January to June 2012				
Elective caesareans	10.4%	580	12.5%	101.5 (z = 0.1)
Emergency caesareans	14.5%	777	16.8%	109.7 (z = 0.7)
Total caesarean rate	24.9%	1,357	29.3%	106.1 (z = 0.8)
July to December 2012				
Elective caesareans	10.6%	746	15.7%	124.4 (z = 2.0)
Emergency caesareans	14.5%	719	15.2%	99.3 (z = -0.1)
Total caesarean rate	25.1%	1,465	30.9%	110.7 (z = 1.2)

Source: Hospital Episode Statistics

Figure 4: Cross sectional funnel plot of standardised elective caesarean section rates among all trusts (July to December 2012)



Source: Hospital Episode Statistics

Elective Caesarean rates by NHS or private funding

- In their response to a previous alert relating to elective caesarean section rates in 2010, the trust stated that their high proportion of private patients was skewing their overall elective caesarean rate. Therefore, we carried out analysis to investigate whether the trust's rate is higher than nationally across both NHS and privately funded patients. It also looks at the previous six month period to see whether the increase in rates is attributable to one subset of patients.
- Table 5 shows that the national elective caesarean rate among private patients is around three times higher than the rate among NHS patients.
- Between July and December 2012 the trust's elective caesarean rates were higher than the national rates both for NHS and private patients. When compared to the previous six months, rates increased at the trust across both groups of patients.

Table 5: Elective caesarean rates (January to December 2012)

	England	Imperial College Healthcare NHS Trust	
	Elective Caesarean rate	Elective Caesareans (n)	Elective Caesarean rate
January to June 2012			
NHS patients	10.3%	465	10.8%
Private patients	31.8%	115	37.5%
July to December 2012			
NHS patients	10.5%	558	13.0%
Private patients	33.2%	188	42.6%

Source: Hospital Episode Statistics

Elective Caesarean rates by delivery characteristics

The following analysis looks at elective caesarean rates among categories of women for whom the likelihood of having a caesarean differs. The availability of the detail needed to make these groupings depends on the quality and completeness of data (which, at this level of detail, is very variable among trusts). Therefore, this information should be viewed only as a guide as to where the main differences appear to be compared to national rates.

At the trust, 2.7% of deliveries did not have enough information to be given one of these categories, compared to 15.5% in England. Therefore, the proportion of women who could be categorised was better at the trust than nationally. Notes about the information used to make the groupings are shown below Table 6.

The trust's elective caesarean rates were raised compared to nationally across all delivery characteristic categories (see Table 6). In addition, rates had increased since the previous six month period (January to June 2012) across all groups.

Table 6: Elective caesarean section rates by delivery characteristics (July to December 2012)

Delivery characteristics	England	Imperial College Healthcare NHS Trust	
	Elective Caesarean rate	Elective Caesareans (n)	Elective Caesarean rate
1. Single pregnancy, head down, 37 weeks or more	2.8%	138	4.0%
2. Women who had a previous C/S, single pregnancy, head down, 37 weeks or more	58.6%	359	66.9%
3. Single pregnancy, feet-first (breech)	51.2%	140	60.3%
4. Single pregnancy, presentations other than feet-first or head-first (e.g. shoulder)	5.8%	9	16.1%
5. Multiple pregnancy	35.3%	49	50.0%
6. Single pregnancy, head-first, premature birth (less than 37 weeks)	8.2%	33	13.1%

Source: Hospital Episode Statistics
Notes:
a) Single pregnancy means no information was available to suggest a multiple pregnancy (using 'numbaby' and a diagnosis code in any position of O30 'Multiple gestation' or Z37.2 to Z37.7 'Outcome of delivery – twins or other multiple births').
b) Marker for a previous caesarean section was a diagnosis code (in any position) of O34.2 'Maternal care due to uterine scar from previous surgery', or O75.7 'Vaginal delivery following previous caesarean section'.
c) Marker for breech presentation was a diagnosis code (in any position) of O32.1 'Maternal care for breech presentation', O32.2 ' Maternal care for transverse and oblique lie', O64.1 'Obstructed labour due to breech presentation', or a delivery method (derived from primary procedure) of 'Breech Extraction delivery' or 'Other Breech delivery'.
d) Marker for unusual presentation was a diagnosis code (in any position) of O32 'Maternal care for known or suspected malpresentation of fetus' (excluding O32.1 and O32.2), or O64 'Obstructed labour due to malposition and malpresentation of fetus' (excluding O64.1).

Appendix 2: Glossary

Cross-sectional analysis
The cross-sectional analysis measures the standardised ratio (SR) for a chosen single period and the extent to which it deviates from the norm. SR's are presented on a funnel plot. The control limits, with their distinctive funnel shape, represent a specified significance level.

CUSUM
This technique identifies persistent deviations from expected values over time. If outcomes are lower than the national average plus a predefined tolerance level then the plot will stay at zero. If higher, the CUSUM plot will move upwards. If a significant run of high values is detected, the plot crosses a fixed 'control limit' and the plot is then reset to zero. Resetting the plot after an alert allows for further runs of high values to be detected.

Expected elective caesareans
Expected numbers of elective caesareans are calculated by comparing rates at a given trust to national rates on a quarterly basis. Within this comparison, indirect standardisation is carried out to adjust for differences in the age of women delivering at the trust. Please note that home births are excluded from the analysis.

HES data
Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contain details of all NHS outpatient appointments in England.

Outlier Status
An outlier is a trust performing significantly differently than expected on a given measure - here this generally relates to standardised rates in comparison to national levels. The method used to identify outliers among the basket of maternity indicators was a type of statistical process control (a methodology that is used to identify significant deviations from a predefined standard) called CUSUM (short for Cumulative Sum).

Spells
A spell of treatment is a continuous period of treatment within a single hospital provider (a period commencing with admission to hospital and ending on discharge) and can be made up of a number of care episodes.

Statistical Process Control
Statistical process control (SPC) is a methodology that uses control charts to identify significant deviations from a predefined standard. These methods originated in manufacturing industry and are now regularly applied to the monitoring of healthcare.

Z Score
The z-scoring approach enables us to measure outcomes on a common scale. The z-score measures the number of standard deviations away from the mean, preceded by a plus or minus depending on whether it is respectively above or below the mean (the mean value is commonly the average value for all trusts, or all trusts of a specific type). High z-scores indicate worse outcomes and low z-scores good outcomes. Z-scores correspond to p-values in that a p-value of 0.01 is equal to a z-score of 2.3 and a p-value of 0.001 matches a score of 3.0.

Appendix 3: Information regarding case note reviews

INFORMATION REGARDING CASE NOTE REVIEWS

When a trust carries out a review of case notes in order to establish whether there have been any concerns about the quality of care provided to their patients, it is very useful for the Care Quality Commission to be provided with information regarding the methodology used, as well as the full findings.

Please ensure that the following level of information is included in the report of any case note review that is carried out in response to an outlier alert: -

- Whether the case notes for all the patients concerned were examined or a sample was identified. If a sample was used, details should be given of how it was chosen.
- Whether all the cases identified were available for review. If they were not, details should be given as to why.
- Whether all available cases were actually reviewed. If they were not, please give details as to why.
- The roles of those involved in extracting the clinical information from the notes should be provided.
- The extent of medical and/or clinical involvement should be described.
- Where possible, those involved in reviewing the case notes should be independent of those responsible for the patients' treatment.
- An assessment of the quality of care given should be included for each of the patients reviewed.
- Please give details of the process used and evidence for the conclusions drawn, including if the review considered whether:
    - Any adverse events were avoidable.
    - The diagnosis and care provided could have been improved.
- Anonymised individual patient level summaries and any proforma used should be provided.
- When a proforma is used, the response should include the findings for each of the aspects covered.
- Details and/or reference(s) to any published methodology used for the review.
- Whether changes were made to the clinical coding as a result of the case note review. If so, please provide details of these changes.
- How **all** areas identified for improvement will be addressed. Please include details of how these actions will be implemented, and provide timescales for completion and the names or roles of the personnel responsible for each of the actions planned. It should also be clear how you plan to assess the impact of these actions.

Imperial College Healthcare NHS
NHS Trust

Report Title: Update on Results of GMC National Trainees Survey 2013

To be presented by: Jeremy Levy, director of education

Executive Summary:
The national trainees survey is conducted every year by the GMC, with response rates from junior doctors across London of >97%. Overall our results this year are significantly better than in 2012, with far fewer red flags (trainees reporting aspects of training being in the bottom 25% of the UK) but also fewer green flags (top 25%). We are excellent in training particularly within emergency medicine on all sites at all levels and specialist paediatric services at StM, in GUM, sports medicine, GP paediatrics and aspects of a number of other specialties. Trainees raise significant concerns especially in surgical specialties at FY1 and FY2 level, in haematology (but this is significantly better than 2012) and clinical oncology (unchanged from 2012) .
A summary and detailed breakdown of these results are attached, and will be disseminated widely.

Compared with the other Shelford group Trusts we have improved since 2012: but still remain in the bottom half with fewer green and more red flags overall. In NW London we are in the upper half of Trusts.
Action plans are being developed in all departments where concerns were raised.

Key Issues for discussion: implementation plans for changes with departments need to be seen by divisional/CPG boards to support improvements in trainee experience. Individual departments within CPGs need to ensure follow-up from action plans. The healthcare education board will oversee across the Trust

Legal Implications or Review Needed
No

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare improving patient safety and satisfaction
2. Attract and retain high caliber workforce, offering excellence in education
3. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:
Due Diligence

Purpose of Report
a. For Decision
b. For information/noting/action plan ☒

Imperial College Healthcare NHS
NHS Trust

GMC trainees survey 2013report

Jeremy Levy

This is a summary of the results from this year's GMC national trainees survey (http://www.gmc-uk.org/help/nts2013reportingtool.htm) and a comparison with last the last 2 years results. This is important. The results are public and used by the NHSLA, CQC, GMC, Deanery and other regulators when considering quality of training, quality of patient care and patient safety issues. The results are also used in determining where trainees should be removed during the inevitable future reductions in training posts in London. There are of course many important caveats, but regardless the results are important. Small numbers of trainees can alter the results significantly, but this is true for all trusts and we must use the data to focus improvements. This is not the only source of feedback about training.

I have highlighted red and green "flags", which signify we are reported as being in the top or bottom 25% of the UK, and that the mean scores do not overlap with the national mean scores, ie we are truly an outlier for that criterion.

Overall we have far fewer red flags than in previous years which is excellent, but also fewer green flags. Our performance against other Shelford trusts has improved.

		2010	**2011**	**2012**	**2013**
Trust overall	**Red**	**81**	**93**	**63**	**40**
	Green	**78**	**66**	**44**	**16**

Where are we good?	**Where are we poorest?**
Emergency Medicine GUM Infectious Diseases Sports and Exercise Medicine Anaesthetics for F2 Dermatology GP paediatrics Plastic surgery Urology Neurology at St Mary's Geriatrics CX and HH Diabetes and endocrinology at CX Gastroenterology CX and HH ENT St Mary's Paediatric immunology and paediatric EM	Clinical Oncology Surgery F2 posts Surgery F1 posts These have been consistently poor for > 2 years Aspects of clinical radiology, GP posts in O+G, haematology, medical microbiology, Medicine F2, ophthalmology, trauma and orthopaedics Haematology has improved significantly but still retains red flags (no longer for work load but for induction and handover)

Consultant and other staff undermining: No data in 2013

Clinical supervision:

Poor (Red flags) in Surgery F2, trauma and orthopaedics, clinical radiology

Excellent in Sports and Exercise medicine, gastro, geriatrics, ID, neurology and medicine F1

Handover and induction:

Poor (Red flags) only in haematology and surgery F2

These areas (clinical supervision, handover and induction) are significantly better than in 2012

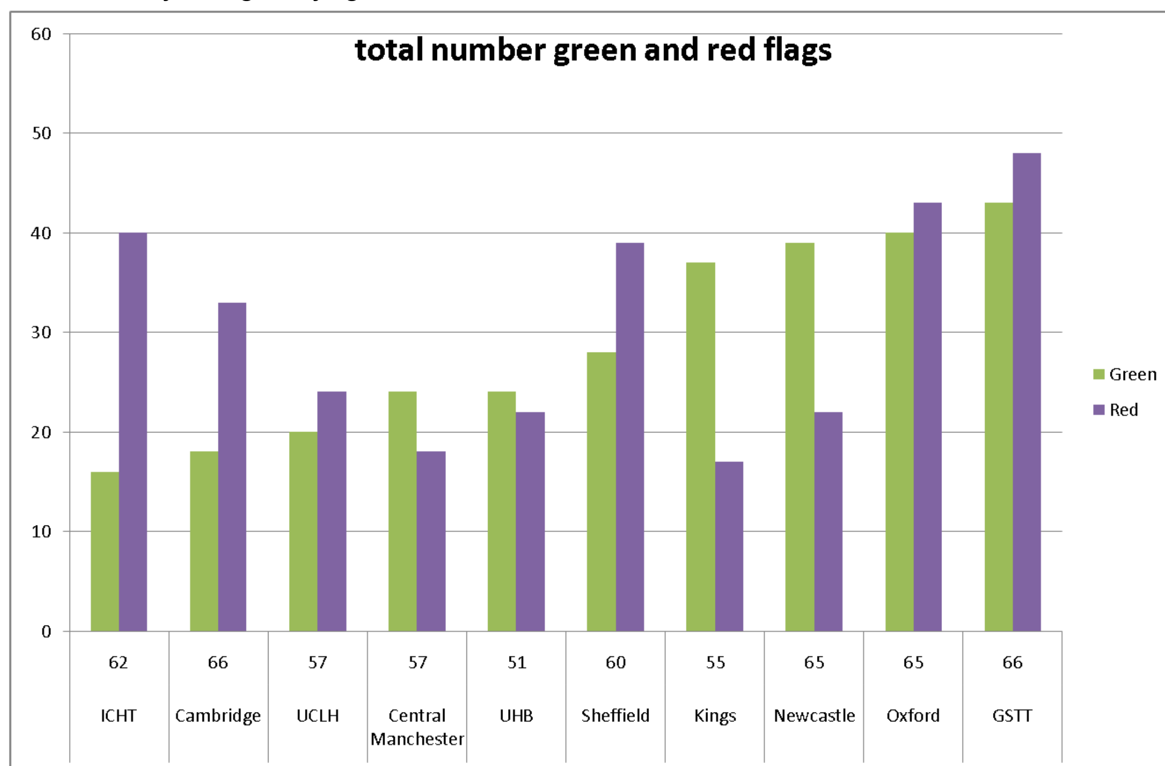
These results have been disseminated to Heads of education and department training leads and action plans being generate for the DMEs to review.

Comparison with Shelford group trusts:

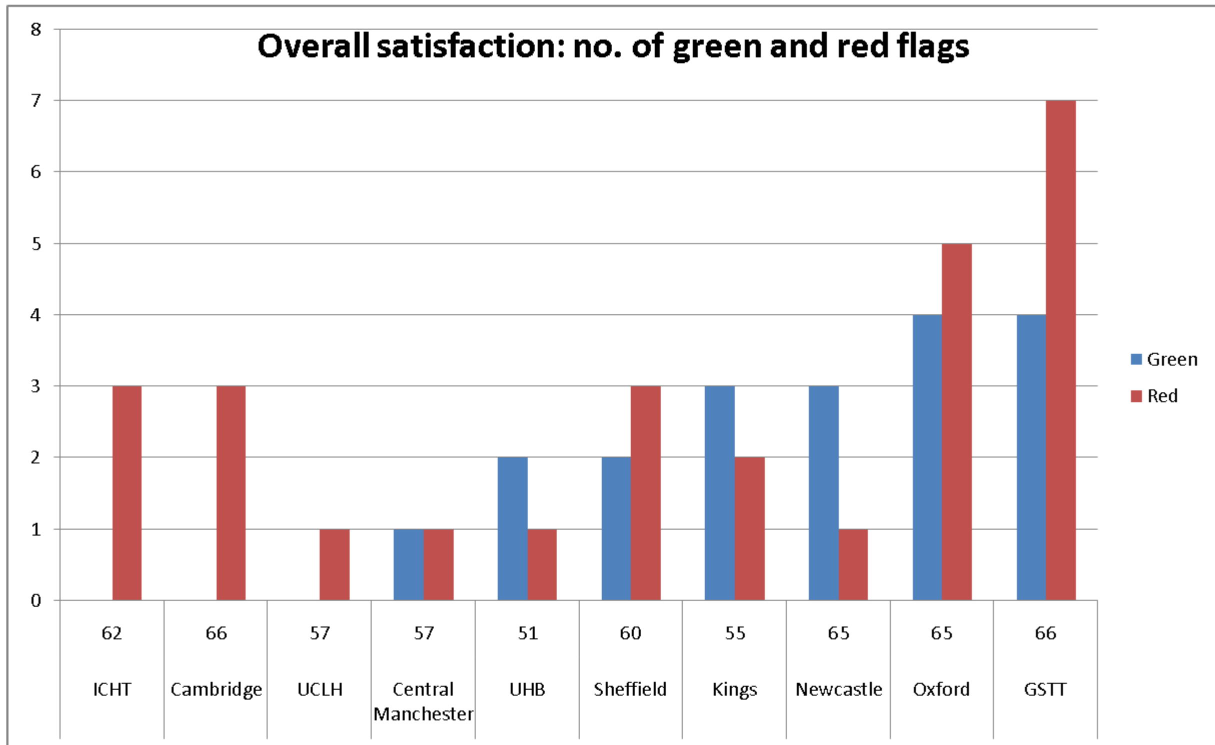
Analysis of the total number of red and green flags overall (ie where depts. within Trusts are outliers: top or bottom 25% and statistically outlying) for all specialties (measured as programmes not individual posts). Each trust will have slightly different numbers of training programmes but this is approximately 60 for most of these Trusts. .

Imperial no longer has the most red flags having overtaken GSTT and Oxford.

ICHT still has fewer green flags than other Trusts.



Looking at the one question "overall how satisfied are you with your training", in all 86 specialty programmes for which GMC report data (not all programmes are undertaken or provide data in all Trusts), and examining how many specialties have red or green flags for this question within each Shelford trust, Imperial is no longer the poorest, however in no specialty do we achieve a green flag in this question overall as a Trust, but we do when analysed by site: for Geriatrics at CX, endocrinology at CX and Gastoenterology at HH. Overall we received 3 red flags for this measure.


Overall satisfaction: no. of green and red flags
8
7
6
5
4
3
2
1
0
Green
Red
62
ICHT
66
Cambridge
57
UCLH
57
Central Manchester
51
UHB
60
Sheffield
55
Kings
65
Newcastle
65
Oxford
66
GSTT

Program Group	Site	Overall Satisfaction	Clinical Supervision	Handover	Induction	Adequate Experience	Work Load	Educational Supervision	Educational Resources	Feedback	Local Teaching	Regional Teaching	Study Leave
ACCS	CXH												
	HH												
	SMH												
	ICHT												
Acute Internal Medicine	CXH												
	SMH												
	ICHT												
Anaesthetics	CXH												
	HH												
	QCH												
	SMH												
	ICHT												
Anaesthetics F1	SMH												
Anaesthetics F2	CXH												
	HH												
Anaesthetics F2	ICHT												
Audio vestibular medicine	CXH												
Cardio-thoracic surgery	HH												
Cardiology	CXH												
	HH												
	SMH												
	ICHT												
Chemical pathology	CXH												
	SMH												
	ICHT												
Clinical oncology	CXH												
	HH												
	ICHT												
Clinical pharmacology and therapeutics	HH												
	SMH												
	ICHT												

Clinical radiology	CXH												
	HH												
	SMH												
	ICHT												
CMT	CXH												
	HH												
	SMH												
	ICHT												
Core Anaesthetics	CXH												
	HH												
	SMH												
	ICHT												
CST	CXH												
	HH												
	SMH												
	ICHT												
Dermatology	HH												
	SMH												
	ICHT												
Emergency medicine	CXH												
	SMH												
	ICHT												
Emergency Medicine F2	CXH												
	SMH												
	ICHT												
Endocrinology and diabetes mellitus	CXH												
	HH												
	SMH												
	ICHT												
Gastroenterology	CXH												
	HH												
	SMH												
	ICHT												
G(I)M	HH												
General surgery	CXH												

	HH												
	SMH												
	ICHT												
Genito-urinary medicine	SMH												
Geriatric medicine	CXH												
	HH												
	SMH												
	ICHT												
GP Prog - Emergency Medicine	SMH												
GP Prog - Medicine	CXH												
	St Johns Hospice - JOH01												
	SMH												
	ICHT												
GP Prog - Obstetrics and Gynaecology	HH												
	SMH												
	ICHT												
GP Prog - Paediatrics and Child Health	CXH												
	HH												
	SMH												
	ICHT												
GP Prog - Surgery	CXH												
Haematology	ICHT												
Histopathology	CXH												
	HH												
	SMH												
	ICHT												
Infectious diseases	CXH												
	HH												
	SMH												
	ICHT												
Intensive care medicine	CXH												
	HH												
	ICHT												
Medical microbiology	SMH												

Specialty	Site
Medical microbiology and virology	CXH
	HH
	ICHT
Medical oncology	CXH
	HH
	ICHT
Medical Virology	SMH
Medicine F1	CXH
	HH
	SMH
	ICHT
Medicine F2	CXH
	HH
	SMH
	ICHT
Neurology	CXH
	SMH
	ICHT
Neurosurgery	CXH
Obstetrics and gynaecology	HH
	QCH
	SMH
	ICHT
O&G F1	QCH
O&G F2	SMH
Occupational medicine	Imperial College Medical School - RYJIC
Ophthalmology	CXH
	WEH
	ICHT
Otolaryngology	CXH
	SMH
	ICHT
Paediatrics	HH
	SMH

	ICHT
Paeds a&CH F1	SMH
Palliative medicine	HH
Pathology F2	SMH
Plastic surgery	CXH
Radiology F2	CXH
Renal medicine	HH
Respiratory medicine	CXH
	HH
	SMH
	ICHT
Rheumatology	CXH
	HH
	SMH
	ICHT
Sport & Exercise Medicine	CXH
Surgery F1	CXH
	HH
	SMH
	ICHT
Surgery F2	CXH
	HH
	SMH
	ICHT
Trauma and orthopaedic surgery	CXH
	SMH
	ICHT
Urology	CXH

Trust Board: 24th July 2013:

Education directorate: update on action plan for educational issues for doctors and medical students within ICHT

July 2013 *Jeremy Levy, Director of Education*

Issue	Action (March 2013)	Update July 2013
Lack of physical space for simulation based training	1. For skills and simulation based learning, agreement has been reached with Prof Hanna to use resources within the Paterson Building, however this remains insufficient for need across all specialties due to the high throughput of students currently, and limited rooms. 2. Needs analysis being undertaken currently by newly appointed simulation lead to determine detailed requirements for simulation space across all specialties and for multiprofessional training and training based on significant and serious incidents: current estimates indicate a significant shortfall. 3. We continue to use (and pay for) trainees to attend simulation sessions at Chelsea and Westminster and other Trusts and this will continue unless we can develop more space locally 4. It is unlikely Paterson can offer sufficient space to meet Trust needs and will require space for which significant funds were awarded by the Deanery in 2013, but at risk if not used.	Simulation officer/manager appointed and detailed analysis of all simulation undertaken. 116 medical staff (mostly consultants) trained as simulation faculty. 187 courses planned on being run in simulation centre. Currently plans for delivery of 93 days of simulation training to 784 staff not actionable from lack of space covering training for FY1 doctors, core medical, obstetric & renal trainees, nursing, advanced faculty development, surgical laparoscopic skills, registrar skills, airway course and SI simulations. Prof Hanna determining how we jointly share simulation centre but currently large shortfall predicted in available simulation rooms.
Lack of physical space for small group teaching and training, especially at St Mary's	1. Remains a significant problem. Teaching rooms have been removed by Trust for clinical service over last 3 years and not replaced. The Education team have not identified any new space for converting to seminar rooms despite further assessment in December 2012 and February 2013. Proposals to use Mint Wing and V+A ward have been shelved by Trust but no	Space remains un-identified at St Marys although current plans suggest renovation of Mint Wing could accommodate new teaching rooms. Other options including MDT rooms have not emerged.

	replacements identified. No space available for this within Paterson. Head of estates formally asked to identify space again in March 2013, following similar requests in 2011 and 2012. 2. Room identified within renal building at Hammersmith which could be more widely used for teaching but ongoing conversations with renal department preventing ease of access for teaching	Teaching space identified at Hammersmith in renal centre for undergraduate teaching on ground floor renal block although access not ideal.
Postgraduate medical training: trainee feedback on quality of training	1. internal survey of all trainees completed in February 2013: many positive aspects reported, but concern over work intensity in some areas (52% reported workload heavy or very heavy), rota patterns, very poor IT infrastructure on wards (too few computers and unreliable, slow, too many systems and log-ins), significant burden of administrative duties including phlebotomy and high level of reported “undermining” by consultants and others. Summary results presented to MB and details from every department sent to CPG directors and CPG Heads of Education from DMEs for further dissemination to departments and actions. Medical Director asked to raise in monthly meeting with consultants. CPG directors need to solve workload issues and poor admin support for doctors including lack of phlebotomy. Dir of ICT made aware of ongoing feedback concerning doctors perception of poor IT. Directors of medical education meeting directly with education leads in all departments to ensure local actions in place to improve outcome 2. Detailed actions from every department from 2012 GMC national survey presented regularly to healthcare education board (HEB) and to management board and ongoing oversight by DMEs 3. restructuring of HEB to separate meetings for discussion and oversight of response to trainee survey to ensure more rigorous assessment of actions to be chaired by NED	2013 GMC national trainees’ survey results released June 2013. ICHT has shown significant improvements (attached). We are excellent in training particularly within emergency medicine on all sites at all levels and specialist paediatric services at StM, in GUM, sports medicine, GP paediatrics and aspects of a number of other specialties. Trainees raise significant concerns especially in surgical specialties at FY1 and FY2 level, in haematology (but this is significantly better than 2012) and clinical oncology (unchanged from 2012). Undermining has not been reported in 2013 to date, however trainees individual comments suggest this remains an issue for ICHT (data awaited from GMC). Further actions plans in response being developed (July 2013) for review at healthcare education board. Special healthcare education board has met once to give oversight of department action plans from 2012 (with Rodney Eastwood) which highlighted association of red flags with heavy

		trainee workloads (especially inpatient) and in departments using trust doctors to support patient care with high risk to trainees when posts vacant and not re-filled immediately.
Future reduction in number of doctors in postgraduate training in secondary care	1. This is a national agenda. 2. ICHT needs to ensure highest quality training to protect as much as possible from inevitable future reductions. See all above 3. Departments need to develop plans to manage patients with fewer doctors either by consultant expansion, role change (eg perioperative physicians/geriatricians) or expansion of specialist nurses or acute care teams	Trainees' perception of clinical training has objectively improved. No plans available currently from departments about managing with fewer trainees.
Quality of undergraduate teaching	1. Detailed feedback requested from ICL more frequently to come to Dir Education in addition to site based directors of clinical studies (DCS). Feedback was previously annual only. 2. Student feedback data to be presented to CPGs (directors and heads of education) regularly and actions logged: follow-up from DCS reported to HEB.	Feedback from ICL awaited for 2013. Directors of clinical studies more aware of student feedback and taking actions with departments. Major challenge remains service movement's impact on delivery of undergraduate teaching, and consultant job planning putting pressure on non-clinical PAs and therefore willingness of consultants to teach.

Appendix A

Monthly Infection Prevention and Control Summary
July 2013
(June 2013 data)

Key Indicators

June 2013	Month 3: June			CPG						
	Threshold	Trust		1	2	3	4	5	6	PPs
MRSA BSI (>48hrs)	0	0		0	0	0	0	0	0	0
MSSA BSI (>48hrs)	N/A	7		0	1	4	0	1	1	0
E Coli BSI (>48hrs)	N/A	7		1	2	0	1	2	1	0
Clostridium difficile (>72 hrs)	5	8		6	1	0	1	0	0	0

Year to Date 2013/14	YTD 2013/14				CPG						
	Threshold		Cases								
	Year	YTD	Trust		1	2	3	4	5	6	PPs
MRSA BSI (>48hrs)	0	0	4		2	1	0	0	0	1	0
MSSA BSI (>48hrs)	N/A	N/A	14		2	1	6	0	2	3	0
E Coli BSI (>48hrs)	N/A	N/A	14		3	4	0	1	4	2	0
Clostridium difficile (>72 hrs)	65	17	26		13	6	0	6	0	0	1

N/A = Not applicable

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

There is a national expectation of zero MRSA blood stream infections for all Trusts for 2013/14. In June 2013 there were no Trust attributed MRSA BSI cases reported at the Trust, however in May there were four Trust attributed MRSA BSI cases reported. Indwelling vascular devices were the most likely sources in these complex patients,

Case summaries:
Case 1: This patient was admitted for a bone marrow allograft. He was screened on admission and a tunnelled intravascular line was inserted in the radiology department the day following admission. The positive MRSA screening result was available after this procedure. The bacteraemia was probably associated with this vascular line.

Case 2: This patient was transferred to the Trust for gastrointestinal surgical management. Surgery did not take place prior to bloodstream infection (day 22 of admission) due to his debilitated clinical condition. He had numerous central and peripheral vascular access devices placed for clear indications; these had incomplete documentation with regard to their insertion and ongoing management. The bloodstream infection was central vascular access related

Case 3:. This patient with diabetes was admitted onto a medical ward with several invasive devices including a long term intravascular device and a recent gastrostomy tube. An admission MRSA screen was negative but MRSA was identified in her gastrostomy site several weeks post admission (day 87) and subsequently a blood culture was positive for MRSA. The source may have been the site of the gastrostomy or the long term intravascular device.

Case 4:. This patient with polycystic renal disease was admitted onto a medical ward and required several invasive devices including vascular, urethral and a drainage devices during their admission. Though the patient was negative on MRSA admission screening, an MRSA bacteraemia occurred on day 44 of admission and the source of infection was probably a peripheral venous device.

In June an MRSA bacteraemia was identified in a cardiology patient. Initially, based on timing of blood culture, this was allocated as non-Trust, but the patient had a recent hospital admission and so the allocation to Trust is under consideration via the post infection review process

1.1 Update on key elements of the MRSA BSI prevention action plan

Actions in relation to the cases outlined above:
Case 1: The local actions are to screen all such patients for MRSA in a pre-admission clinic to ensure MRSA results are available prior to admission.

Case 2: Local actions include mandating the documentation of vascular access device insertion and management to ensure all steps of insertion and care are followed, mandatory ANTT competency assessments all new and existing clinical staff and following practice relating to hand hygiene and use of personal protective equipment. Divisions to provide assurance that staff are following policy.

Case 3: Actions include reviewing gastrostomy care, identification of long term high risk patients with ward staff, IPC risk assessment of these patients, along with post-admission MRSA screening and following practice relating to hand hygiene and use of personal protective equipment. Isolates were sent for typing in view of prior blood stream infection on this ward over the last year and were unrelated strains.

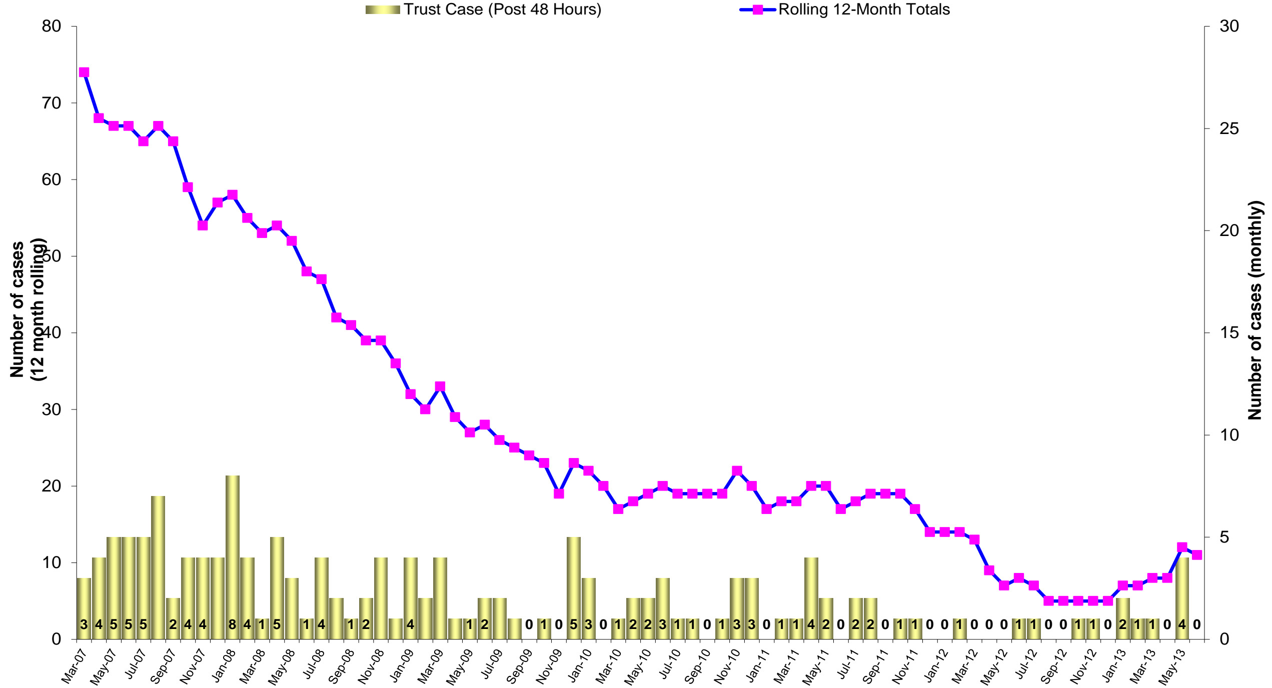
Case 4: Actions will include identification of long term high risk patients with ward staff, IPC risk assessment of these patients, along with post admission MRSA screening and following practice relating to hand hygiene and use of personal protective equipment.

The Trust has taken the following actions to re-enforce patient safety practice and infection prevention and control on all of our wards and clinical areas through:

- Adherence to checklists for best practice when inserting intravenous lines
- Checking all intravenous lines and devices in patients every day and ensuring they are removed as soon as they are not needed.
- Introduction of alert systems to identify high risk patients
- Additional weekly MRSA screening on wards with vulnerable patients (high risk)
- Ensuring rigorous infection prevention and control practice and hand hygiene
- Consideration of universal decolonization outside intensive care

External experts are being invited into our Trust to examine and comment on our safety systems for patients who require intravenous lines, and on hand hygiene.
Weekly performance and action review meetings have been initiated with our clinical programme group (CPG) directors/Divisions, reporting on ward practice and activity, and further actions required.

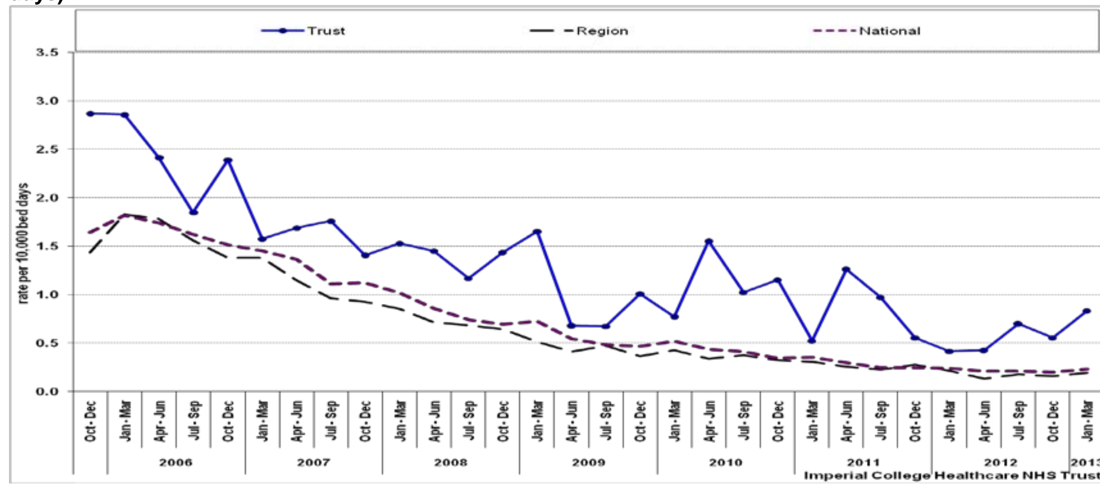
Figure 1: Rolling 12-month and monthly number of Trust attributed MRSA BSI cases



1.2 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 0.83 per 10,000 bed compared to a regional rate of 0.19 and national rate of 0.23.

Figure 2: Trend in the Trust-attributable MRSA BSI rate compared to the national & London Region rates (rate/10,000 bed days)



Source: HPA Trust reports June 2013

2. *C. difficile* infections

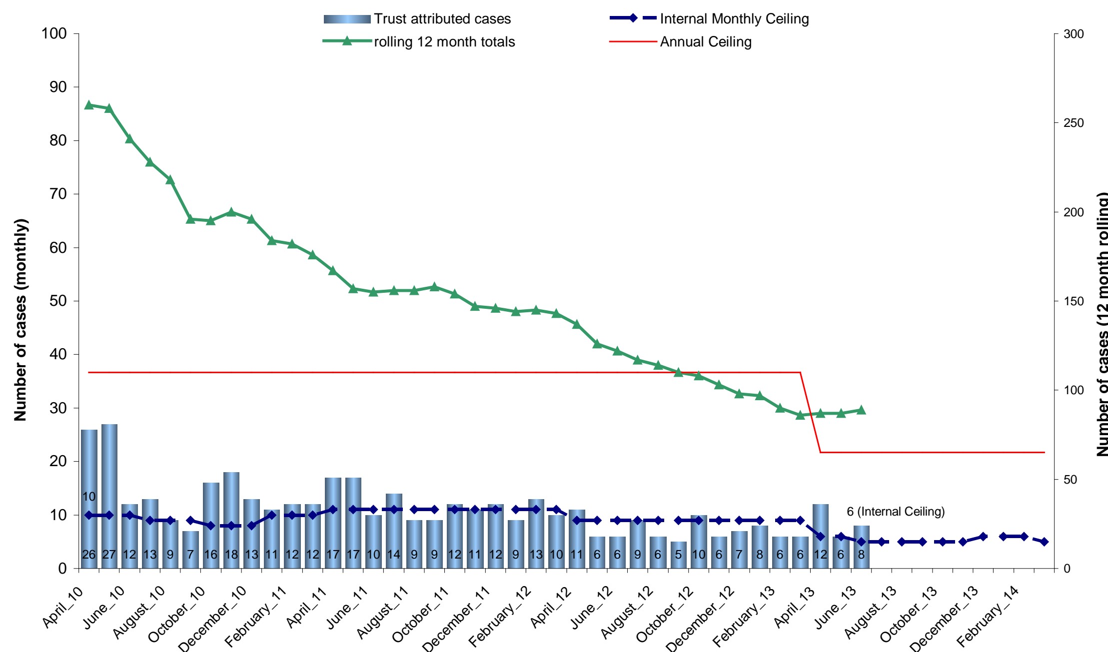
For 2013/14, the Department of Health annual ceiling for the Trust is 65 cases of *C. difficile* infection. 15 cases were reported in June 2013, of which eight cases were Trust attributable.

Of these eight Trust attributable cases, six had evidence of clinical *C.difficile* disease, while in two patients there were other reasons to which the diarrhoea was attributed.

Isolation in a side room within 24 hours occurred in three cases. All had exposure to antibiotics: one was admitted on prophylactic antibiotics against UTI; the remaining seven had antibiotics initiated in hospital. These seven were all in line with policy or approved by infection clinical team.

One had received long term antibiotics for osteomyelitis treatment; one patient had treatment for catheter related (long term urinary) *E.coli* UTI; one was treated for post operative (oesophagectomy) pneumonia; one was treated for severe hospital acquired pneumonia; one for pyelonephritis; one for urosepsis related to enterococcal bacteraemia; one had recurrent pneumonia related to impaired swallowing and had clinically appropriate antibiotic choices, although no input from infection clinicians until *C. difficile* identified.

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



2.1 Update on key elements of the *C. difficile* prevention action plan

Each case of *C.difficile* has a detailed case review undertaken to help understand the organism's prevalence and contributory factors for acquisition. As of 1st July, all *C.difficile* cases will have a detailed antibiotic review by the infection pharmacy team. They will examine if antibiotics were a factor in the case, if there were areas where improvement could have been made, and if so the consultant will be contacted directly including by email. These improvements will act as educational tools when discussing and managing *C.difficile* patients going forward.

The Trust diarrhoea and vomiting and *C.difficile* polices were revised in light of recent revised guidance from Public Health England and the Infection Prevention Society and were launched in June 2013. In particular, in line with national recommendations, the time to isolation for cases of suspected and confirmed infectious diarrhoea has been reduced from four hours to two hours. Although the guidance on the clinical management of *C.difficile* has not changed, the infection clinicians have been prompted about the availability of fidaxomicin (a macrocylic antibiotic approved by New Drugs Panel in 2012 for use in the Trust on the recommendation of consultant microbiologist or infectious diseases clinician now on Trust's formulary and the system of collating details of the patients on whom it is used.

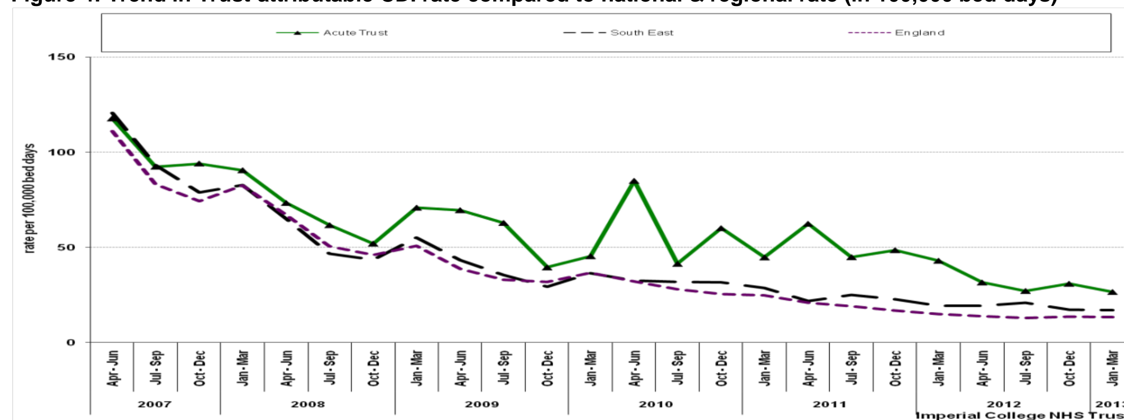
C.difficile rounds on all patients are being standardised in development across the Trust as well as additional clinical input on wards as required by the infection clinicians.

The Trust is working closely with other London Trusts at the Acute London Teaching Trusts Infection Control Forum to identify and share areas of best practice with regard to *C. difficile.*

2.2 Benchmarking Trust-attributable *C. difficile* rates

Provisional data presented by Public Health England in figure 4 shows that the Trust had a quarterly rate of 26.6 per 100,000 bed days compared to a regional rate of 17.0 and national rate of 13.4

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



Source: HPA Trust reports June 2013

3. MRSA Screening

Increased incidence of MRSA colonisation.

During May and June an increased incidence of MRSA colonisation was identified on a surgical ward, upon weekly screening. On investigation, it is likely that colonisation was acquired during admission. A number of interventions were put in place including weekly incident meetings, increase IPC education, auditing and feedback and re-assessment of IPC competencies (hand hygiene, use of personal protective equipment and application of aseptic non-touch technique). Typing is awaited to determine if these cases are linked. All patients affected were managed appropriately and none developed signs of clinical infection. Since early June, there have been no further cases identified on the ward, however vigilance remains high.

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

There is no threshold for this indicator at present. In June 2013, there were 11 cases of MSSA BSI reported to Public Health England (PHE) of which 7 were Trust attributable (i.e. post 48 hours of admission) and 4 were non-Trust attributable.

Four were associated with vascular access devices, including one in a neutropenic patient and one in a premature infant. Three occurred in patients on a single ward, although the cases appear un-related, (one source was a septic arthritis, and the other two were trauma patients). These isolates have been sent for typing to inform further investigation.

Figure 6a: Monthly MSSA BSI cases

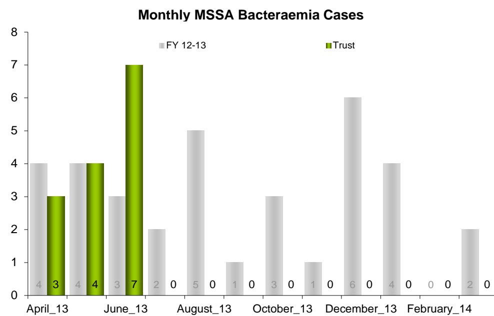
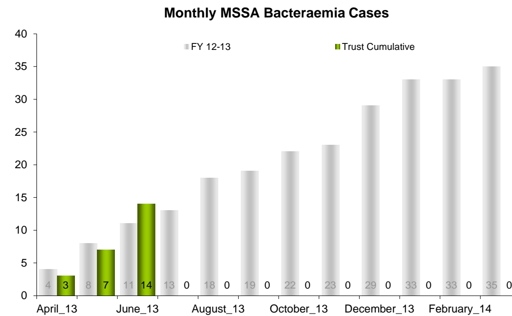


Figure 6b: Cumulative MSSA BSI cases



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

There is no threshold for this indicator at present. The steep rise in *E.coli* BSIs nationally is a cause of significant concern. In June 2013 there were 27 cases of *E. coli* BSI reported to Public Health England (PHE) of which seven were Trust attributable cases (i.e. post 48 hours of admission).
None of the seven Trust attributable cases were related to a vascular access device.
Three were related to urinary sources (one in a post partum patient, one with ureteric stent and one with epididymo-orchitis); in two further patients the source was unknown (one was immunosuppressed on chemotherapy for lymphoma) and in two additional cases that were just around 48 hours of admission, one was probably related to a urinary source and the other occurred in a patient undergoing hepatobiliary surgery for malignant disease.

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

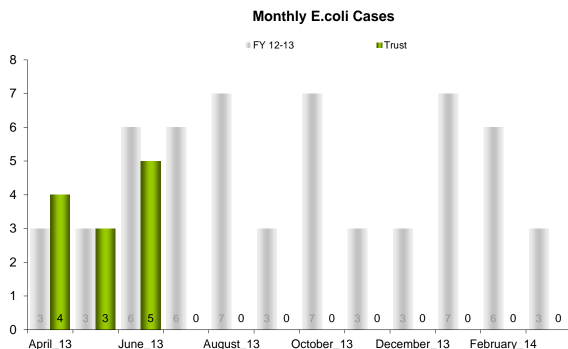
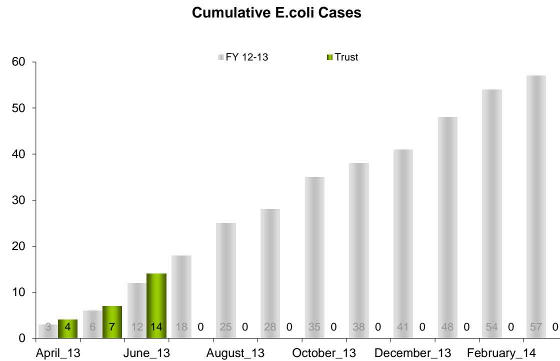


Figure 7b: Cumulative Trust-acquired *E. coli* BSI cases



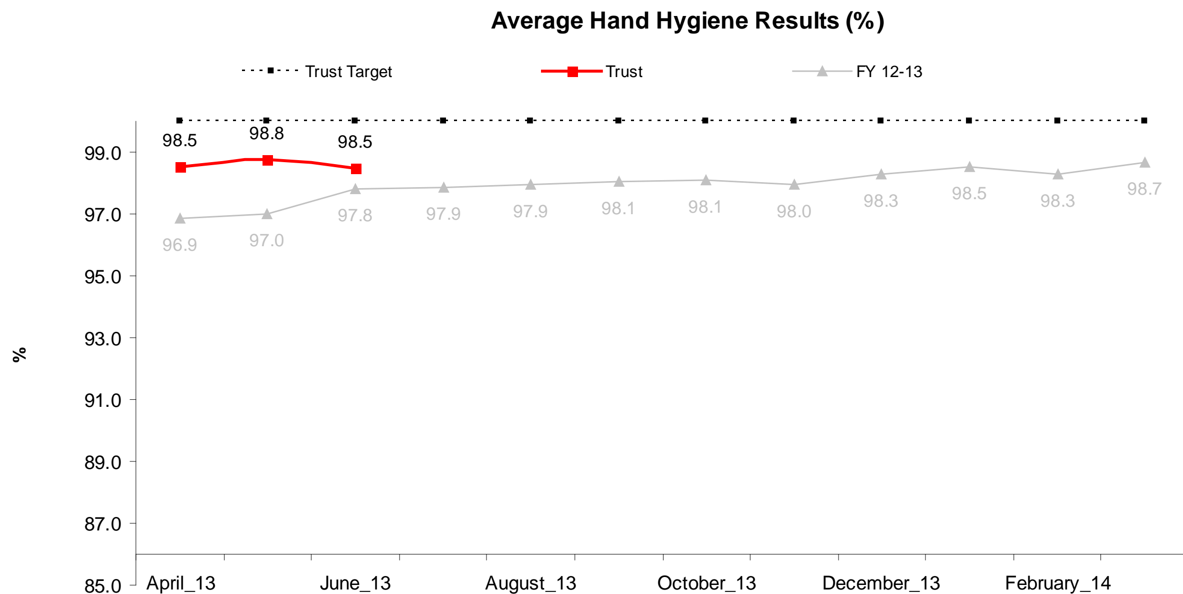
6. Hand hygiene compliance

In June 2013, 91.0 percent of clinical areas submitted a total of 6370 observations (as measured by the current Trust audit procedures based on a minimum of ten observations per ward, per week) was 98.5 percent, and compliance with bare below elbows was 98.6 percent.

Hand hygiene compliance audit process

Hand hygiene is one of the most effective methods to prevent health care associated infections. Audits of hand hygiene compliance measured against the WHO 5 moments of hand hygiene are currently undertaken by each ward monthly and a more detailed and rigorous validation audit is undertaken yearly by the infection prevention and control team.

Figure 8: Average performance of hand hygiene practice



7. 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. Completion of assessments has steadily been increasing from 75 percent in March to 85 percent (5369 clinical staff) at the end of June 2013.

8. Antibiotic stewardship

As part of the on-going Trust antibiotic stewardship initiative, a number of antibiotic policies have been approved by the Trust antibiotic review group. These include, a newly developed trust wide surgical prophylaxis policy, an updated renal unit antibiotic policy and a policy on the recommended safety of antibiotics in pregnancy and breastfeeding. The current empiric treatment of infection policy is currently being reviewed by Trust stakeholders and is due for dissemination later in the year together with a new version of the Trust antibiotic smart phone app.

The pharmacy point prevalence survey on antimicrobial use has been conducted (May/June 2013) with results due imminently. These results will be disseminated through clinical and managerial structures to drive improvement in antimicrobial prescribing.

9. Adult ICU Bloodstream infections

In June there were 19 positive blood cultures from 8 patients in adult ICUs at the time of their cultures. 10 blood cultures from four patients yielded coagulase negative staphylococcal species (one of these patients additionally grew *Enterobacter aerogenes*); one additional patient cultured MSSA and is accounted for in details above; five blood cultures from one patient cultured enterococcal species from a presumed abdominal source of sepsis; one blood culture grew yeast and another Pseudomonas aeruginosa.

10. Other matters

10.1 Parvovirus
A staff member was diagnosed with Parvovirus during May. A total of 19 patients were identified as requiring follow up of immunity following risk assessment and serology has been completed to determine immunity. Additionally, information about parvovirus was distributed to staff in the area where they may have had contact with the index case asking them to contact Occupational Health should they have any concerns.

10.2 Fusarium oxyspora
Colleagues from Public Health England (PHE) visited the Trust to assist in this investigation which began following the identification of *Fusarium oxyspora*, an unusual environmental fungus, in respiratory specimens taken during bronchoscopy from three outpatients. The bronchoscope used is currently not in use and has gone for repair. The three patients did not require any treatment and were not admitted to hospital. Following this visit, PHE has advised that a more extensive look back is not required.

10.3 VIM producing Pseudomonas
Between November 2012 and May 2013 three patients have been found to be colonised with VIM-producing *Pseudomonas aeruginosa* (acarbapenemase-producing, multi-resistant strain of *Pseudomonas aeruginosa*). It is likely that two of these three patients acquired this organism and became colonised while on the unit. All three patients have been colonised with the organism and have not had any proven infection attributed to the VIM-Pseudomonas.
A weekly patient screening programme had been put in place so as to detect any further cases of cross transmission. The third colonised case was detected on one of these routine weekly rectal screening swabs. Both weekly and admission patient screening for VIM-Pseudomonas is ongoing.
Environmental screening, additional cleaning, strict contact precautions, review by PHE colleagues of water supply to the unit and input from estates have taken place to reduce the risk to further patients. PHE have been liaising closely and advising on the situation.

10.4 Chickenpox
Two patients were identified with chicken pox during this period in two different clinical areas at the Trust. Contact tracing of patients and staff was carried out in conjunction with the clinical team, occupational health and PHE. Following risk assessment no patients or staff members were identified as at risk and none required follow up.
A separate case of a non-clinical staff member with chicken pox attending a clinical area occurred. PHE were informed. Patient contacts followed up and all found to be immune. No further action required.

10.5 TB Lookback Investigation
Two patients were admitted to the Trust over the period May to June 2013 with symptoms later proven to be related to respiratory tuberculosis (one pulmonary, one laryngeal). These have initiated contact tracing exercises and discussion with PHE and TB colleagues to determine extent of any look back involving in-patients or staff.

10.6 Pertussis
A staff member working was diagnosed with pertussis during May. Contact tracing of patients and staff was carried out in conjunction with the clinical team, occupational health and the PHE. Two contacts, one patient and one member of staff were assessed as being at risk and were followed up appropriately with chemoprophylaxis. No contact went on to develop symptoms.

10.7 Group A Streptoccal (GAS) infection
A patient was readmitted unwell with GAS, PHE has been informed. Staff are being followed up for signs of infection. It is most likely that this has been related to household exposures, household contact has symptoms consistent with possible GAS infection.

10.8 CXH Riverside Theatres

Riverside theatres were closed on 26 June 2013. The decision was made when problems with the air ventilation system were identified during planned testing; air ventilation was not meeting required levels. A response team was convened and continues to meet daily to manage patient flow and delivery of planned theatre activity during this period of reduced theatre capacity. Following rapid work one theatre re-opened on 5 July 2013. The ventilation systems to the remaining theatres are undergoing urgent repairs.

10.9 Middle East Respiratory Syndrome

Two patients were assessed for novel coronavirus infection, MERS-CoV (Middle East Respiratory Syndrome) based on their severe respiratory illness and their recent travel history. In both cases, staff used the appropriate national guidance to access testing for this virus and to implement respiratory precautions until the results were confirmed as negative.

11. Applied Research, Education and Innovation.

The UKCRC Centre of Infection Prevention and Management (CIPM)

- NIHR Health Protection Research Unit (HPRU) bid- Imperial has successfully been shortlisted to make a full application with PHE to host a HPRU in Healthcare Associated Infection and Antimicrobial Resistance. One other university has been invited to make a full submission. The deadline for full applications is September 2013 and the outcome will be known in Nov/Dec 2013
- The CIPM annual research day – was held on 3 July at the Hammersmith House Conference Centre. The event was closed by Professor Mike Catchpole of Public Health England and showcased the work of CIPM. CIPM continues to publish with 6 publications since the March Board report and two more in press .
- CIPM hosted another international visit in May with Dr. Ingrid Smith, Infectious Diseases Specialist and five members of her team from The National Unit for Patient Safety at Haukeland University Hospital, Norway, travelling to Hammersmith Hospital to meet the CIPM team to learn about their work and research. The visitors also represent Norway's National Centre for prudent use of antibiotics in hospitals, and discussions are now on going in relation to joint funding applications, collaboration and involvement in national roll-out programmes.
- CIPM again participated in the Imperial Festival- an event aimed at engaging the public in science. This year's team of CIPM volunteers, included Luke Moore Clinical Research Fellow, Shelby Yamamoto, Research Fellow and Mindy Gore, Research Associate. The event, which ran over the May Day Bank Holiday weekend was a huge success and attracted much interest from families. On Saturday 4th May, over 200 people visited the CIPM stand.
- Antimicrobial Resistance is currently very high on the national agenda following the publication of Volume 2 of the Chief Medical Officers Report. Funding calls are expected from the NIHR and the MRC on the subject in the Autumn. CIPM Director, Professor Alison Holmes will also be participating at an event at Chatham House in October see http://www.chathamhouse.org/antimicrobial_resistance/speakers

WHO

The WHO APPS team have just completed a second successful visit to our partnership hospital in Butare, Rwanda. A full report will be made available to the Trust next month. A micro-site is currently being developed, highlighting all the collaborative work both hospitals are involved in.

Heath Foundation (HF) Shared Purpose Award

The 'Workforce Analysis for Safer Care' programme funded by the HFShared Purpose grant is six months into the two-year intervention stage of the programme. The Programme Board has been re-established with Jayne Mee as Chair and the next meeting is on 5th August 13.

The quantitative project is at the data collation and cleaning stage. Information governance approval has been granted, enabling workforce and clinical outcome data collation, cleaning and mapping, supported by the HF funded epidemiologist and data analyst. Stakeholder engagement with clinical teams is good, regular re-engagement with corporate and senior clinical stakeholders is required owing to organisational restructuring. The project milestones are being revised in response to difficulties recruiting a statistician, however an appointment will be made shortly.

The qualitative project to assess staff perceptions of risk and safety has been designed and ethics approval is being sought. The systematic review of links between multi-professional staffing predictors and clinical outcomes is planned for September – November 13.
The next steps are to engage a statistician and senior statistical support to plan the data analysis.

Trust Board Performance Report
Report Period Month 3
(to end June 2013/14)

Trust Board on 24th July 2013

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	QLTY 2	Patient Experience - key questions from National Survey	**Page 4**
	QLTY 3	Infection Prevention Control (MRSA and Clostridium Difficile)	**Page 5**
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	QLTY 5	Stroke care	**Page 7**
	QLTY 6	Venous Thromboembolism	**Page 8**
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Operations	OPS 1	Accident & Emergency - 4 hour maximum waiting time	**Page 11**
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Workforce	WF 1	Bank and Agency Spend	**Page 20**
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	WF 5	Sickness Absence	**Page 20**
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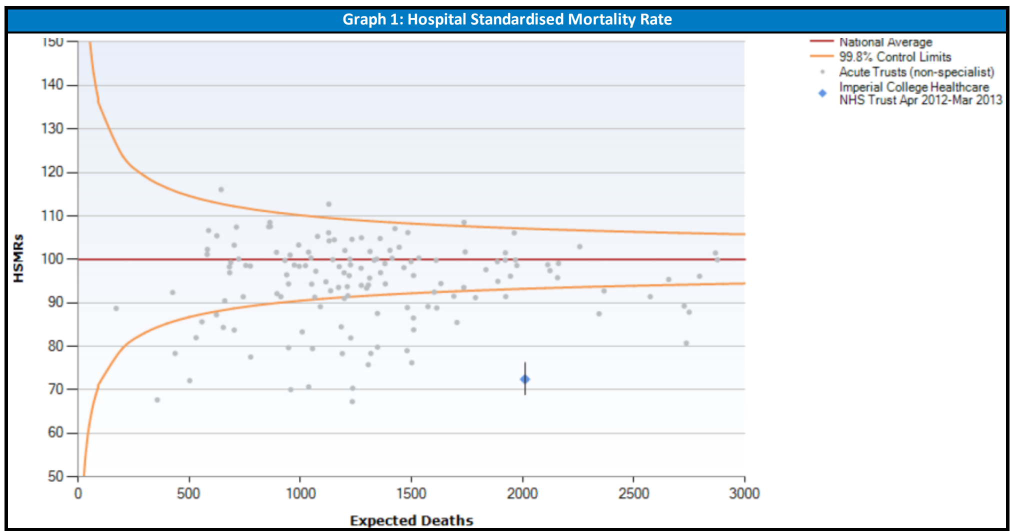
QLTY 1: Mortality - **Supports compliance with Care Quality Commission Outcome 4**

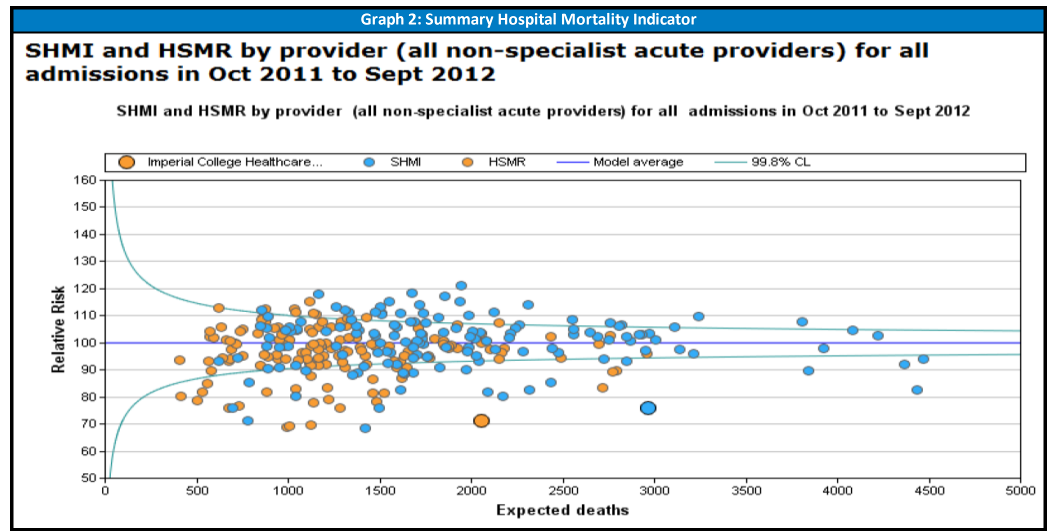
Domain	Indicator	National average	Unit	Apr2012 - Mar2013	Year to date
Mortality	Hospital Standardised Mortality Rate (HSMR) (*)	100	number	**73** ●	**73** ●

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

Graph 1: Hospital Standardised Mortality Rate



Graph 2: Summary Hospital Mortality Indicator

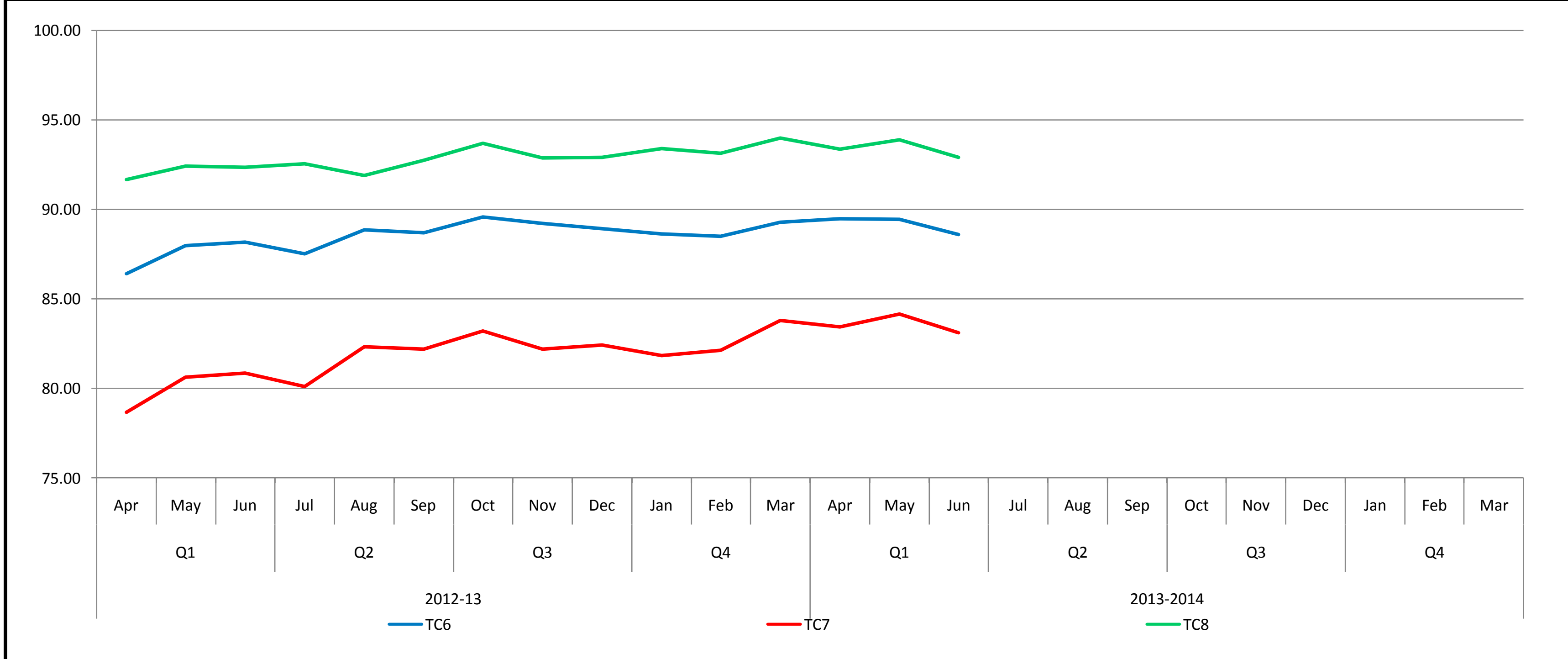


Source: Dr. Foster Intelligence

QLTY 2: Patient Experience - key questions from National Survey - Supports compliance with Care Quality Commission Outcome 16 and 17

Core Question	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
TC6: Were you involved as much as you wanted to be in decisions about your care and treatment?	89.5	89.4	88.6									
TC7: Did you find someone on the hospital staff to talk to about your worries and fears?	83.5	84.2	83.1									
TC8: Were you given enough privacy when discussing your condition or treatment?	93.4	93.9	92.9									

Graph 3: Patient Experience - key questions from National Survey by month

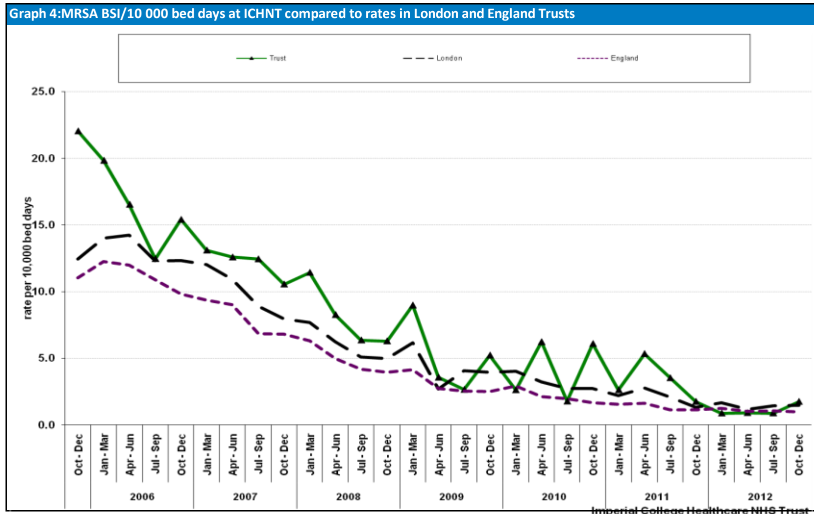


Source: iTrack

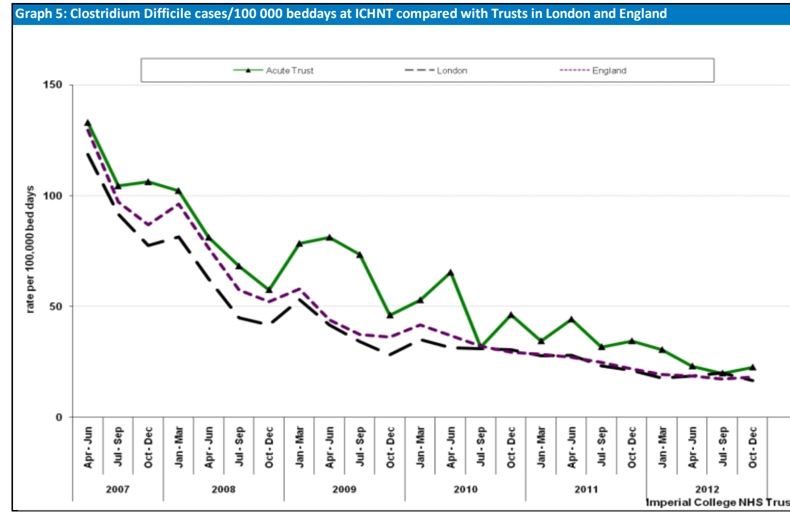
QLTY 3: Infection Prevention Control - NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 8

Domain	Indicator	Annual Trust Ceiling	Unit	Month 3		Year to date	
Infection Prevention and Control	Methicillin-Resistant Staphylococcus Aureus (MRSA) Bloodstream Infection (BSI) Bacteraemias	<=0	Cases	0	●	4	●
	Clostridium Difficile (C-Diff) post 72 Hours - Enzyme Immuno-Assays (EIA) - (Nationally Monitored)	<= 65	Cases	8	●	26	●

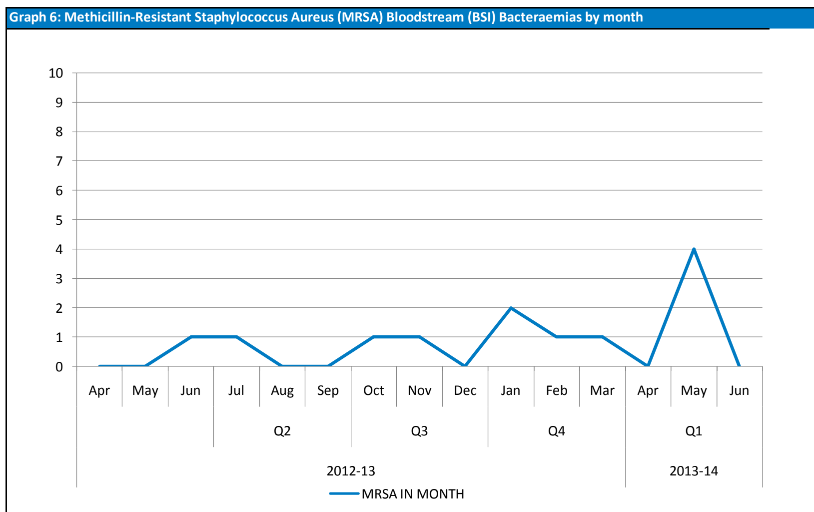
Graph 4:MRSA BSI/10 000 bed days at ICHNT compared to rates in London and England Trusts



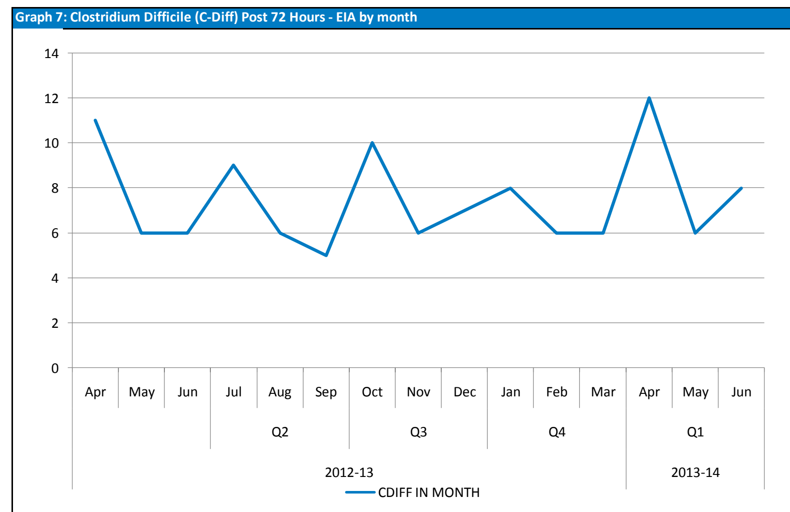
Graph 5: Clostridium Difficile cases/100 000 beddays at ICHNT compared with Trusts in London and England



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



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

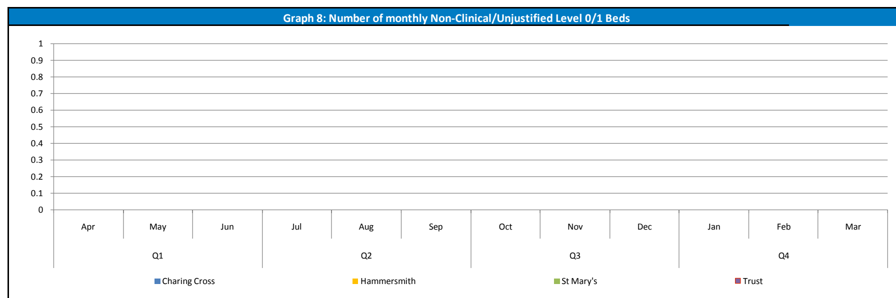


Source: Health Protection Agency & Infection Prevention Control Team

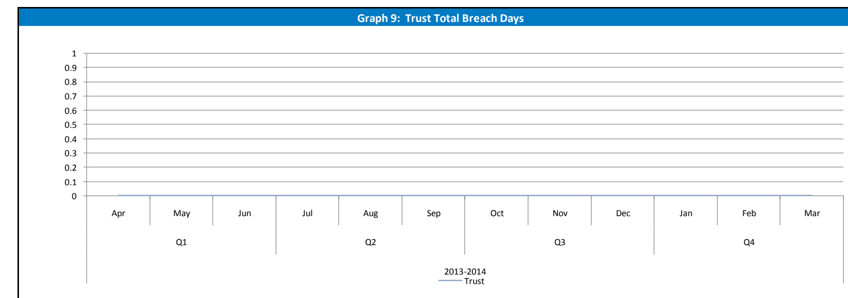
QLTY 4: Eliminating Mixed Sex Accommodation - EMSA - NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4

Domain	Indicator	Threshold	Unit	Month 3		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	●
	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

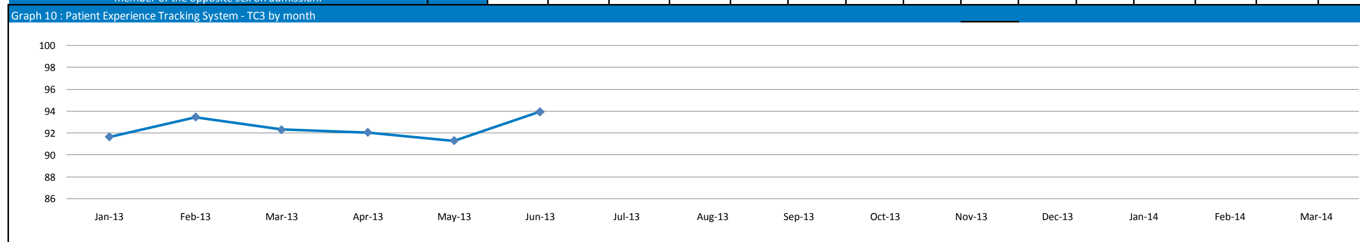


Source: Information Team

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

		Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
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**	92	93	92	92	91	94									

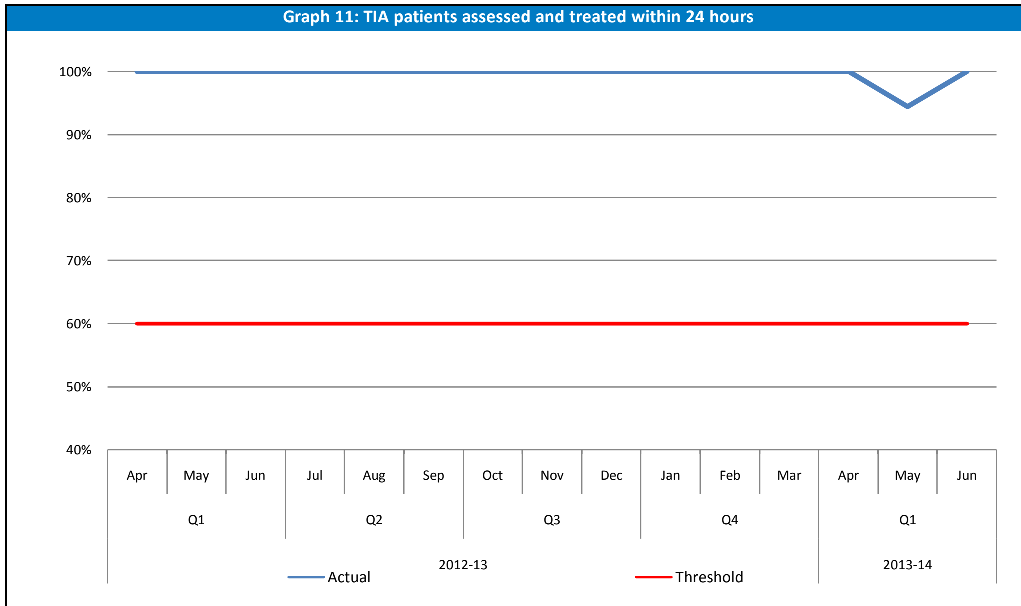
Graph 10 : Patient Experience Tracking System - TC3 by month

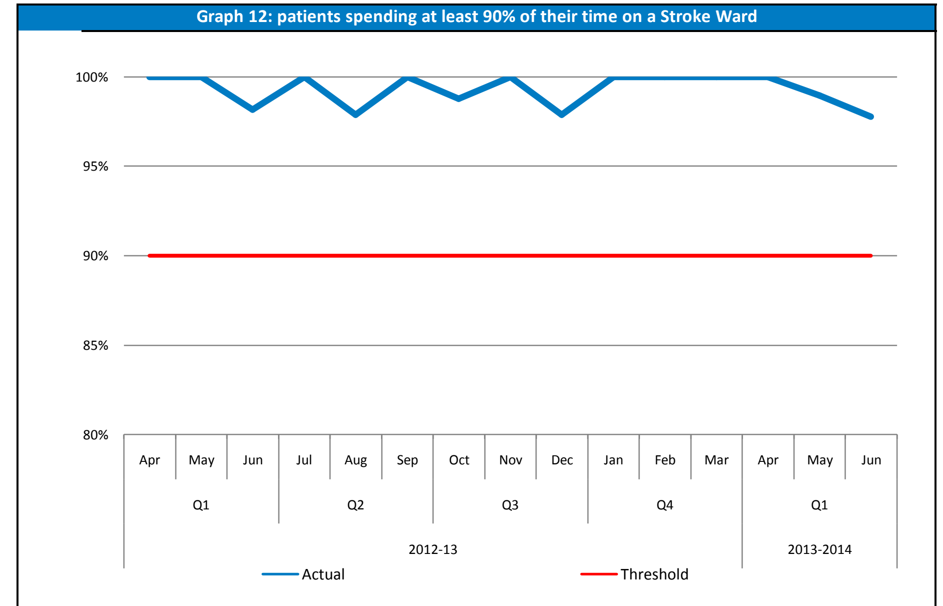


Source: iTrack

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

Domain	Indicator	Threshold	Unit	Month 3		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	●	97.50	●
	Patients who spend at least 90% of their time in hospital on a Stroke Unit	90.0	%	97.8	●	99.02	●



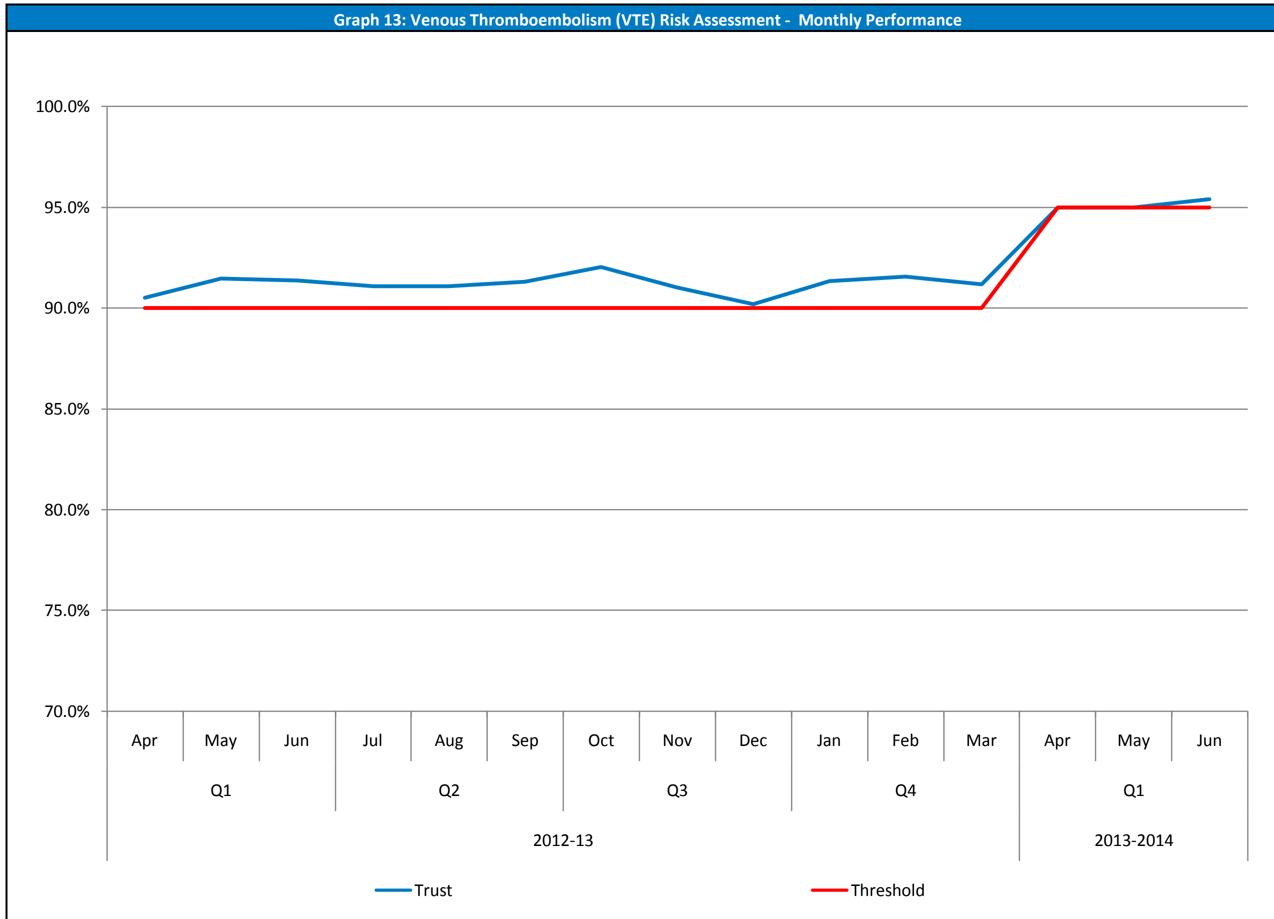


Source: Information Team

QLTY 6: Venous Thromboembolism - **NHS Performance Framework 2013/14 Indicator & Supporting Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 3	Year to date
Venous Thromboembolism (VTE) Risk Assessment	Adult Inpatients who have had a Venous Thromboembolism (VTE) Risk Assessment	95.0	%	95.40 ●	95.13 ●

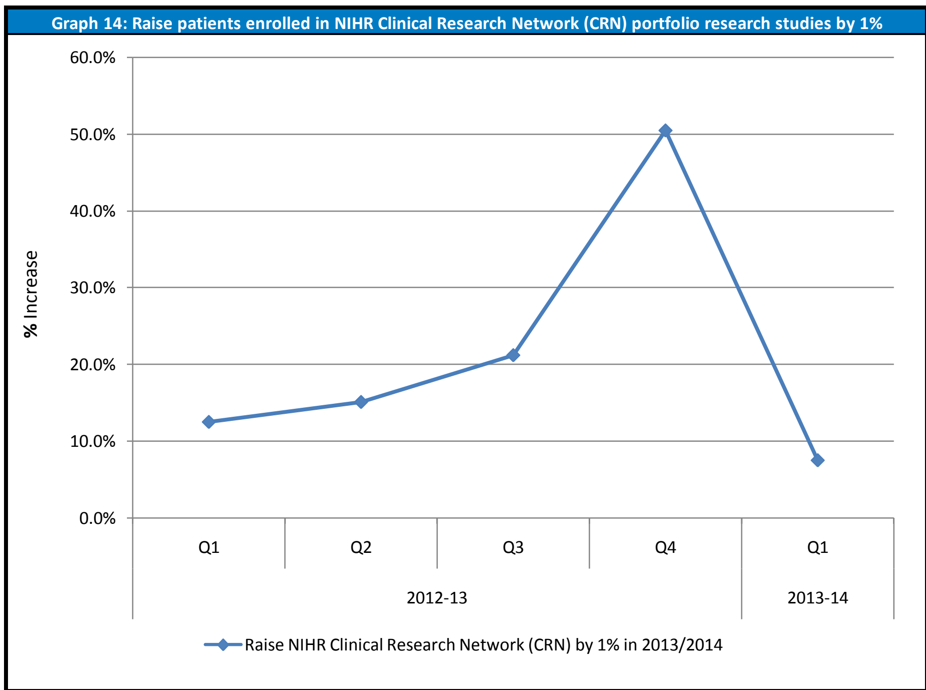
Graph 13: Venous Thromboembolism (VTE) Risk Assessment - Monthly Performance



Source : Information Team

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

Domain	Indicator	Target	Unit	Quarter 1	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	%	7.5 •	7.5 •



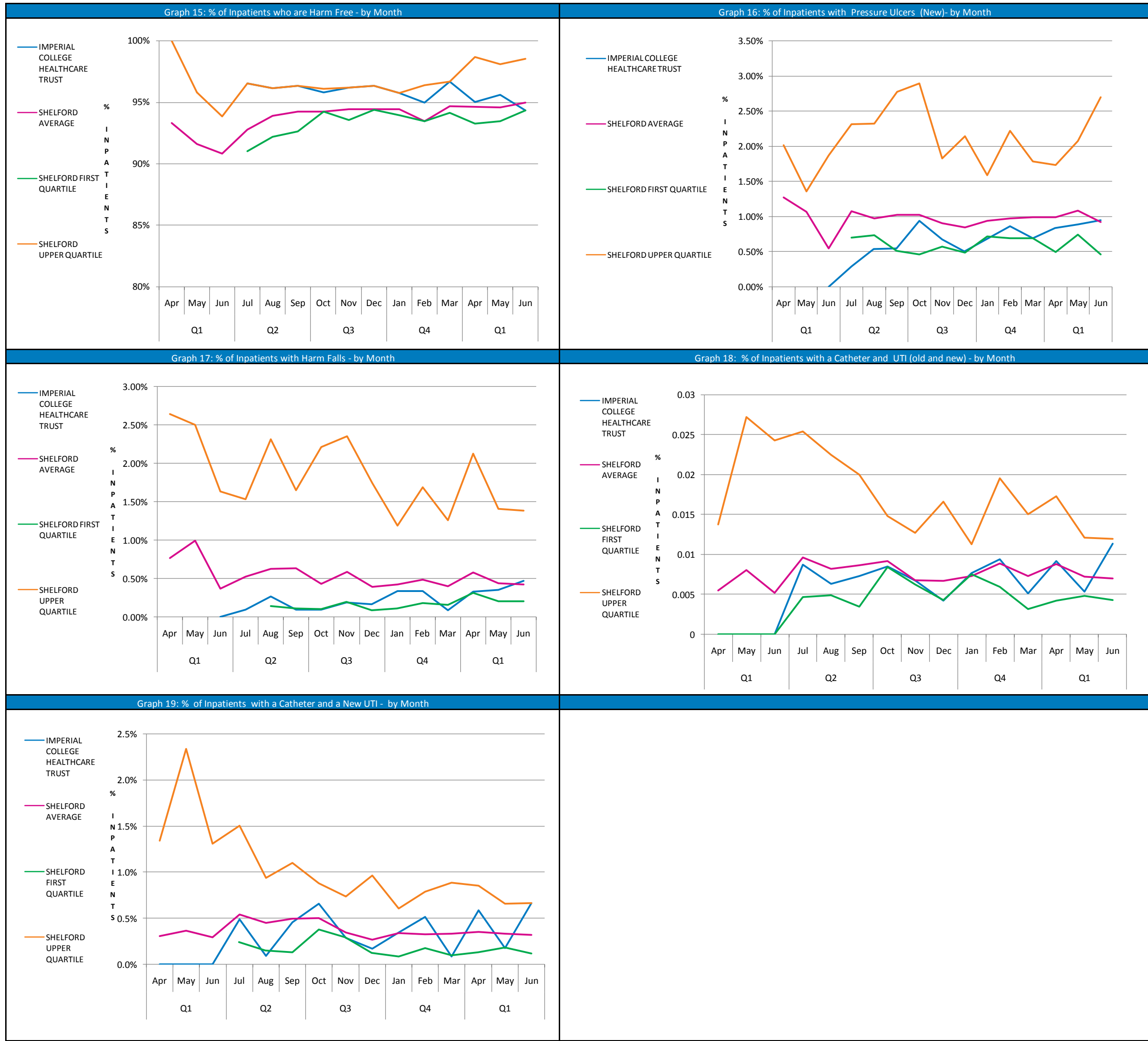
Source: Joint Research Office

Trust Board: 24 July 2013 Agenda Number: 4.1, Appendix Paper: 10

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

Domain	Indicator	Threshold	Unit	Month 3	Year to date
Safety Thermometer	Harm free	-	%	94.32	94.96
	Pressure Ulcers - All	-	Number	47	44.66
	Pressure Ulcers - New	-	Number	10	10
	Falls with Harm	-	Number	4	4
	Catheter's & UTI	-	Number	6	8.5
	Catheter's & New UTI	-	Number	2	4.5
	New VTE's	-	Number	0	0

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



OPS 1: Accident & Emergency - 4 hour maximum waiting time - NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4

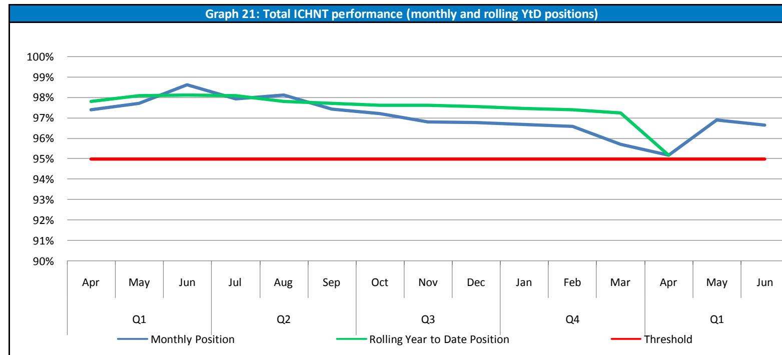
Domain	Site	Type	Threshold	Month 3		Year to date	
4 hour maximum waiting time In Accident & Emergency	Trust	All (Type 1,2,3)	95.0%	96.6%	● green	96.2%	● green
	Trust	Type 1	95.0%	93.4%	● red	92.5%	● red
	Hammersmith	Type (1,2,3)	95.0%	98.7%	● green	97.4%	● green
	Charing Cross	Type (1,2,3)	95.0%	96.8%	● green	95.3%	● green
	St Mary's	Type (1,2,3)	95.0%	95.8%	● green	96.4%	● green
	Hammersmith	Type 1	95.0%	97.6%	● green	94.3%	● red
	Charing Cross	Type 1	95.0%	92.5%	● red	89.1%	● red
	St Mary's	Type 1	95.0%	92.6%	● red	93.5%	● red
London Ambulance Service (LAS) Handover	London Ambulance Service Patient Handover - within 60 Minutes		100%	100%	● green	100%	● green
	London Ambulance Service Patient Handover - within 30 Minutes		95.0%	99.4%	● green	98.5%	● green
	London Ambulance Service Patient Handover - within 15 Minutes		85.0%	94.9%	● green	92.6%	● green
	London Ambulance Service Breaches Handover > 60 Min		0	0	● green	0	● green

Key

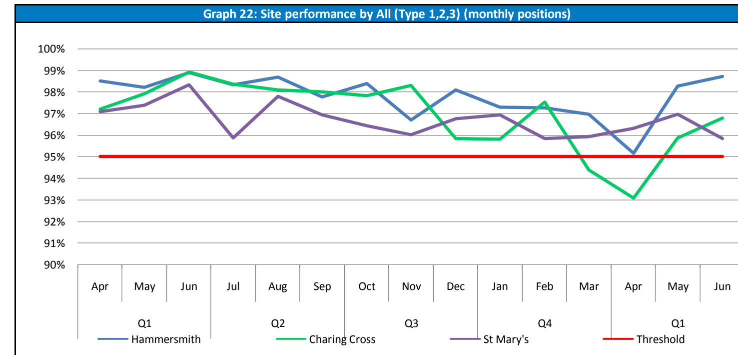
Type 1 = A consultant led 24 hour service with full resuscitation facilities (known previously as 'Majors') ie those patients who attend the main emergency departments across all 3 sites

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

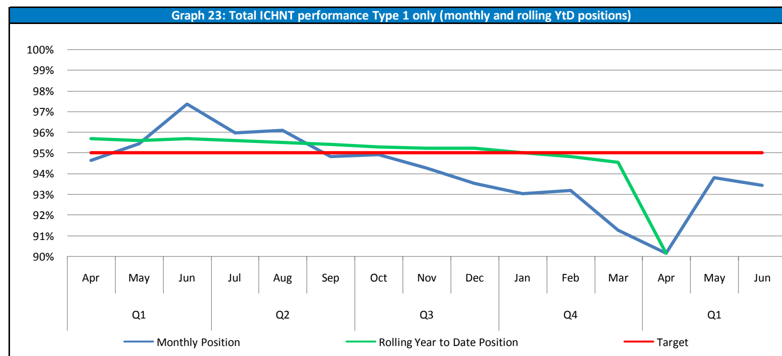
Type 3 = Other type of A&E/minor injury units (MIUs), Urgent Care Centre. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community



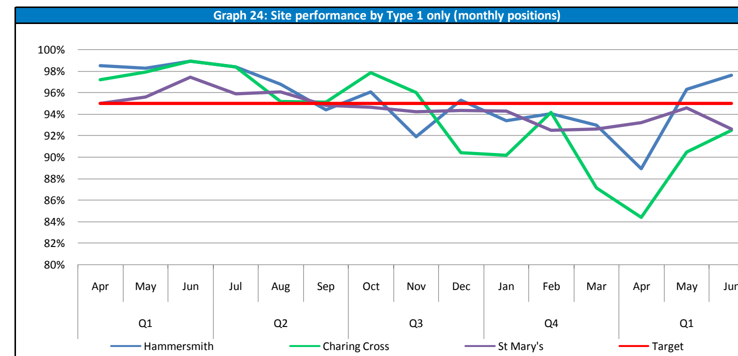
Graph 21: Total ICHNT performance (monthly and rolling YtD positions)



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)

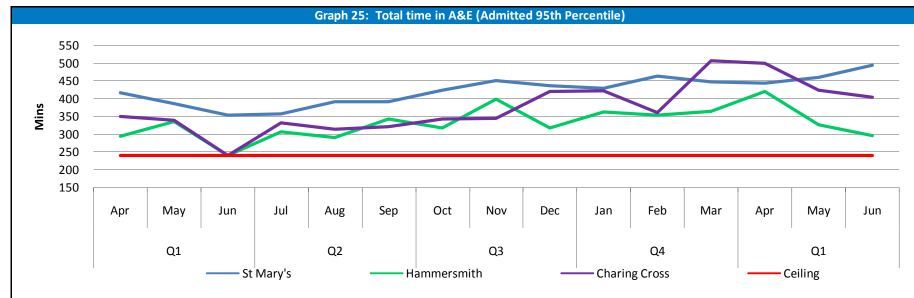
Source: Emergency Medicine

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

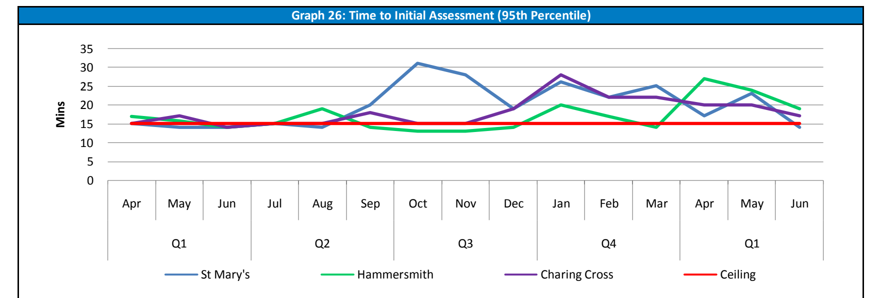
Domain	Indicator	Ceiling	Unit	St Mary's Month 3		St Mary's Year to date		Hammersmith Month 3		Hammersmith Year to date		Charing Cross Month 3		Charing Cross Year to date	
Accident & Emergency - Quality Indicators	**Unplanned re-attendance at A&E within 7 days (*)**	5	%	N/A		N/A		N/A		N/A		N/A		N/A	
	Total time spent in A&E														
	Admitted - 95th Percentile	240	Minutes	495	🔴	467	🔴	296	🔴	370	🔴	403	🔴	447	🔴
	Non-Admitted - 95th Percentile	240	Minutes	239	🟢	239	🟢	240	🟢	240	🟢	239	🟢	271	🔴
	Left Department Without Being Seen Rate	5	%	3.23%	🟢	2.91%	🟢	0.41%	🟢	0.23%	🟢	0.76%	🟢	0.86%	🟢
	Time To Initial Assessment (ambulance cases only)														
	95th Percentile	15	Minutes	14	🟢	17	🔴	19	🔴	20	🔴	17	🔴	19	🔴
	Time To Treatment In Department														
	Median Time	60	Minutes	67	🔴	67	🔴	55	🟢	55	🟢	39	🟢	41	🟢

(*) Data for this indicator was not available at time of publication.

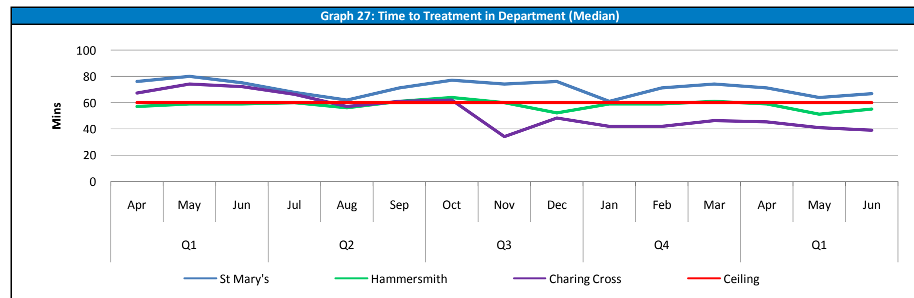
Graph 25: Total time in A&E (Admitted 95th Percentile)



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



Graph 27: Time to Treatment in Department (Median)

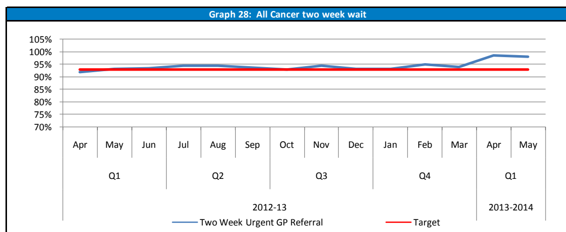


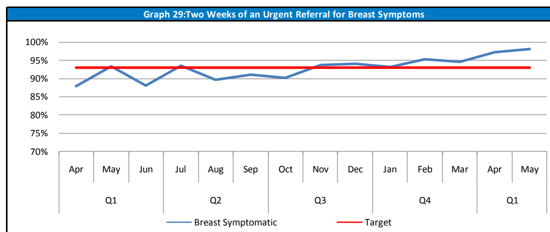
Source: Emergency Medicine

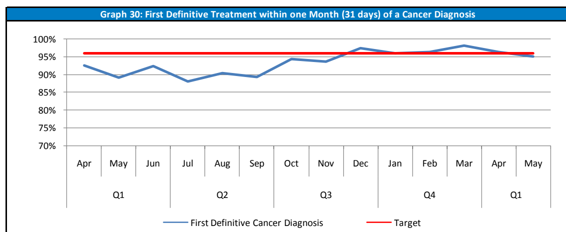
OPS 3: Elective Access - Cancer Waiting Times - **NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

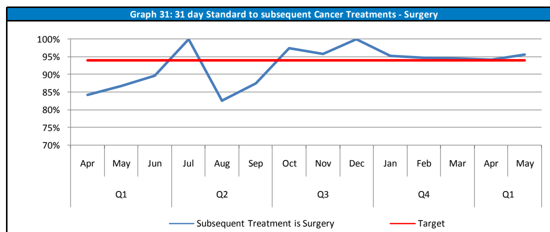
Domain	Indicator	Target	Unit	Month 2		Year to date	
Elective Access - Cancer Waiting Times (*) (**)	All Cancer two week wait	93	%	97.9	●	98.3	●
	Two week GP referral to 1st outpatient - Breast Symptoms	93	%	98.0	●	97.6	●
	First Definitive Treatment within one month (31 days) of a Cancer Diagnosis	96	%	95.1	●	95.8	●
	31 day standard to subsequent cancer treatments - Surgery	94	%	95.7	●	95.0	●
	31 day second or subsequent treatment - Drug	98	%	100.0	●	100.0	●
	Proportion of patients waiting no more than 31 days for second or subsequent cancer Treatment - Radiotherapy Treatment	94	%	97.8	●	97.9	●
	All Cancer Two Month Urgent Referral to Treatment wait	85	%	74.5	●	74.8	●
	62-Day wait for First Treatment following referral from an NHS Cancer Screening Service	90	%	97.4	●	88.4	●

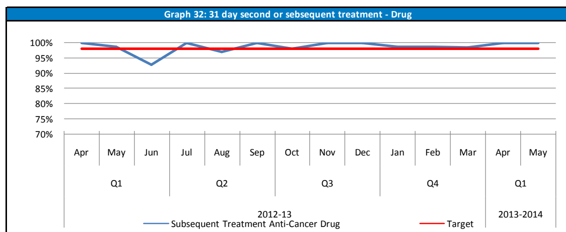
* Cancer data reported one month in arrears as shown on Open Exeter

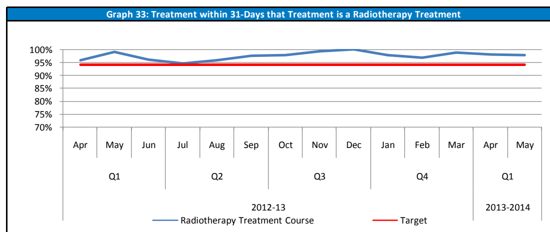


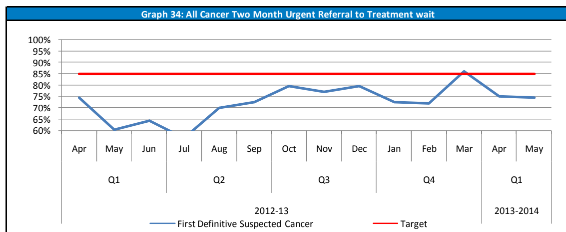


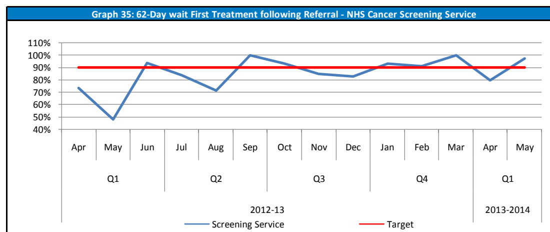










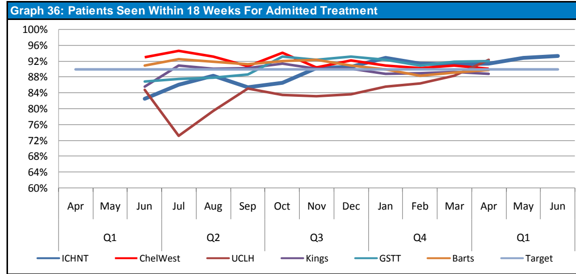


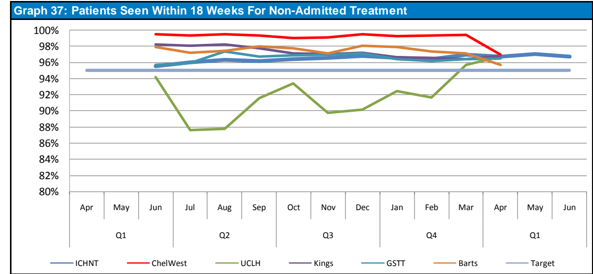
Source: Cancer Services

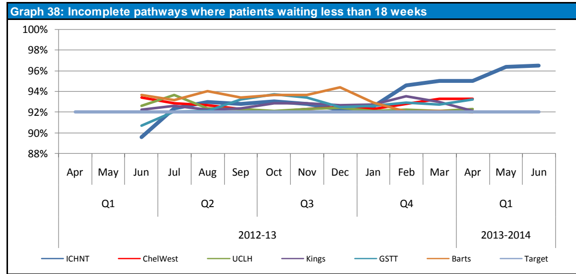
OPS 4: Elective Access - Referral To Treatment - NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4

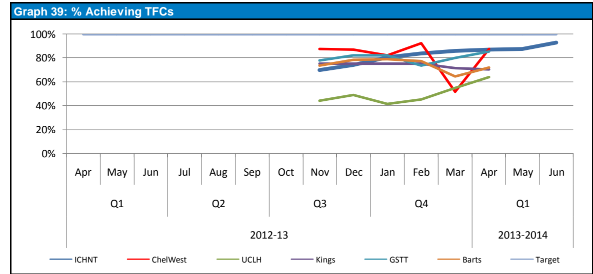
Domain	Indicator	Threshold	Unit	Month 3	Treatment Functions Not Achieving Target M1
Elective Access - Referral To Treatment	Total number of completed Admitted pathways - waiting 18 weeks or less	90.0	%	93.31	1
	Total number of completed Non-Admitted pathways - waiting 18 weeks or less	95.0	%	96.77	2
	Incomplete pathways where patients waiting less than 18 weeks	92.0	%	96.50	1
	Number of Treatment functions where standards are not delivered (admitted, non-admitted and incomplete pathways)	<=20	Number		4

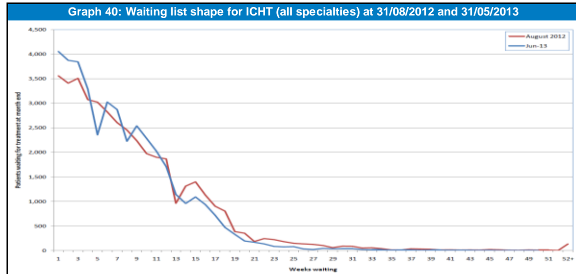
* London Peer comparison not available from Department of Health at time of publishing

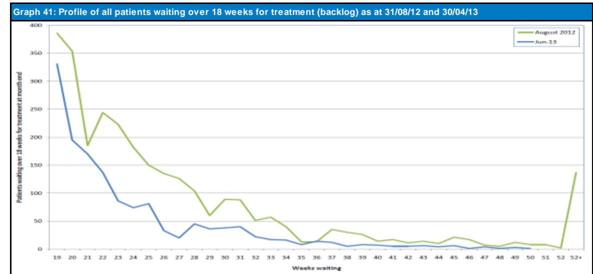

Graph 36: Patients Seen Within 18 Weeks For Admitted Treatment

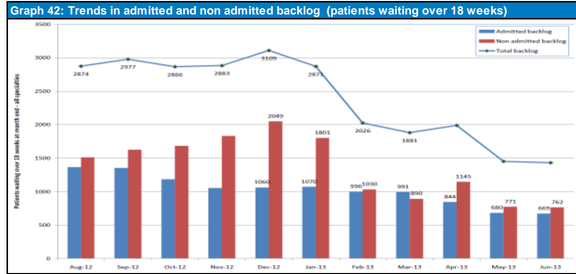

Graph 37: Patients Seen Within 18 Weeks For Non-Admitted Treatment


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


Graph 39: % Achieving TFCs


Graph 40: Waiting list shape for ICHT (all specialties) at 31/08/2012 and 31/05/2013


Graph 41: Profile of all patients waiting over 18 weeks for treatment (backlog) as at 31/08/12 and 30/04/13


Graph 42: Trends in admitted and non admitted backlog (patients waiting over 18 weeks)

Source: Department of Health

OPS 5: Elective Access - Diagnostics - **NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 3	Year to date
Elective Access - Diagnostics	Patients waiting 6 weeks or more for a diagnostic test	<1	%	0.13 ●	0.14 ●

Graph 43: Patients waiting 6 weeks or more for a Diagnostic Test

Source: Information Team

Diagnostic waiting list and Breaches waiting more than 6 weeks

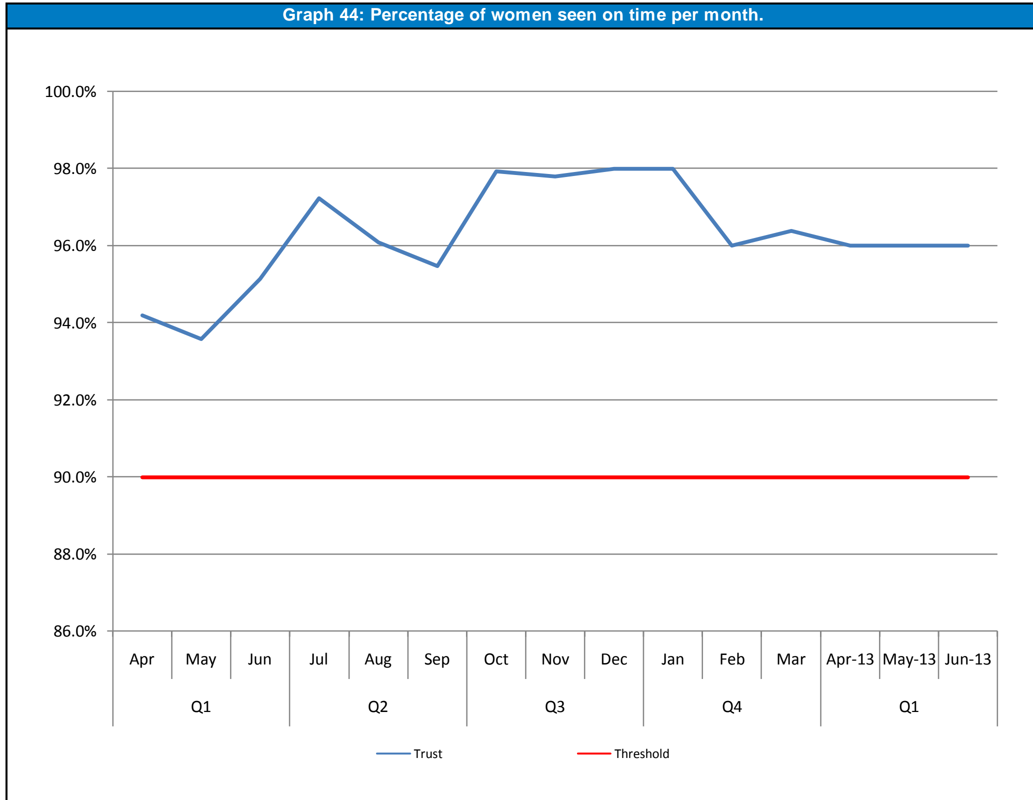
April		May		June		July		August		September	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches
8576	18	8010	6	8757	11						

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

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

Domain	Indicator	Threshold	Unit	Month 3	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	%	96.00 ●	96.00 ●

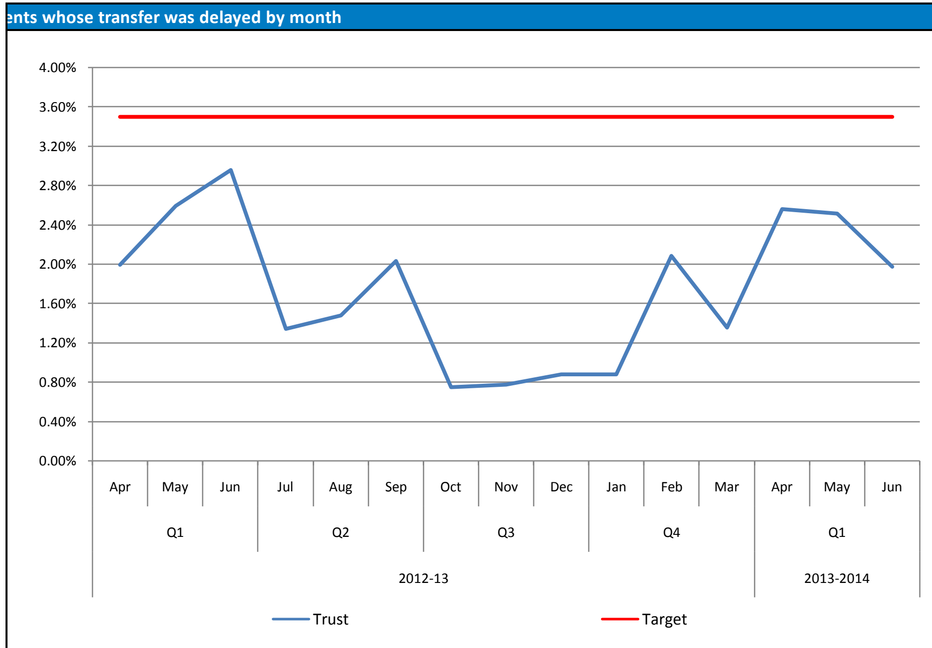
Graph 44: Percentage of women seen on time per month.



Source: Information Team

OPS 7: Delayed Transfer of Care - **NHS Performance Framework 2013/14 Indicator & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Quarter 1	Year to date
Delayed Transfer of Care	Average number of Acute patients (aged 18+) per day whose transfer of care was delayed	3.5	%	2.36 •	2.36 •

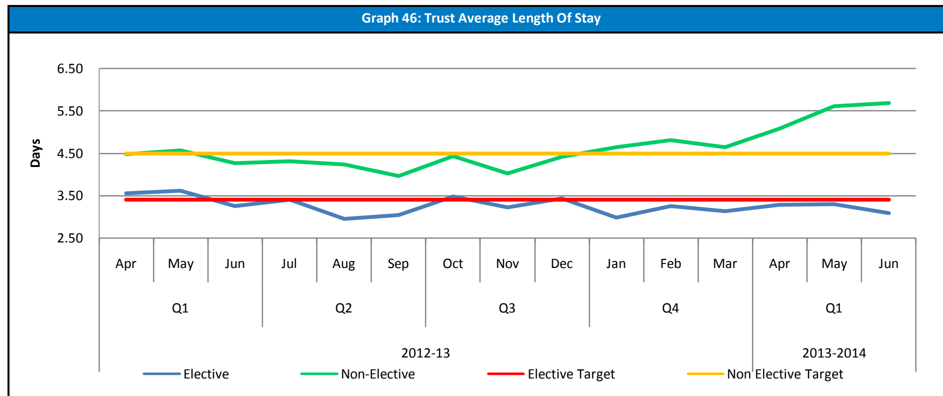


Source: Discharge Team, Clinical Site Management Team & Information Team

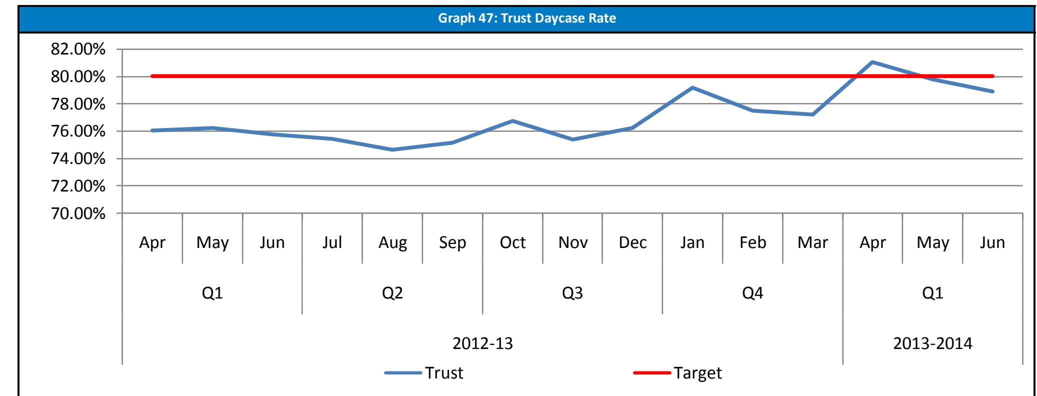
OPS 8: Quality, Innovation, Productivity and Prevention - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Target	Unit	Month 3		Year to date	
Productivity	Average Elective Length of Stay	3.40	Days	3.08	●	3.22	●
	Average Non-Elective Length of Stay	4.49	Days	5.69	●	5.46	●
	Daycase Rate	80.0	%	78.89	●	79.90	●
	New to Follow Up Outpatient Ratio	1.67	Ratio	2.44	●	2.50	●
	Theatre Utilisation Rate	>= 81	%	78.36	●	78.8	●

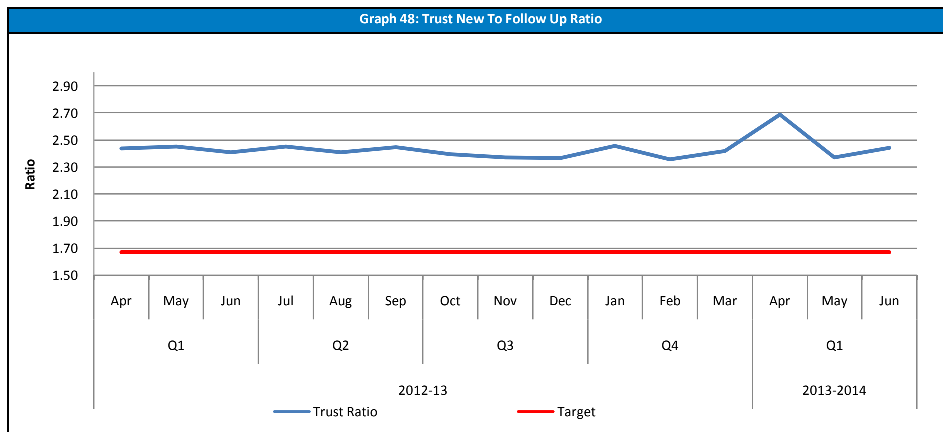
Graph 46: Trust Average Length Of Stay



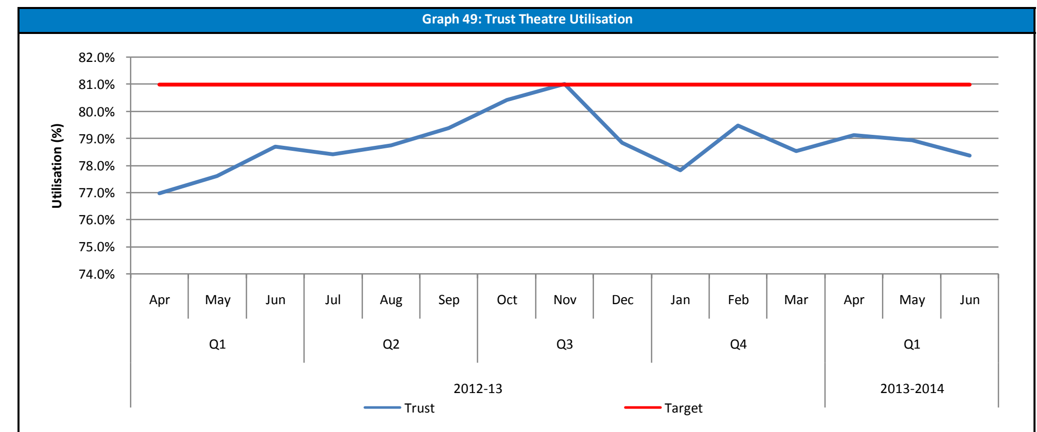
Graph 47: Trust Daycase Rate



Graph 48: Trust New To Follow Up Ratio



Graph 49: Trust Theatre Utilisation



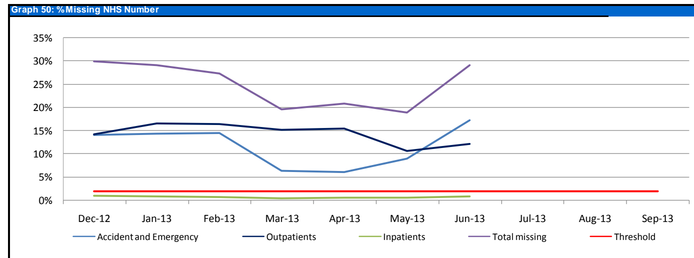
Source: Information Team, Finance Team & Theatre's Team

Trust Board: 24 July 2013 Agenda Number: 4.1, Appendix Paper: 10

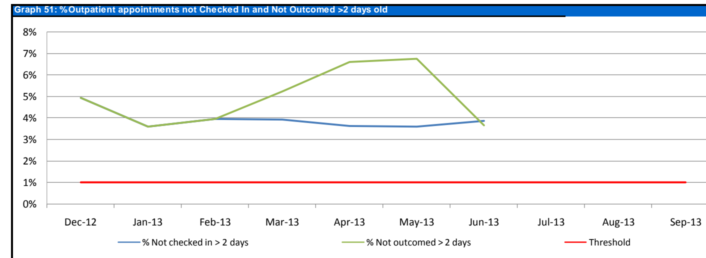
OPS 6: Data Quality - Supports Compliance with Care Quality Commission Outcome 21

Domain	Indicator		Threshold	Unit	Month 3		Year to date
The operational data quality indicators are important for: 1. Patient Safety 2. Income Recovery (or avoidance of penalties) 3. Tracking Patient Pathways 4. Supporting the Quality Accounts 5. Readiness for Cerner@Imperial	Missing NHS Number (Accident and Emergency attendances)		314	Number	2712	•	5183
	Missing NHS Number (Outpatient activity)	*	40	Number	2024	•	6485
	Missing NHS Number (Inpatient activity)		19	Number	942	•	2146
	Outpatient appointments not checked in >2 days old		42	Number	4176	•	12423
	Outpatient appointments not outcomed > 2 days old		39	Number	3942	•	19101
	Patients added to elective waiting list > 2 days after decision to admit date (over last 30 days)		89	Number	1780	•	5259
	Admissions Recorded > 1 Hour After Admission		301	Number	4149	•	9494
	Transfers Recorded > 1 Hour After Transfer		226	Number	2255	•	6656
	Discharges Recorded > 1 Hour After Discharge		10	Number	7284	•	14201

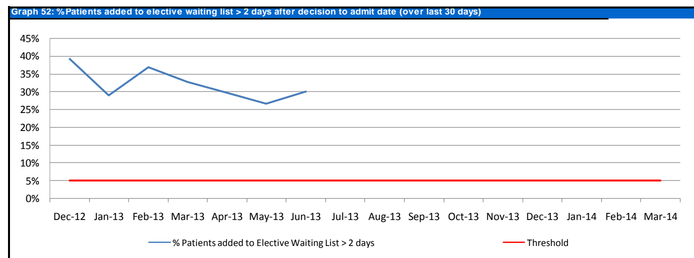
Graph 50: %Missing NHS Number



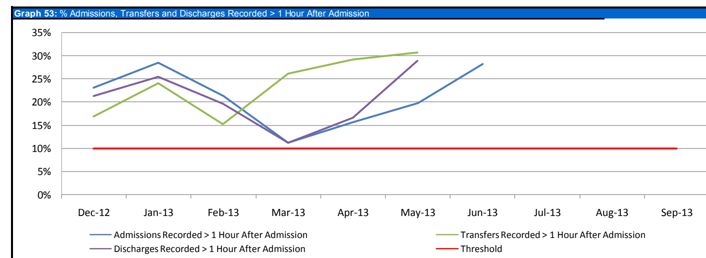
Graph 51: %Outpatient appointments not Checked In and Not Outcomed >2 days old



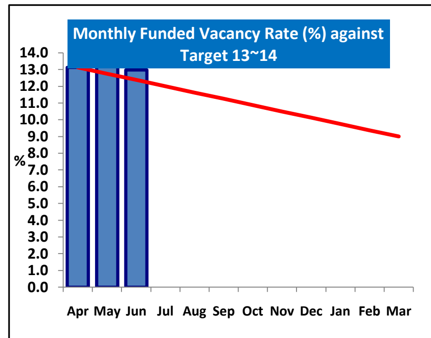
Graph 52: %Patients added to elective waiting list > 2 days after decision to admit date (over last 30 days)

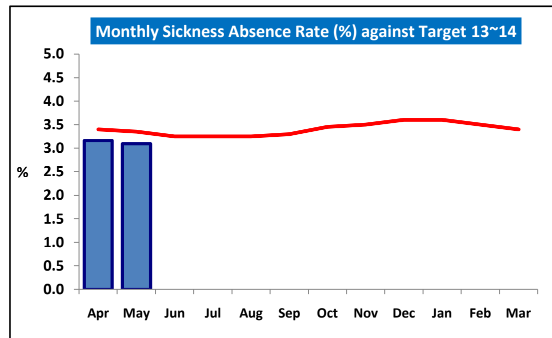


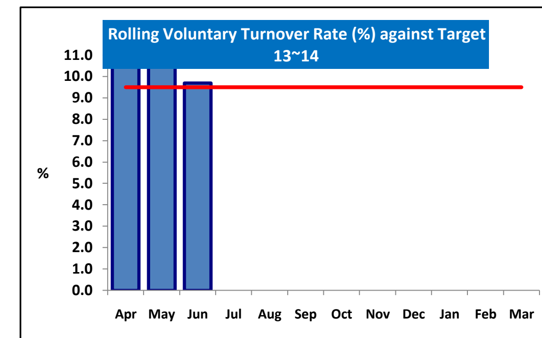
Graph 53: % Admissions, Transfers and Discharges Recorded > 1 Hour After Admission



Source: Patient Administration System (ICHIS) and Cymbio Data Quality Reporting Tool







VACANCY RATE TARGET (YEAR-	<9.00%	
Current in-month POSITION aga	12.97%	●

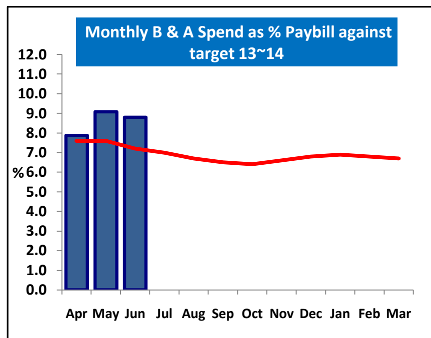
% of ESR post WTE that is vacant (ESR post WTE minus staff inp

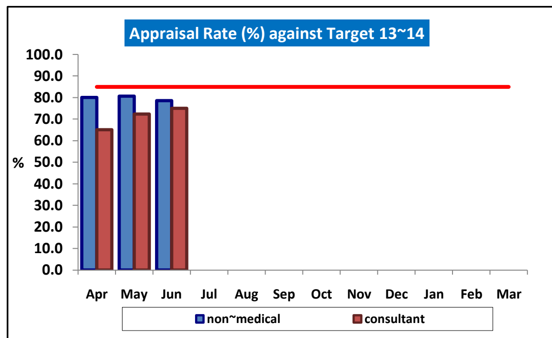
SICKNESS RATE TARGET (YEAR-END)	<3.40%	
CURRENT in-month POSITION against target	unavailable	
12 Month Rolling POSITION (to May 2013)	3.49%	●

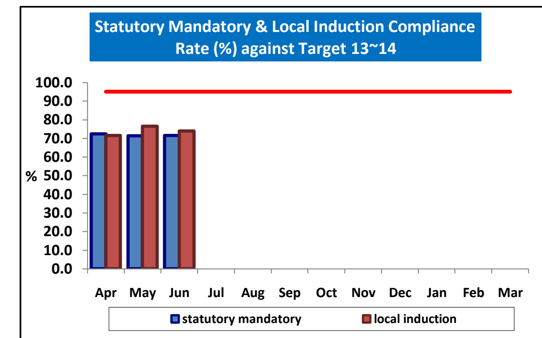
% of contracted working hours lost to sickness

TURNOVER RATE TARGET (YEAR-END)	<9.50%	
12 Month Rolling POSITION against target	9.69%	●

voluntary leavers as % of workforce(average headcount) over 12-month period







B&A SPEND as% PAYBILL TARG	<7.0%	
CURRENT in-month POSITION a	8.80%	●
12 Month Rolling POSITION	7.69%	●

% of total paybill attributable to bank and agency spend

APPRAISAL RATE TARGET (YEAR-END)	>85.00%	
NON~MEDICAL STAFF ~ CURRENT POSITION	78.60%	●
CONSULTANT APPRAISAL ~ CURRENT POSITION	75.00%	●

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

COMPLIANCE RATE TARGET	>95.00	
STATUTORY MANDATORY ~ CURRENT POSITIO	71.58%	●
LOCAL INDUCTION ~ CURRENT POSITION	73.94%	●

% of current staff with compliant with statutory mandatory training requirement
% of current staff, who joined in last 12 mths, with a local induction recorded

People Numbers: Substantively employed people numbers, in June, were 8,647 WTE. This is 15 WTE more than in May with the main increase seen within the Qualified Nursing group; a reflection of the recent recruitment activity to reduce the ward based vacancies to 5%.

Vacancy: Using the post establishment held on ESR, there was a vacancy rate of 12.97% in June; the equivalent of 1,289 WTE positions. A review of all vacant posts will be completed by the end of July, removing all posts which have no active recruitment or bank and agency cover.

Sickness: *currently unavailable for June 2013*

Turnover: During June, there were 67 voluntary leavers bringing the 12-month rolling turnover rate to 9.69%. Across CPG's and Corporate Directorates, this rate varies from 7 to 30% ; a similar range is seen within the different occupational groups.

Bank & Agency Spend: During June, bank and agency spend accounted for 8.8% of total pay expenditure; bringing the 12-month rolling position to 7.69% against a full-year target of 7.0%. Within CPG's and Corporate Directorates, between 2.5 and 33% of total pay expenditure was attributable to bank and agency spend.

Appraisal: Non medical appraisal across the Trust came down from 81 to 79% in June; ranging from 73 to 82% across the CPG's and 43 to 94% within Corporate Directorates. The Trust Consultant appraisal rate rose from 72 to 75% in month; ranging from 51 to 90% within the CPG's. Weekly reporting, for both measures, will commence in July to support local plans to improve performance to reach the Trust target of 85%.

Statutory Mandatory & Local Induction: Both Statutory Mandatory and Local Induction training metrics remain below the 95% Trust target at 72 and 74% respectively. Within the CPG and Corporate Directorates, performance against these two metrics ranges from 50 to 100% for Local Induction and 46 to 85% for Statutory Mandatory Training.

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

Imperial College Healthcare NHS
NHS Trust

Contents

Finance Performance Report for the month ending 30th June 2013

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

Building world class finance

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	Forecast £000s	Variance £000s
Income									
Clinical	61,821	63,650	1,829	183,848	189,176	5,328	745,934	760,609	14,675
Research & Development & Education	9,562	8,330	(1,232)	28,686	26,409	(2,277)	114,743	114,743	0
Other	6,649	7,667	1,018	19,949	19,540	(409)	79,799	79,799	0
TOTAL INCOME	**78,032**	**79,646**	**1,614**	**232,483**	**235,125**	**2,642**	**940,476**	**955,151**	**14,675**
Expenditure									
Pay - In post	(38,303)	(39,197)	(893)	(114,802)	(117,699)	(2,897)	(462,891)	(468,099)	(5,208)
Pay - Bank & Agency	(3,757)	(3,937)	(180)	(11,349)	(11,437)	(87)	(44,540)	(46,037)	(1,497)
Drugs & Clinical Supplies	(17,938)	(18,151)	(213)	(53,878)	(54,524)	(646)	(214,761)	(218,288)	(3,527)
General Supplies	(2,962)	(3,291)	(329)	(8,886)	(9,446)	(560)	(35,551)	(36,223)	(672)
Other	(9,418)	(9,913)	(495)	(28,286)	(26,473)	1,813	(112,879)	(116,650)	(3,771)
TOTAL EXPENDITURE	**(72,378)**	**(74,489)**	**(2,111)**	**(217,201)**	**(219,579)**	**(2,377)**	**(870,622)**	**(885,297)**	**(14,675)**
EBITDA	**5,654**	**5,158**	**(497)**	**15,282**	**15,546**	**265**	**69,854**	**69,854**	**0**
Financing Costs	(4,612)	(4,793)	(181)	(13,838)	(14,481)	(643)	(55,371)	(55,371)	0
SURPLUS / (DEFICIT) before Impairment	**1,042**	**365**	**(677)**	**1,444**	**1,065**	**(379)**	**14,483**	**14,483**	**0**
Impairment of Assets, Stock losses & Donated Asset treatment	49	26	(23)	147	292	145	592	592	0
SURPLUS / (DEFICIT)	**1,091**	**391**	**(700)**	**1,591**	**1,357**	**(234)**	**15,075**	**15,075**	**0**

Surplus / (Deficit): The Trust delivered a surplus of £391k in month, which is an adverse variance of £700k from the plan. The actual achievement of CIP YTD was £7,895k and this is behind plan by £3,406k.
Income: Clinical income is ahead of plan and is mainly associated with over-performance on the CCG SLA. The adverse variance on R&D is linked to an equivalent underspend on expenditure to ensure a net zero impact for R&D projects. The adverse variance on other income is due to Parkhill Audit income being behind plan.
Expenditure: The adverse variances on pay and non pay expenditure are mainly attributable to CIPs being behind plan.
Financing costs: The over-spend is attributable to depreciation on fixed assets and timing of receipt of capital grants.

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

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	Forecast £000s	Variance £000s
Income from Clinical Activities									
Clinical Commissioning Groups	32,824	33,530	706	97,610	103,452	5,842	396,073	410,748	14,675
NHS England	23,458	25,921	2,463	69,761	70,299	538	283,046	283,046	0
Other NHS Organisations	1,448	293	(1,155)	4,307	3,204	(1,103)	17,469	17,469	0
Sub-Total NHS Income	**57,730**	**59,743**	**2,013**	**171,678**	**176,956**	**5,278**	**696,588**	**711,263**	**14,675**
Local Authority	790	669	(121)	2,349	2,360	11	9,529	9,529	0
Private Patients	2,720	2,881	161	8,093	8,095	2	32,801	32,801	0
Overseas Patients	150	203	53	446	495	49	1,820	1,820	0
NHS Injury Scheme	114	126	12	339	343	4	1,373	1,373	0
Non NHS Other	317	28	(289)	943	926	(17)	3,823	3,823	0
Total - Income from Clinical Activities	**61,821**	**63,650**	**1,829**	**183,848**	**189,176**	**5,328**	**745,934**	**760,609**	**14,675**
Other Operating Income									
Education, Research & Development	9,562	8,330	(1,232)	28,686	26,409	(2,277)	114,743	114,743	0
Non patient care activities	2,942	2,649	(293)	8,826	7,813	(1,013)	35,306	35,306	0
Income Generation	506	340	(166)	1,518	1,015	(503)	6,070	6,070	0
Other Income	3,201	4,677	1,476	9,605	10,713	1,108	38,423	38,423	0
Total - Other Operating Income	**16,211**	**15,997**	**(214)**	**48,635**	**45,949**	**(2,686)**	**194,542**	**194,542**	**0**
TOTAL INCOME	**78,032**	**79,646**	**1,614**	**232,483**	**235,125**	**2,642**	**940,476**	**955,151**	**14,675**

Income from Clinical Activities: The variance is mainly associated with an over-performance of CCG SLA contracts. It is expected that the CCG QIPP programmes will not deliver the anticipated reductions in admitted care and outpatient activity. The adverse variance on other NHS organisations is due to retrospective adjustments to move community clinical services previously outside PCT SLAs into the main contracts with CCGs and NHS England.
Other Operating Income: The adverse variance on R&D is linked to an equivalent underspend on expenditure to ensure a net zero impact for R&D projects. The adverse variance on non patient care is due to Parkhill Audit income being behind plan.

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

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	Forecast £000s	Variance £000s
Pay - In Post									
Medical Staff	(12,364)	(12,388)	(25)	(37,077)	(37,885)	(807)	(150,440)	(151,648)	(1,208)
Nursing & Midwifery	(11,911)	(12,347)	(436)	(35,696)	(36,702)	(1,006)	(144,068)	(145,868)	(1,800)
Scientific, Therapeutic & Technical staff	(5,522)	(5,689)	(167)	(16,514)	(17,003)	(489)	(66,586)	(67,586)	(1,000)
Healthcare assistants and other support staff	(2,033)	(2,287)	(254)	(6,133)	(6,660)	(527)	(24,633)	(25,433)	(800)
Directors and Senior Managers	(2,433)	(2,476)	(43)	(7,300)	(7,447)	(147)	(28,761)	(29,161)	(400)
Administration and Estates	(4,040)	(4,009)	31	(12,082)	(12,003)	79	(48,403)	(48,403)	0
Sub-total - Pay In post	**(38,303)**	**(39,197)**	**(893)**	**(114,802)**	**(117,699)**	**(2,897)**	**(462,891)**	**(468,099)**	**(5,208)**
Pay - Bank/Agency									
Medical Staff	(682)	(847)	(165)	(2,077)	(1,934)	143	(8,002)	(8,002)	0
Nursing & Midwifery	(1,235)	(1,218)	17	(3,706)	(4,056)	(350)	(14,693)	(15,590)	(897)
Scientific, Therapeutic & Technical staff	(370)	(482)	(111)	(1,151)	(1,302)	(151)	(4,565)	(4,965)	(400)
Healthcare assistants and other support staff	(353)	(354)	(1)	(1,058)	(1,117)	(59)	(3,992)	(4,042)	(50)
Directors and Senior Managers	(334)	(280)	54	(1,002)	(602)	400	(4,010)	(4,010)	0
Administration and Estates	(782)	(756)	27	(2,355)	(2,426)	(71)	(9,278)	(9,428)	(150)
Sub-total - Pay Bank/Agency	**(3,757)**	**(3,937)**	**(180)**	**(11,349)**	**(11,437)**	**(87)**	**(44,540)**	**(46,037)**	**(1,497)**
Non Pay									
Drugs	(8,051)	(8,144)	(93)	(24,064)	(25,067)	(1,002)	(99,268)	(100,678)	(1,410)
Supplies and Services - Clinical	(9,887)	(10,007)	(120)	(29,814)	(29,458)	356	(115,493)	(117,610)	(2,117)
Supplies and Services - General	(2,962)	(3,291)	(329)	(8,886)	(9,446)	(560)	(35,551)	(36,223)	(672)
Consultancy Services	(1,289)	(1,297)	(8)	(3,867)	(3,126)	741	(15,464)	(15,464)	0
Establishment	(625)	(572)	53	(1,875)	(1,707)	168	(7,435)	(7,435)	0
Transport	(824)	(975)	(151)	(2,472)	(2,614)	(142)	(9,892)	(9,892)	0
Premises	(3,351)	(3,073)	278	(10,053)	(9,566)	487	(40,219)	(40,219)	0
Other Non Pay	(3,329)	(3,995)	(666)	(10,019)	(9,459)	560	(39,869)	(43,640)	(3,771)
Sub-total - Non Pay	**(30,318)**	**(31,355)**	**(1,037)**	**(91,050)**	**(90,443)**	**607**	**(363,191)**	**(371,161)**	**(7,970)**
TOTAL EXPENDITURE	**(72,378)**	**(74,489)**	**(2,111)**	**(217,201)**	**(219,579)**	**(2,377)**	**(870,622)**	**(885,297)**	**(14,675)**
Financing Costs									
Interest Receivable	24	19	(5)	72	56	(16)	287	287	0
Receipt of Grants for Capital Acquisitions	67	61	(6)	201	61	(140)	798	798	0
Interest Payable	(71)	(72)	(1)	(215)	(217)	(2)	(859)	(859)	0
Other Gains & Losses	0	(10)	(10)	0	(10)	(10)	0	0	0
Depreciation	(2,916)	(3,074)	(158)	(8,748)	(9,222)	(474)	(35,001)	(35,001)	0
Public Dividend Capital	(1,716)	(1,716)	(0)	(5,148)	(5,149)	(1)	(20,596)	(20,596)	0
TOTAL - FINANCING COSTS	**(4,612)**	**(4,793)**	**(181)**	**(13,838)**	**(14,481)**	**(643)**	**(55,371)**	**(55,371)**	**0**

Pay: The adverse variance on pay expenditure is mainly attributable to CIP being behind plan. It is concerning to note that the nursing expenditure is an adverse variance of £1.4m when considering permanent and temporary staff. The majority of this is within the medicine division, hence the weekly controls focused on turnaround.

Non Pay: The drugs over-spend is mainly associated with the bulk prescribing of HIV drugs and over-spend on PbR excluded drugs.The spend on drugs is subject to further investigation.

Financing costs: The over-spend is attributable to depreciation on fixed assets and timing relating to receipt of grants for capital projects which are expected to be back on plan before the year end.

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

PAGE 4 - Financial Risk Rating for Clinical & Non Clinical Divisions

CPG 1

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability	Amber	Amber	Amber									
Cost Control	Amber	Amber	Amber									
Forecasting Accuracy	Red	Red	Red									
Financial Governance	Amber	Amber	Amber									
Working Capital & Equipment	Red	Red	Red									

CPG 4

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability	Amber	Amber	Green									
Cost Control	Amber	Amber	Amber									
Forecasting Accuracy	Amber	Amber	Amber									
Financial Governance	Amber	Amber	Amber									
Working Capital & Equipment	Red	Red	Red									

CPG 2

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability	Amber	Amber	Amber									
Cost Control	Red	Red	Red									
Forecasting Accuracy	Amber	Amber	Amber									
Financial Governance	Amber	Amber	Amber									
Working Capital & Equipment	Red	Red	Red									

CPG 5

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability	Amber	Amber	Red									
Cost Control	Amber	Amber	Amber									
Forecasting Accuracy	Amber	Amber	Amber									
Financial Governance	Amber	Amber	Amber									
Working Capital & Equipment	Red	Red	Red									

CPG 3

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability	Amber	Amber	Green									
Cost Control	Red	Red	Amber									
Forecasting Accuracy	Amber	Amber	Amber									
Financial Governance	Amber	Amber	Amber									
Working Capital & Equipment	Red	Red	Red									

CPG 6

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability	Green	Green	Amber									
Cost Control	Amber	Amber	Amber									
Forecasting Accuracy	Amber	Amber	Amber									
Financial Governance	Amber	Amber	Amber									
Working Capital & Equipment	Red	Red	Red									

Non-Clinical

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability												
Cost Control	Red	Red	Red									
Forecasting Accuracy	Red	Red	Amber									
Financial Governance	Amber	Amber	Amber									
Working Capital & Equipment	Red	Red	Red									

This is the second time that Divisional financial performance has been assessed against the Financial Risk Rating. The metrics shown in the tables above reflect the 5 key themes and summarise performance against 25 detailed metrics. Self-assessment has been used where there are currently gaps in data

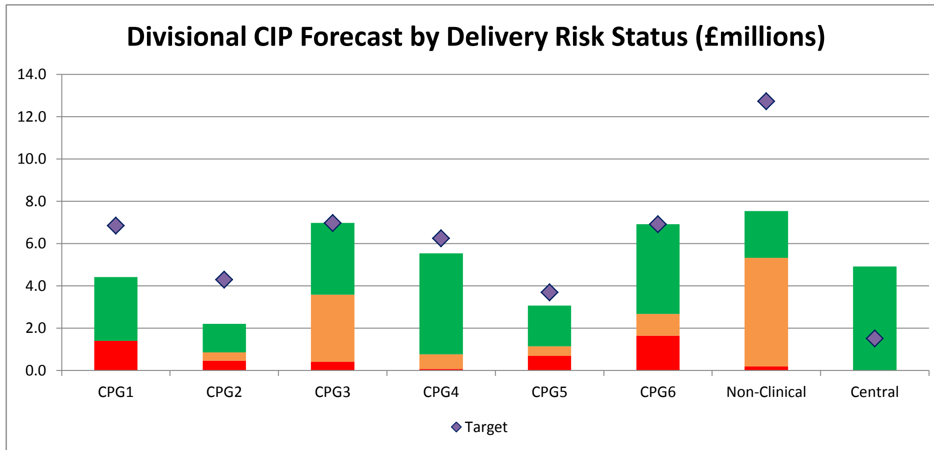
Key issues arising from review of performance against metrics will provide the focus for objectives for Clinical Divisions, Non-Clinical Directorates and the Finance & Procurement Directorate.

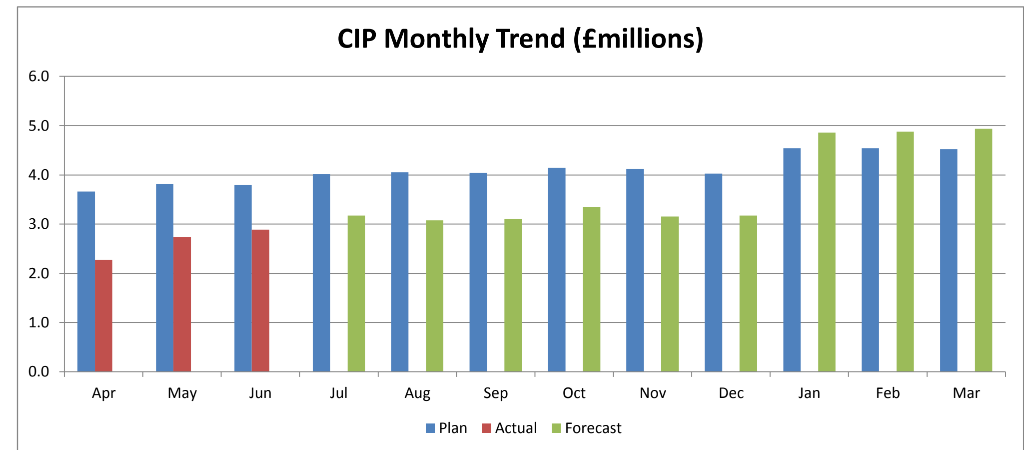
Feedback on the basis of calculation will be reflected in a refined approach to calculation as the Financial Risk Rating is embedded.

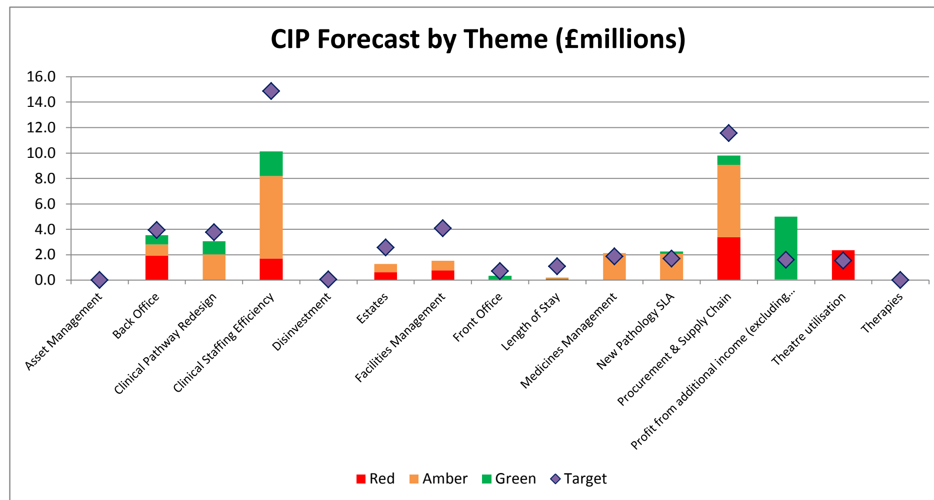
The majority of budget managers have completed a 4 hour training course on the Financial Performance Management framework with all managers planned to have received training by the end of June.

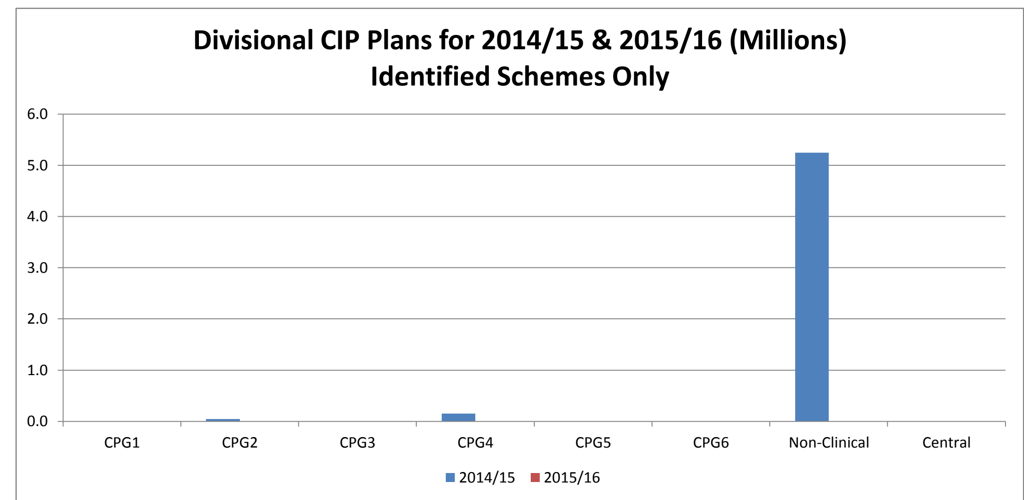
Statement of Comprehensive Income (SOCI) Risk: A

PAGE 5 - Cost Improvement Programme









Key Issues:

- £7.9m savings delivered year to date (deficit of £3.4m against plan)
- £41.6m of savings forecast for current year (deficit of £7.6m against plan)
- The Trust has committed to the Trust Development Authority delivery of the full £49.25m plan. Current CPG and Non-Clinical Directorates forecasts are £41.6m, leaving a gap of £7.6m to be mitigated.
- £5.44m of savings identified for 2014/15 by CPGs and Non-Clinical Dirctorates (0.7% of operating costs)
- £0.0m of savings identified for 2015/16 by CPGs and Non-Clinical Directorates (0% of operating costs)

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

PAGE 6 - STATEMENT OF FINANCIAL POSITION

		Opening Balance £000s	Current Month Balance £000s	Previous Month Balance £000s	Monthly Movement £000s	Forecast Balance £000s
Non Current Assets	Property, Plant & Equipment	715,616	709,944	711,796	(1,852)	711,071
	Intangible Assets	1,681	1,583	1,615	(32)	1,225
Current Assets	Inventories (Stock)	17,652	18,160	19,173	(1,013)	17,652
	Trade & Other Receivables (Debtors)	65,462	84,011	84,099	(88)	63,462
	Cash	55,326	52,212	49,606	2,606	60,326
Current Liabilities	Trade & Other Payables (Creditors)	(127,930)	(136,560)	(137,717)	1,157	(140,202)
	Borrowings	(3,059)	(3,059)	(3,059)	0	(2,685)
	Provisions	(37,353)	(37,832)	(37,419)	(413)	(11,656)
Non Current Liabilities	Borrowings	(23,362)	(23,362)	(23,362)	0	(20,677)
	Provisions	0	0	0	0	0
	TOTAL ASSETS EMPLOYED	**664,033**	**665,097**	**664,732**	**365**	**678,516**

Ratio/Indicators	Risk Rating		
	Current Month	Previous Month	Forecast
Debtor Days	32	32	25
Trade Payable Days	55	57	59
Cash Liquidity Days	31	30	34

The decrease in property, plant & equipment is due to depreciation for the month exceeding capital expenditure.

The decrease in inventories is predominantly due to the utilisation of stents bulk purchased in month 1 by CPG4.

The decrease in debtors, although minimal, is as a result of the following:

- Reduction of trade debtors of £3m
- Increase in overall accruals of £2m resulting predominantly from an increase for over performance of £6.9m and reduction in accruals for R&D, MFF and Project Diamond of £4m now invoiced
- Increase re June VAT refund of £1.2m received in July

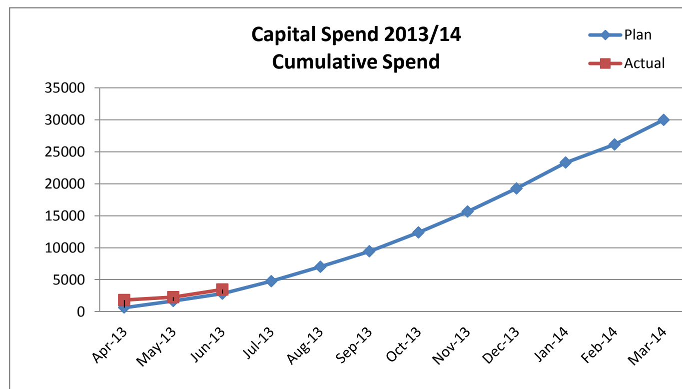
The increase in creditors is predominantly due to:

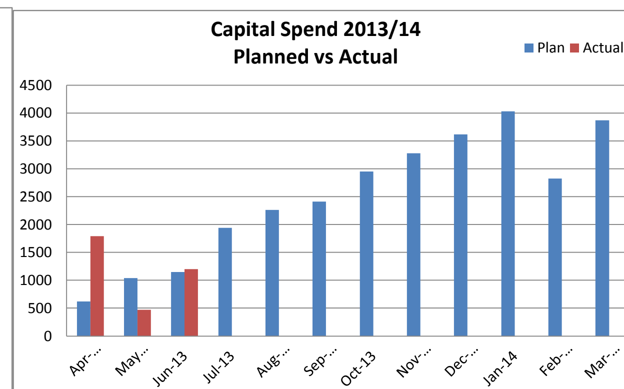
- Increase in PDC accrual of £1.7m. PDC dividend is paid in September and March each year
- Decrease in NHS England deferred income of £4.6m
- Increase in deferred income for Project Diamond and R&D MFF of £4.4m as quarter 2 invoiced in advanced
- Increase of accruals for Lloyds Pharmacy invoices of £1.4m
- Decrease in R&D Non-Commercial deferred income of £3.7m

Statement of Financial Position (SOFP)	Risk:	G

PAGE 7 - 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
Imaging Improvements HH	39	(1)	40	117	7	110	2,093	350	1,743
ICT Investment Programme	300	95	205	900	886	14	4,500	4,500	0
Endoscopy QEQM	88	232	(144)	460	259	201	5,674	5,674	0
Cardiac Relocation (EP)	90	398	(308)	600	514	86	1,708	1,708	0
Medical Equipment	0	4	(4)	0	609	(609)	4,000	4,061	(61)
Capital Maintenance CXH	100	6	94	100	24	76	1,000	1,000	0
Capital Maintenance HH	100	17	83	100	63	37	1,200	1,200	0
Capital Maintenance SMH	100	(5)	105	100	(21)	121	1,000	1,000	0
Access Control Upgrade	0	0	0	0	0	0	900	900	0
CCTV Development	0	0	0	0	0	0	65	65	0
Imaging Review	0	0	0	0	0	0	3,000	2,750	250
Theatre Upgrade	0	0	0	0	0	0	900	900	0
Pathology Equipment	30	0	30	30	0	30	140	140	0
Minor Works	0	0	0	0	0	0	500	500	0
Bathroom Upgrade HH Private Patients	0	0	0	0	0	0	250	250	0
Bio-Resource Centre	200	0	200	300	0	300	350	850	(500)
Aggregate Site Developments	100	54	46	100	321	(221)	1,470	1,470	0
Contingency	0	32	(32)	0	15	(15)	1,250	543	707
Shaping a Healthier Future Site Development	0	0	0	0	0	0	0	1,300	(1,300)
Radiotherapy Improvements	0	369	(369)	0	787	(787)	0	900	(900)
Total Capital Expenditure	**1,147**	**1,201**	**(54)**	**2,807**	**3,464**	**(657)**	**30,000**	**30,061**	**(61)**
Donations	**0**	**(61)**	**61**	**0**	**(61)**	**61**	**0**	**(61)**	**61**
Government Grants	0	0	0	0	0	0	0	0	0
Total Charge against Capital Resource Limit	**1,147**	**1,140**	**7**	**2,807**	**3,403**	**(596)**	**30,000**	**30,000**	**0**
Capital Resource Limit							**(30,000)**	**(30,000)**	**0**
Over/(Under)spend against CRL							**0**	**0**	**0**



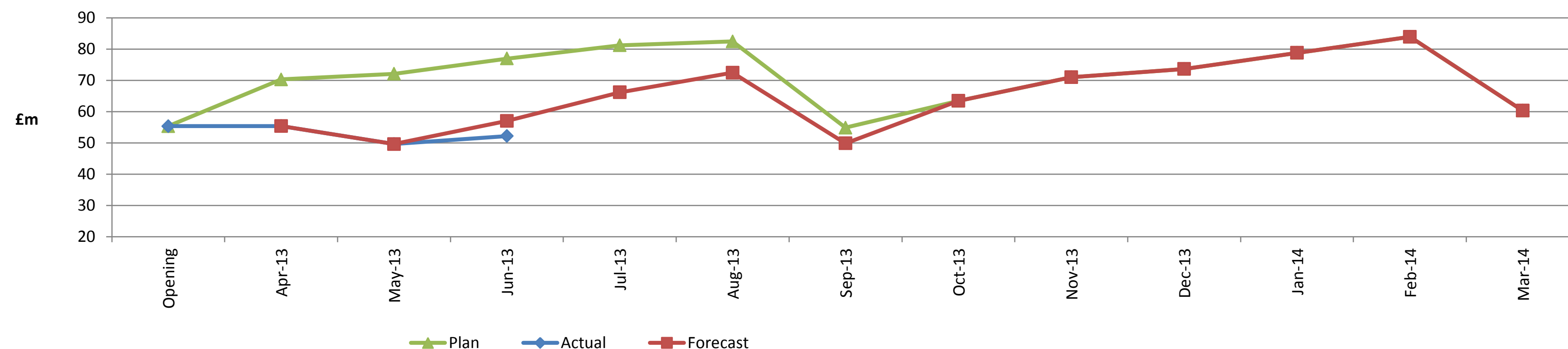


The programme is slightly ahead of plan, due to medical equipment and radiotherapy equipment being delivered earlier in the year than anticipated when the plan was compiled.

Significant changes in full-year forecasts for Imaging at HH represent slippage due to external approval delays and also uncertainty over the choice of equipment type to be procured.
The Bio-resource centre at CXH has increased due to expanded scope to maximise income opportunities, but still shows a good financial return.
Funding for the work to design new buildings under Shaping a Healthier Future is a new line, reflecting the ramping-up of work required to deliver site reconfigurations.

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

PAGE 8 - CASH



	Opening	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Plan	55,326	70,306	72,102	76,982	81,195	82,441	54,846	63,442	71,004	73,683	78,828	83,960	60,326
Actual	55,326	55,410	49,606	52,213									
Forecast		55,410	49,606	56,982	66,195	72,441	49,846	63,442	71,004	73,683	78,828	83,960	60,326

Aged Debtor Analysis

Category	0-30 Days	30-60 Days	60-90 Days	90 Days-6 Months	6 Months to 1 Year	Over 1 year	Total Debt		Previous Month Total
NHS	£ 13,859,058	£ 2,452,340	£ 4,397,376	£ 3,491,451	£ 762,464	£ 36,707	**£ 24,999,396**		**£ 28,845,073**
Non-NHS	£ 2,548,785	£ 246,426	£ 517,821	£ 3,923,019	£ 617,460	£ 421,694	**£ 8,275,205**		**£ 7,106,359**
Overseas Visitors	£ 159,615	£ 112,619	£ 141,242	£ 935,775	£ 1,279,615	£ 537,405	**£ 3,166,271**		**£ 3,147,487**
Private Patients	£ 1,396,717	£ 1,175,221	£ 1,155,728	£ 1,600,147	-£ 64,538	-£ 10,700	**£ 5,252,575**		**£ 5,575,908**
Total	**£ 17,964,175**	**£ 3,986,605**	**£ 6,212,166**	**£ 9,950,392**	**£ 2,595,001**	**£ 985,107**	**£ 41,693,447**		**£ 44,674,827**
% of Total Debt	**43.1%**	**9.6%**	**14.9%**	**23.9%**	**6.2%**	**2.4%**	**100.0%**		

Aged Creditor Analysis

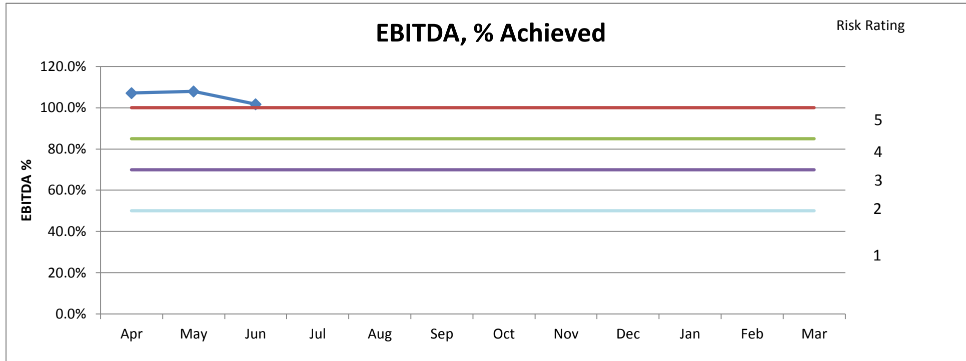
Category	0-30 Days	30-60 Days	60-90 Days	90 Days-6 Months	6 Months to 1 Year	Over 1 year	Total Creditors		Previous Month Total
All AP Creditors	£ 4,872,238	£ 574,460	£ 244,423	-£ 80,954	£ 245,064	£ 299,316	**£ 6,154,547**		**£ 6,862,396**
Total	**£ 4,872,238**	**£ 574,460**	**£ 244,423**	**-£ 80,954**	**£ 245,064**	**£ 299,316**	**£ 6,154,547**		**£ 6,862,396**
% of Total Creditors	**79.2%**	**9.3%**	**4.0%**	**-1.3%**	**4.0%**	**4.9%**	**100.0%**		

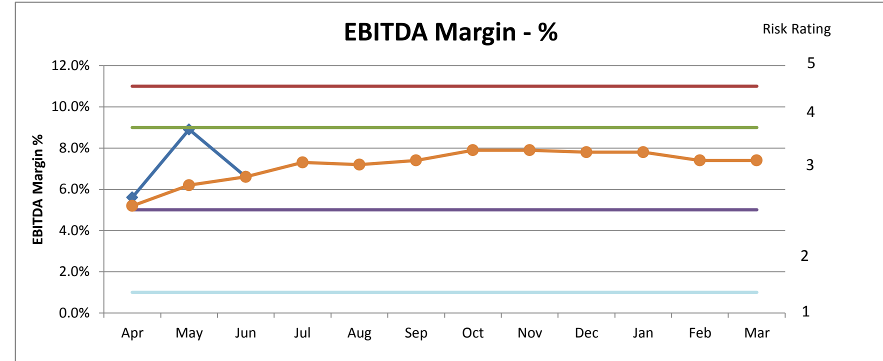
Organisational changes in the NHS and delays in agreeing contracts with commissioners continue to impact on the cash position in June. The main elements are the quarter 1 Project Diamond and R&D MFF of £4.4m invoiced to Central London (Westminster) CCG and the £4.2m of the quarterly invoice of £14.2m invoiced to Health Education England. These amounts are not deemed to be at risk.

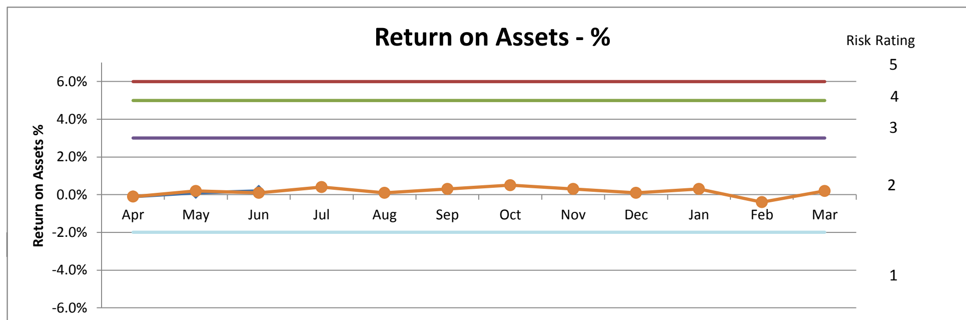
At the end of June, the balance of cash invested in the National Loan Fund scheme totalled £40m. This amount was invested for 7 days at an average rate of 0.39%. Total accumulated interest receivable at 30th June 2013 was £58k.

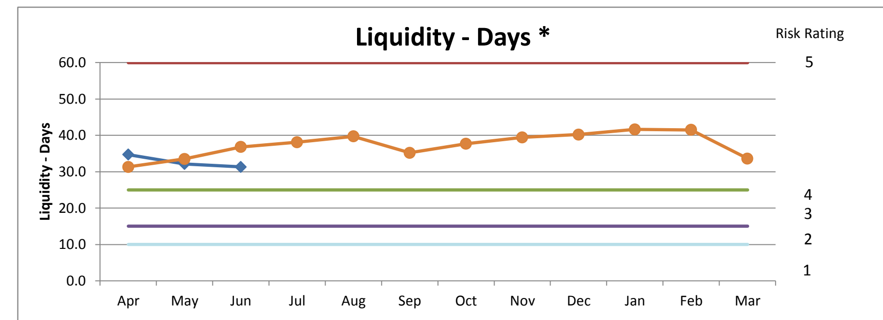
Aged creditors are 10% lower than at the end of May and there is a decrease in the percentage of invoices over 30 days. This is due in part to the implementation of the Early Payment Scheme.

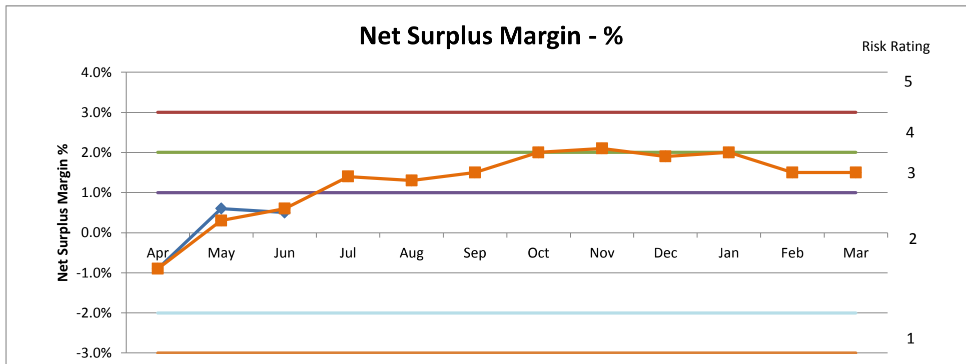
Statement of Financial Position (SOFP) Risk: A

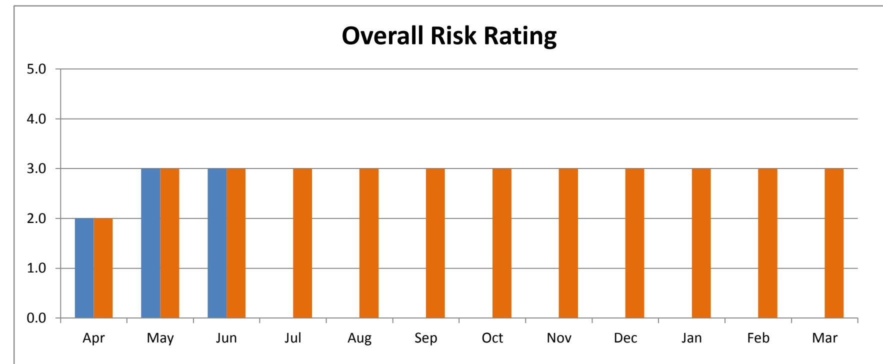












Each chart plots the current performance against each of the five Financial Risk Rating (FRR) metrics.

The Trust's overall FRR based on the results to the end of June 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 10 - SLA Activity & Income by POD (Estimate for June 2013)

Point of Delivery	Year to Date (Activity)			Year to Date (Income)		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s
Admitted Patient Care						
- Day Cases	16,431	17,676	1,245	14,319	14,827	508
- Regular Day Attenders	3,487	3,551	64	1,618	1,601	(17)
- Elective	5,195	4,774	(421)	17,918	16,195	(1,723)
- Non Elective	20,661	22,129	1,468	39,432	41,312	1,880
Accident & Emergency	48,449	51,299	2,850	5,518	5,815	297
Adult Critical Care	10,177	21,486	11,309	12,349	12,965	616
Outpatients - New	57,071	68,966	11,895	10,860	12,575	1,715
Outpatients - Follow-up	109,022	128,571	19,549	15,468	17,341	1,873
Ward Attenders	1,718	2,541	823	280	244	(36)
PbR Exclusions	65,898	163,858	97,960	15,290	16,355	1,065
Direct Access	540,449	573,695	33,246	3,730	4,241	511
CQUIN				4,044	4,353	309
Others	91,820	103,267	11,447	30,954	34,220	3,266
Commissioning Business Rules	(4,783)	(5,872)	(1,089)	(4,754)	(4,048)	706
SLA Income	965,595	1,155,941	190,346	167,026	177,996	10,970
Less Non English Organisations				(934)	(954)	(20)
Other SLA Outside the Main SLA				730	455	(275)
Other						
Non Patient Care CCG Income				1,216	913	(303)
Overperformance				4,661		(4,661)
TOTAL	**1,931,190**	**2,311,882**	**380,692**	**172,699**	**178,410**	**5,711**

Income by Sector	Year to Date (Income)		
	Plan £000s	Actual '£000s	Variance £000s
North West - London	78,684	85,852	7,168
London - Others	10,310	10,784	474
Non London	5,162	5,534	372
NHS England	68,692	70,299	1,607
Local Authorises	2,678	2,703	25
Non Contracted Activities	1,548	2,548	1,000
Out of Area Treatment	234	235	1
Other SLA			0
Others	730	455	(275)
Overperformance	4,661		(4,661)
TOTAL	**172,699**	**178,410**	**5,711**

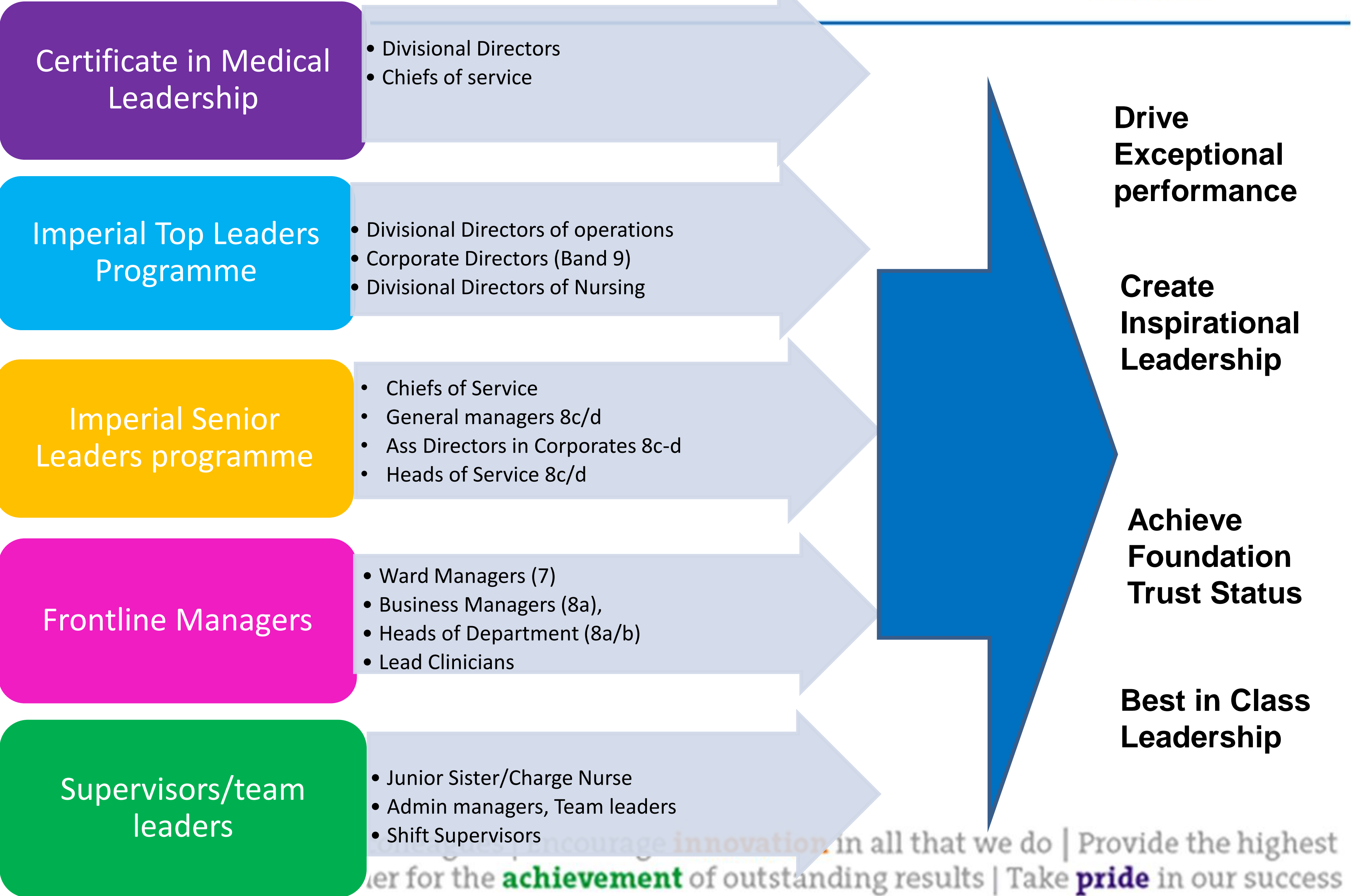
The report is an analysis of NHS SLA Income from clinical activities excluding other NHS organisations (non England within th e actuals).

The Year to Date Month 3 position is favourable against plan by £ 5.7m. The main reasons are :

1. Increase in Non Elective work with the key over performing specialties being A&E £0.98m, Vascular Surgery £0.25m, Cardiol ogy £0.16m and Thoracic Medicine £0.15m.
2. Outpatients first appointments have increased against plan e.g. Diagnostic Imaging £0.79m, Cardiology £0.46m and Gynaeco logy £0.25m.
3. Outpatients follow up appointments have also increased against plan e.g. Cardiology £0.27m, Gynaecology £0.23m and Dermato logy £0.16m.
4. Direct Access is above plan by £0.5m
5. Other areas include Stroke HASU £0.12m, Paediatrics ICU and Neo Natal Intensive Care £0.44m and Renal Services £0.12m.
6. There are areas of under performance mainly in Elective work, with the key under performing specialties being Trauma & O rthopaedics £0.48m, Vascular Surgery £0.26m and Cardiology £0.19m.

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

Leadership Programmes…..NEW for 2013



Certificate in Medical Leadership

Sponsor: Mark Davies & Nick Cheshire

The programme

- A 15 month Certificate Programme co-designed and co-delivered by Imperial College Business School
- A Bespoke programme for a tight cohort of emerging top clinicians

Design Principles

- To inspire participants as leaders and as individuals
- Bring them beyond their personal and local organisational stakes and issues
- Create opportunities for networking to create a cohesive cohort of engaged AHSC leaders
- Includes Case Studies, group work, Guest speakers, networking dinners and a group project
- 1 teaching day per month approx over 15 months

Trust Board: 24 July 2013
Agenda Number: 4.3
Paper: 12

Certificate in Medical Leadership

October 2013

June 2014

Year 1

Start 360 feedback tool

Classroom Delivery 9 Modules

Executive Coaching

Sept 2014

Jan 2015

Year 2

Repeat 360 feedback tool

Classroom Delivery

Executive Coaching

Group work on projects

Presentation of Projects

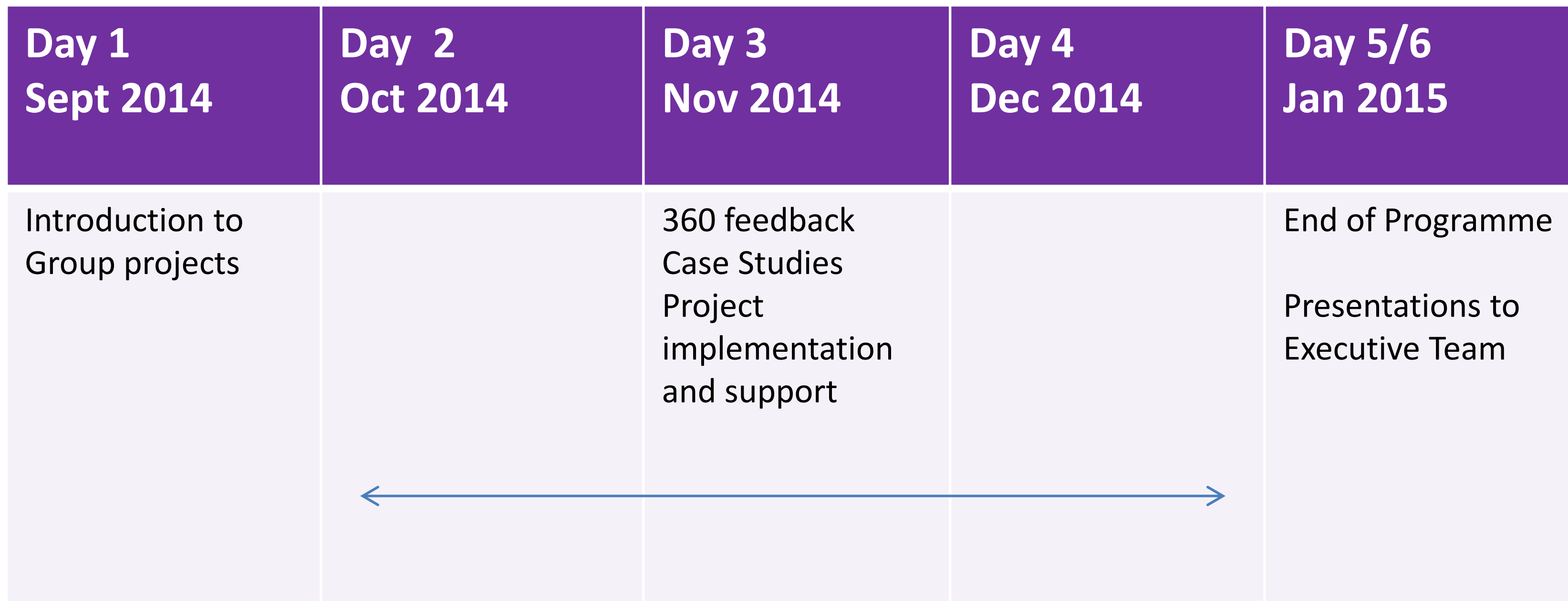
Imperial College Healthcare NHS
NHS Trust

Certificate in Medical Leadership: Overview: YEAR 1

Day 1 Oct 2013	Day 2 Oct 2013	Day 3 Nov 2013	Day 4 Dec 2013	Day 5/6 Jan & Feb 2014
Why are we here? The AHSC vision and strategic context Global and Health Landscape	**Leadership and Team development** What is Leadership? Developing High Performance teams	**Personal Leadership Style** MBTI, Emotional intelligence, Influencing	**How do we Decide what we offer?** Strategy and key strategic frameworks Turning strategy into action	**Money makes our world go around** Understanding Finance and Cost in the NHS Business cases Value for Money Entrepreneurship
Day 7 March 2014	**Day 8 April 2014**	**Day 9 May 2014**	**Day 10 June 2014**	**Day 11 June 2014**
Operations Management and Systems Delivering excellence with fewer resources Stripping out complexity	**The Culture of the Customer** Who are our Customers The Patient experience	**Culture and the Challenge of Change** What is culture? How can culture be changed? Changing hearts and minds	**How do they do it in other sectors?** Transparency and Accountability Risk management and Governance	**Handling Media and Public Scrutiny** Improving your media presence and presentation

Imperial College Healthcare NHS
NHS Trust

Certificate in Medical Leadership: Overview: YEAR 2



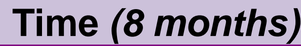
Day 1 Sept 2014	Day 2 Oct 2014	Day 3 Nov 2014	Day 4 Dec 2014	Day 5/6 Jan 2015
Introduction to Group projects		360 feedback Case Studies Project implementation and support		End of Programme Presentations to Executive Team

Imperial Top Leaders Programme

Trust Sponsor	**Steve McManus & Jayne Mee**
Delivery	Sue Grange and External Provider
Cohort	Divisional Directors of Operation, Divisional Directors of Nursing Deputy Directors of Corporates
Key Focus	Setting Direction and Vision Designing the Strategy Personal leadership style and Behaviour Transformational Change Politics and the wider healthcare context
Style of programme	Performance Coaching 360 degree feedback Work based projects Core modules
Timescale	October 2013 – October 2014

Imperial Top Leaders Programme

Imperial College Healthcare NHS



Pre programme

Start up 360

Module 1
Leading Yourself
1.5 days

*Introductions and keynotes from HR,/ CEO of Imperial NHS Trust or a Key external figure from healthcare.
*Getting to know each other
*Forming Project teams /dinner
Self Awareness: (Hogan)
Strengthscope- leading from your strengths.
Personal Values – going deeper- what is your "why" and personal purpose/ brand.
Advanced Coaching skills
Meeting their (External) coaches

Module 2
Leading Leaders and Followers
1.5 days

* Leadership style, mission, strategy & Culture (Kouze and Posner)
High performing teams across industries- case studies – learning from the best
Situational Leadership
Leading and engaging across boundaries
Lessons from the other sectors

Module 3
Leading Strategic Stakeholders
1.5 days

*Advanced Relationship & Stakeholder Management- strategic and political and external relationship management
Attracting and visioning with passion and purpose
Advanced Positive politics
"One Imperial" Collaborating across geographical, national and interdisciplinary boundaries
Coaching for strategic stakeholder relationships

Module 4
Leading the Trust
1.5 days

*Leading transformational Change to our services
Context for transformational change (PESTLE)
Applying Improvement methodologies (Lean/ Six Sigma)
(lessons and parallels from industry)
Values based leadership –Living the ICHT values for Trust transformation
Leading Innovation and the entrepreneurial mindset
Coaching for transformation

Module 5
Leading with your Performance Edge
1.5 days

*Coaching and action planning for developing your performance edge
Coaching for peak personal performance
Managing for high performance and managing conflict
Difficult conversations and transformational performance conversations

Module 6
Leading for results
1.5 days

*Project Presentations and Dinner (Recommendations/Outcomes for the Trust)
- Keynote wrap up

360 Feedback (2)
Sustaining strategic networks and project team feedback
Maintaining Momentum - Personal Commitment and Action Planning
"Why would anyone want to be led by me."- Sharing ones leadership manifesto

Coaching for sustainable results

Post programme

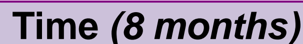
Lessons Learned: Organisational impact

Imperial Senior Leaders Programme

Trust Sponsor	**Steve McManus & Jayne Mee**
Delivery	Sue Grange and Head of Leadership Development
Cohort	Chiefs of Service, General Managers, Associate Directors - Corporates
Key Focus	Designing and Delivering Strategy Transformational Change and Innovation Personal leadership Style and Behaviour Working with others/Building high performing teams Improvement strategies for success Creating a culture of Engagement
Style of programme	In House Coaching 360 degree feedback Work based projects Core modules
Timescale	October 2013 – October 2014

Senior Leaders Programme

Imperial College Healthcare NHS



Time *(8 months)*

Pre programme

Start up 360

Module 1
Managing Yourself
1.5 days

*Introductions and keynotes from HR, Sponsor/s and CEO/
*Icebreakers and relationship building exercises
*Forming Project teams /dinner
Self Awareness: (MBTI, Strengthscope)
Personal Effectiveness: Job Roles and Time management (Covey)
Personal Values and Brand
Giving & receiving Feedback: 360 Feedback
Introduction to Coaching/ their internal coaches

Module 2
Managing Teams
1.5 days

*High Performing Teams – Roles & Characteristics (Belbin, Tuckman)
The five dysfunctions of a team.
Management style & Climate
Managing Remote Teams
Courageous PM conversations
Coaching (team issues)

Module 3
Managing stakeholders
1.5 days

*Relationship & Stakeholder Management

Influencing & Engaging (the four styles)
Positive politics
"One Imperial" Collaborating across geographical and professional boundaries
Coaching

Module 4
Managing change
1.5 days

*Managing & Delivering Effective Change in our services
Guiding Others Through Change in delivering our services
Cascading Communications during change and transition
Coaching for effective change management

Module 5
Managing Performance
1.5 days

Coaching and action planning for developing your performance edge
Coaching for peak personal performance
Managing for high performance and managing conflict
Difficult conversations and transformational performance conversations

Module 6
Making an Impact
1.5 days

*Project Presentations and Dinner (Recommendations/Outcomes for the Trust)
* Keynote wrap up

360 Feedback (2)
Coaching for future success
Sustaining networks and project team feedback
Maintaining Momentum - Personal Commitment and Action Planning
"Why would anyone want to be managed by me."

Post programme

Lessons Learned: Organisational impact

Frontline Managers

2013: Current Ward Manager Development Programmes to continue (Leading to Green, Effective Ward Manager)

2014: Design Multi Disciplinary programme

Trust Sponsor	Janice Sigsworth/Steve McManus
Delivery Partner	Leadership Development Team
Cohort	Ward Managers, Business Managers, Lead Clinicians
Key Focus	Driving Operational Performance Managing Excellent Services Building High performing teams
Style of programme	In House Coaching 360 degree feedback Work based projects Core modules Self Directed Learning/e-resources Paired learning
Timescale	October 2013 –October 2014

Supervisors & Team Leaders

Trust Sponsor	Jayne Mee
Delivery	Leadership Development Team– accredited by Institute of Leadership and Management
Cohort	Junior Sister/Charge Nurse, Admin managers Team leaders, Shift Supervisors
Key Focus	Leading the team Communication Managing Change Developing your Leadership style
Style of programme	Work based projects Core modules
Timescale	Cohort 12: June - November 2013 Further Cohort 13: 2014

Imperial College Healthcare NHS
NHS Trust

Leadership forum 2013-14

An essential network event for all Imperial executives and senior leaders to:

- **Meet bi-monthly to foster collaboration and two-way communication between senior leaders**
- **To provide opportunities for development and learning in key leadership topics and thinking**
- **To help shape and influence key decision making and strategy development Trust wide**

The leadership forum is an invite only event and all leaders are expected to attend. Deputies are not normally required unless by prior agreement.

Keynote speakers

Wednesday
31 July
14.00 - 16.30

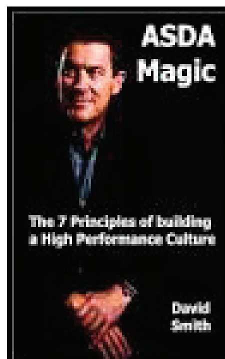
Refreshments and networking from 13.30

Knowing Me, Knowing You

A double bill to kick-off our new programme.

Jayne Mee
director of people and organisational development

Come and listen to our new Director of People and Organisational Development Jayne Mee, as she unveils our new People and OD Strategy. She will share latest thinking of the role leaders can play in transformational change and how she plans to support the development of our new leadership population.



David Smith,
formerly People Director at Asda

Author of best seller "The 7 Principles of a High performance Culture" David Smith was People Director for Asda 2000 - 2009 and was part of the team that turned it around from 4th rank ailing food retailer to the successful number 2 player it is today. He was a key part of the People team which has made it "A Great Place to work" since 1994.

All events to take place in the Oak Suite, W12 Conference Centre.

Keynote speakers

Tuesday
10 Sept
14.00 - 16.30

An Inspector Calls?

David Behan, chief executive, Care Quality Commission

An opportunity to hear first-hand what the future lies ahead for the CQC and what we can expect over the coming year. David Behan, the new chief executive of the CQC will be our keynote speaker, and you will have an opportunity to ask your questions directly to him. You learn more about the changing role of inspection, CQC and the national governance agenda.

Future topics

December
2013
date TBC

Trends in Future Healthcare

Robots, personalised medicine, smartphone monitoring, tele-health, the clinical cloud... are we all as leaders fully up to speed with the future trends in how medicine will be delivered in the future? This promises to be an essential session for all leaders to keep abreast of the latest trends, and hear from some of our own leading clinicians on the important trends in healthcare and think about how we incorporate this into our own planning.

March 2014
date TBC

Putting the Patient First

An opportunity to hear from other industries who rely on customer satisfaction for their survival ie, the hotel industry. What do they do to ensure that all staff go the extra mile and put customer satisfaction at the heart of all they do. Come and hear how this industry strives in the competitive market place and think about what lessons we can learn for our patient experience agenda.

June 2014
date TBC

Money Money Money

An exploration of the wider financial context and economic factors which surround us as we head toward FT status.

September
2014
date TBC

New Beginnings

As we make our final preparation for Foundation Trust status, this session will provide an opportunity to reflect on our journey of application through the eyes of our partners, the Trust Development Authority (TDA). We can also prepare for a new era as an FT, working with Monitor. We hear also from a Trust which is already an FT as they share with us their first year in FT status and lessons learnt.

December
2014
date TBC

The Future is Bright

With a keynote speaker, we will explore innovation in ICT, social media, sociological and political trends that we need to be aware of as leaders and how they impact on our services.

All events to take place in the Oak Suite, W12 Conference Centre.

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month			
	April	May	June
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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).

2. Condition G7 – Registration with the Care Quality Commission.

3. Condition G8 – Patient eligibility and selection criteria.

4. Condition P1 – Recording of information.

5. Condition P2 – Provision of information.

6. Condition P3 – Assurance report on submissions to Monitor.

7. Condition P4 – Compliance with the National Tariff.

8. Condition P5 – Constructive engagement concerning local tariff modifications.

9. Condition C1 – The right of patients to make choices.

10. Condition C2 – Competition oversight.

11. Condition IC1 – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Comment where non-compliant or at risk of non-compliance

1. Condition G4
Fit and proper persons as Governors and Directors.

Timescale for compliance:

2. Condition G7
Registration with the Care Quality Commission.

Timescale for compliance:

3. Condition G8
Patient eligibility and selection criteria.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

4. Condition P1
Recording of information.

Timescale for compliance:

5. Condition P2
Provision of information.

Timescale for compliance:

6. Condition P3
Assurance report on submissions to Monitor.

Timescale for compliance:

7. Condition P4
Compliance with the National Tariff.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

8. Condition P5
Constructive engagement concerning local tariff modifications.

Timescale for compliance:

9. Condition C1
The right of patients to make choices.

Timescale for compliance:

10. Condition C2
Competition oversight.

Timescale for compliance:

11. Condition IC1
Provision of integrated care.

Timescale for compliance:

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Monthly Data.

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BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight (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.

1. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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.

3. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. 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.

4. FINANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.

5. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate.

6. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

7. 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.

7. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. 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.

8. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. 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).

9. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. 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 TDA quality and governance indicators; and a commitment to comply with all known targets going forwards.

10. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. 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.

12. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. 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.

13. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. 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.

14. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

NHS TRUST DEVELOPMENT AUTHORITY

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1. Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. Condition G5 – Having regard to monitor Guidance.
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1. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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.

3. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework 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.

6. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. 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.

8. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. 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).

9. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. 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.

12. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. 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.

13. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. 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.

14. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month	April	May	June
	July	August	September
	October	November	December
	January	February	March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).

2. Condition G7 – Registration with the Care Quality Commission.

3. Condition G8 – Patient eligibility and selection criteria.

4. Condition P1 – Recording of information.

5. Condition P2 – Provision of information.

6. Condition P3 – Assurance report on submissions to Monitor.

7. Condition P4 – Compliance with the National Tariff.

8. Condition P5 – Constructive engagement concerning local tariff modifications.

9. Condition C1 – The right of patients to make choices.

10. Condition C2 – Competition oversight.

11. Condition IC1 – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

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COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Comment where non-compliant or at risk of non-compliance

1. Condition G4
Fit and proper persons as Governors and Directors.

Timescale for compliance:

2. Condition G7
Registration with the Care Quality Commission.

Timescale for compliance:

3. Condition G8
Patient eligibility and selection criteria.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

4. Condition P1
Recording of information.

Timescale for compliance:

5. Condition P2
Provision of information.

Timescale for compliance:

6. Condition P3
Assurance report on submissions to Monitor.

Timescale for compliance:

7. Condition P4
Compliance with the National Tariff.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

8. Condition P5
Constructive engagement concerning local tariff modifications.

Timescale for compliance:

9. Condition C1
The right of patients to make choices.

Timescale for compliance:

10. Condition C2
Competition oversight.

Timescale for compliance:

11. Condition IC1
Provision of integrated care.

Timescale for compliance:

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data.

CONTACT INFORMATION:

Enter Your Name:

Enter Your Email Address

Full Telephone Number: Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust:

Submission Date: Reporting Year:

Select the Month

April	May	June
July	August	September
October	November	December
January	February	March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight (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.

1. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

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.

3. CLINICAL QUALITY
Indicate compliance.

Timescale for compliance:

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Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. 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.

4. FINANCE
Indicate compliance.

Timescale for compliance:

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Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

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5. The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.

5. GOVERNANCE
Indicate compliance.

Timescale for compliance:

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BOARD STATEMENTS:

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6. All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate.

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Indicate compliance.

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BOARD STATEMENTS:

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7. 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.

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Indicate compliance.

Timescale for compliance:

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9. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. 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 TDA quality and governance indicators; and a commitment to comply with all known targets going forwards.

10. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

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14. GOVERNANCE
Indicate compliance.

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Imperial College Healthcare NHS
NHS Trust

Risk Management Strategy

Including Risk Management Process

July 2013

Author:	Helen Potton, Interim Corporate Governance Manager
Contact Details:	Helen.potton@imperial.nhs.uk
Date written	
Version:	3
Approved by:	
Ratified by:	Trust Board
Date Strategy becomes Live:	1 August 2013
Next due for revision:	July 2014
Target Audience:	All Staff
Location of Policy:	Trust Intranet - Policies and Procedures
Related Policies:	Being Open Policy Policy for Supporting Staff Involved in an Incident, Complaint and Claim Incident Reporting Policy Investigation Policy Serious Incident Policy Complaints and Concerns Policy Claims Policy Clinical Audit policy Risk Assessment Policy and Procedure Disciplinary Policy Health & Safety Policy Whistleblowing Policy Statutory and Mandatory Training Policy Risk Awareness Training for Senior Managers Policy

STRATEGY

1. Board Statement

Risk is an inherent part of the delivery of healthcare. All activities associated with healthcare, such as the treatment and care of patients to the employment of staff, maintenance of premises, and financial management attract risk. The Board places strong emphasis on ensuring that an appropriate system of internal control is in place to monitor and manage risk within the Trust, providing effective ongoing oversight of both controls and high level risks, and ensuring that there exists a culture of risk awareness which permeates decision making at all levels. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust and demonstrates an ongoing commitment to improving the management of risk throughout the organisation.

2. Introduction

This document sets out the Trust's strategy for dealing with risk and the risk management policy to be followed throughout the organisation. The Strategy applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Risk Management is a whole organisation exercise and, as such, is the responsibility of all staff at all levels and a fundamental part of every operational area. An open culture is fundamental to the identification and management of risk: it is imperative that issues can be raised and discussed openly at all levels of the organisation.

The achievement of objectives is subject to uncertainty which can have negative and positive effects resulting in threats and opportunities. The uncertainty of an outcome is how risk is defined, and effective risk management enables the Trust to identify, manage, mitigate and monitor, although not necessarily eliminate, a risk in an informed and cohesive manner.

3. Purpose

The purpose of the Risk Management Strategy is to provide a framework which supports the development of an organisational culture whereby risk management is an integral part of providing healthcare and day to day decision-making. Many types of risk exist but those of particular relevance to the Trust include reputation, health and safety, legal and regulatory, business continuity, financial performance and processes, people and culture, and security including data protection. The Board will also need to take account of risks that affect the political, social and financial environment the Trust operates in e.g. demographic shifts, crises risks such as power outages, flooding and major incidents, and those risks associated with stakeholder groups such as suppliers.

4. Risk Management Process

The Trust's risk management process provides a framework for ensuring that risks are identified, assessed, controlled and, where necessary, escalated. These main stages are carried out through:

1. Clarifying objectives
2. Identifying risks to the objectives
3. Defining and recording risks
4. Completion of the risk register and identifying actions to manage the risk
5. Communicating risk to enable discussion of risk appetite and aggregation of risk.

4.1 Governance structures to support risk management

There are different operational levels of risk governance in the Trust:

- Board of Directors
- Management Board
- Divisional or Function Level
- Ward/Clinic/Department level

The Board's key responsibilities are:

- To understand the nature and extent of the risk facing the Trust
- To consider the extent and categories of risk which it regards as acceptable for the Trust to bear ie risk appetite
- To weigh the likelihood of specific risks materialising
- To identify the Trust's ability to reduce incidences occurring and reduce/eliminate the impact on the business
- To direct action on risks that do materialise
- To weigh the costs of operating particular controls relative to the benefits obtained in managing related risks ie cost/risk balance

4.2 Risk Appetite

In particular, the Board will want to consider its appetite for and attitude to risk, updating these where appropriate. Risk appetite is the decision on the appropriate exposure to risk that it will accept in order to deliver its strategy over a given time frame. Risk appetite is not to be confused with risk tolerance: appetite refers to the amount of risk an organisation is prepared to accept, and tolerance is the accepted degree of variance to risk appetite. The greater the appetite for risk the more robust the requirement will be to ensure tolerances are not breached. Risk appetite is a key consideration in objective setting and strategy selection. As the Board sets its strategy, it will take into account whether the proposed strategy and objectives align with its overall risk appetite. The Board will need to consider what boundaries it is willing to set in regard to strategic options; what it or key stakeholders consider too risky or not risky enough; what lessons can be learned from past events, and what

impact the regulatory environment has on risk appetite. In setting its risk appetite, the Board will want to consider:

- The existing level and distribution of risks in categories defined above (eg strategic, safety, operational, financial etc)
- The level of risk the business can bear
- The level of tolerance it is prepared to accept around specific objectives
- The risk versus return equation, and, importantly
- the extent to which an individual risks may give rise to aggregate risk, simultaneous risk ('perfect storm' scenario) or sequential risk ('rising tide' scenario).

All those involved In identifying and assessing risk should consider their own levels of risk appetite for individual risks, but mindful of the potential for individual risks to impact other areas and for the Management Board and Trust Board to take an overview on the potential for aggregation, or sequenced/simultaneous events..,

The Board will also want to consider strategies for dealing with identifiable risks and the indicators for monitoring such risks. It will want to assure itself that authority, responsibility, and accountability for decisions and actions in the area of risk are being taken by the appropriate people and that actions in different parts of the Trust are properly coordinated, in particular, in identifying and managing aggregated risk. The Board will need to assure itself that the Trust's culture, code of conduct, HR policies and reward systems support the objectives and risk management control processes, and that the Trust is communicating to its employees what is expected of them, and their scope and freedom to act, The Board will also need to ensure that an appropriate system exists for horizon scanning, that lessons from incidents both within the Trust and outwith are learned, and that processes and controls are adjusted to reflect new and changing risks.

The Management Board is responsible for ensuring that risk management is seamlessly integrated into all policies, processes and procedures, that appropriate training is available where required, and that it is demonstrating and instilling in others the right leadership and behaviours to support effective risk management. The management Board should also ensure accountabilities and authorities are clear from Board level to Ward/Clinic/Department and that systems are cost-effective and proportionate. The Management Board should also ensure an appropriate system is in place for horizon scanning. Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. It can also identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. By implementing formal mechanisms to horizon scan, the Trust will be better able to respond to changes or emerging issues in a planned, structured and coordinated way. Issues identified should be linked into and inform the business planning process. All staff has the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact upon the Trust delivering its objectives and Management Board members have the responsibility for horizon scanning both at the corporate level and externally, and formally communicating potential issues in their areas of accountability.

4.3 Duties, Roles and Responsibilities

Risk management by the Board is underpinned by a number of interlocking systems of control and reviews, principally via three mechanisms;

- The Board Assurance Framework (BAF) which sets out the strategic objectives, identifies risks in relation to each objective along with the controls in place and assurances available on their operation. The BAF is used to drive the Board agenda. A template for the BAF is attached at Annex 1.
- The Corporate Risk Register is the corporate high level operational risk register used as a tool for managing risk and monitoring actions and plans against them. It demonstrates that an effective risk management approach is in operation within the Trust.
- The Annual Governance Statement, signed by the Chief Executive as the Accountable Officer sets out the organisation's approach to internal control. This is produced at year end and is scrutinised as part of the Annual Accounts process by the Audit & Risk Committee.

Additionally the Audit & Risk Committee and other Board sub-committees exist to provide assurance on the robustness of risk processes and to support the Board of Directors.

Each Division and Function area will have a management forum where risk is discussed, including their risk register, actions to be taken and any required escalation.

4.3.1 Individual Responsibilities

Risk management is the responsibility of all staff, irrespective of their level or job title. Particular roles or forums have additional duties as follows:

4.3.2 Chief Executive

The Chief Executive is the responsible officer for the Trust and is accountable for ensuring that it can discharge its legal duties for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility for implementation of risk management as outlined below.

4.3.3 The Director of Governance and Assurance

The Director of Governance and Assurance has delegated authority for the risk management framework including training, and is the lead for maintaining the Board Assurance Framework and its supporting processes. The Director of Governance and Assurance is also responsible for the overall performance of corporate

governance functions, including monitoring the system of internal control which includes the system and supporting processes for risk registers.

4.3.4 Chief Financial Officer

The Director of Finance has responsibility for financial governance and associated financial risk.

4.3.5 Medical Director

The Medical Director has responsibility for clinical governance, clinical risk and serious incidents and has joint responsibility with the Director of Nursing for quality.

4.3.6 Director of Nursing

The Director of Nursing has responsibility for patient safety and patient experience and joint responsibility with the Medical Director for quality.

4.3.7 Chief Operating Officer

The Chief Operating Office has responsibility for performance management.

4.3.8 Chief Information Officer

The Chief Information Officer is the Senior Information Risk Owner (SIR0) for the Trust and has responsibility for Information Governance and Data Security Risks.

4.3.9 Divisional / Function Directors (or equivalent)

Divisional and Function Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of risk registers and the promotion of risk management training to staff within their division or function, monitoring their systems to ensure that they are robust and appropriate escalation and de-escalation of risk takes place and ensuring compliance with standards.

4.3.10 Senior Managers

Senior managers take the lead on risk management and set the example through visible leadership of their staff. These responsibilities include ensuring that risk registers are regularly reviewed and relevant to the Trust, their staff are adequately trained and understand the principles of good risk management and they maintain an open culture which encourages individuals to take responsibility for risk.

4.3.11 All Staff

All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Their responsibilities include ensuring that they understand the risk management framework and the principles of

good risk management and have received adequate training to enable them to undertake these duties.

4.4 Committee Duties and Responsibilities

4.4.1 Board of Directors

The Board of Directors is the accountable body for risk and is responsible for ensuring that the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems through the Trust.

The Board of Directors will receive the Corporate Risk Register at all of its meetings and the Board Assurance Framework twice a year.

The responsibility for monitoring the risk management process across the organisation has been delegated by the Board to the following:

4.4.2 Audit, Risk & Governance Committee

The Audit & Risk Committee is responsible for providing assurance to the Trust Board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance and regulations governing the NHS.

In particular it will:

- Maintain an overview of the Trust's risk management structures, processes and responsibilities
- Receive the Corporate Risk Register at each of its meetings to enable it to undertake periodic deep dives on individual risks to assure itself of the effectiveness of the risk management structure
- Monitor and review the Board Assurance Framework and report to the Board as appropriate
- Review progress on assessing and managing major risks

4.4.3 Quality Committee

The TBC Committee is responsible for providing the Board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, corporate, workforce, information and research and developmental issues; and regulatory standards of quality and safety. The Committee will consider any relevant risks within the Corporate Risk Register as they relate to the remit of the Committee as part of the reporting requirements and to report any areas of significant concern to the Audit & Risk Committee or the Board as appropriate.

4.4.4 Finance & Investment Committee

The Finance Committee is responsible for providing information and making recommendations to the Board on financial issues and for providing assurance that these are being managed safety. The committee will consider any relevant risks within the Corporate Risk Register as they relate to the remit of the Committee as part of the reporting requirements and to report any areas of significant concern to the Audit & Risk Committee or the Board as appropriate.

4.4.5 Remuneration and Appointments Committee

The Remuneration and Appointments Committee is responsible for providing information and making recommendations to the Board on remuneration and appointments and will consider any relevant risks within the Corporate Risk Register as they relate to the remit of the Committee as part of the reporting requirements and report any areas of significant concern to the Audit & Risk Committee or the Board as appropriate.

4.4.6 Foundation Trust Programme Board

The Foundation Trust Programme Board is responsible for providing information and making recommendations to the Board on issues relating to the Trust's application for Foundation Trust status and for providing assurance that these are being managed safety. The committee will consider any relevant risks within the Corporate Risk Register as they relate to the remit of the Committee as part of the reporting requirements and to report any areas of significant concern to the Audit & Risk Committee or the Board as appropriate.

4.4.7 Management Board

The Management Board is responsible for the operational management and monitoring of risk through the Corporate Risk Register and the Board Assurance Framework and for agreeing resourced treatment plans and ensuring their delivery. The Management Board is the "owner" of the Corporate Risk Register and should consider the Corporate Risk Register monthly and the Board Assurance Framework quarterly as a minimum.

4.4.8 Divisional / Functional Risk Management Arrangements

Divisions and functions will put the necessary arrangements in place within their areas for proper governance, safety, quality and risk management. Their forums have the responsibility through their Directors for the risks to their services and for putting in place appropriate arrangements for the identification and management of risks.

In undertaking this role due account will be taken of the Trust's strategic and corporate objectives particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular division or function.

They will be responsible for managing risks that fall within the defined grades and escalating those risks above set tolerances for information or further action.

4.4.9 Terms of Reference

Terms of Reference for Committees dealing with risk will be developed to comply with the Trust's Template Terms of Reference and will include the requirements of the NHSLA Risk Management Standards 2012-13.

PROCESS

5.1 Process for managing risk

The following sections identify the process for identifying and successfully managing risks.

5.1.1 Stage 1: Clarifying objectives

Clarity of objectives is a critical stage of the risk management process together with an understanding of the status of individual objectives i.e. strategic, corporate or local. This is a key step in ensuring the risk register is both relevant and effective.

5.1.2 Stage 2: Identifying risks to objectives

Consider the risks to achieving the objective. The following questions should be considered:

- What are the risks associated with the delivery of your objectives or work, especially those that impact on delivering high quality, safe services?
- What could happen and what could go wrong?
- How and why could this happen?
- What is required for continued success?
- Is there anyone else who might provide a different perspective of your risks?
- Is the risk operational or a risk to a strategic objective?

5.1.3 Stage 3: Defining the risk

Once the risk has been identified it should be described in terms of cause, effect and impact. It is important that risks are clearly articulated to enable effective controls or actions to be put in place. Use of cause, effect and impact enables the true risk to be articulated making for a more accurate description.

Example:

Cause: Inability to release clinical staff for mandatory training due to staffing levels.
Effect: Results in staff not receiving compulsory training in resuscitation or blood safety.
Impact: Leading to an increased safety risk to patients.

5.1.4 Stage 4: Completing the risk register

The template for the Risk Register can be found at Annex 2. Headings in the risk register that need to be completed are:

Risk Identification Number is the unique identifier to distinguish the risk from the other risks in your register. This will not change during the lifetime of the risk and will be allocated by the Risk Register Owner.

Risk Owner is the individual who is accountable and has overall responsibility for a risk, it may or may not be the same person as an action owner. The Risk Owner must know, or be informed that they are the owner and accept this.

Risk Source of how or where the risk was identified

Date when first identified.

Risk Description including **cause, effect and impact** as set out in 5.1.3 above.

Key controls are the measures put in place as preventative measures to lesson or reduce the likelihood or consequence of the risk happening and the severity if it does. You must ensure that each control or action where a gap in control has been identified has an owner and a target completion date. They must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based process.

Managing Risk
Not all risks can be dealt with in the same way and the 5 Ts provide options to consider how to manage risk:

- **Tolerate**: The likelihood and consequence of a particular risk happening is accepted.
- **Treat**: Work is carried out to reduce the likelihood or consequence of the risk
- **Transfer**: Moving the responsibility or burden to another party eg insurance
- **Terminate**: An informed decision not to become involved in a risk situation
- **Take the Opportunity**: Actively taking advantage, regarding the uncertainty as an opportunity to benefit.

When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. Cost is not in itself a reason not to articulate a risk and it may be that acceptability of cost can only be decided at a higher eg corporate level. But key questions to be considered are:

- Action taken to manage risk may have an associated cost. Is the cost proportionate to the risk it is controlling?
- When agreeing responses or action to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Contingency Plans what would you do if the risk were to materialise? Good risk management is about being risk aware and able to handle the risk. It is not about being risk averse.

Proximity of when the risk is likely to materialise without effective controls being put in place which could affect the score and will focus attention on immediate action that may need to be taken. This can help to compare risks for prioritising and decision making. The three categories are:

- Within three months
- Between three months and twelve months
- Twelve months or longer

Progress Report to be updated each time the Risk Register is reviewed.

Risk Rating columns set out the consequence and likelihood of a risk and enable the risk to be tracked.
Current Risk Score is the score that the risk is currently assessed at

The Trust's guidance on the matrix set out below and advice on scoring is set out in Annex 3.

Consequence / Likelihood Matrix

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
5. Catastrophic					
4. Major					
3. Moderate					
2. Minor					
1. Negligible					

Trend/ Movement shows the direction of travel and will be represented by a directional arrow.

Date Risk last Reviewed is the date when a review of the risk was last conducted.

Target Completion Date is the date that the target risk score is expected to be achieved.

5.1.5 Stage 5: Escalation and De-escalation of Risks

The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Ward Risk Register to a Divisional Risk Register. Risks will be escalated or de-escalated within the defined tolerances and authority to act for each

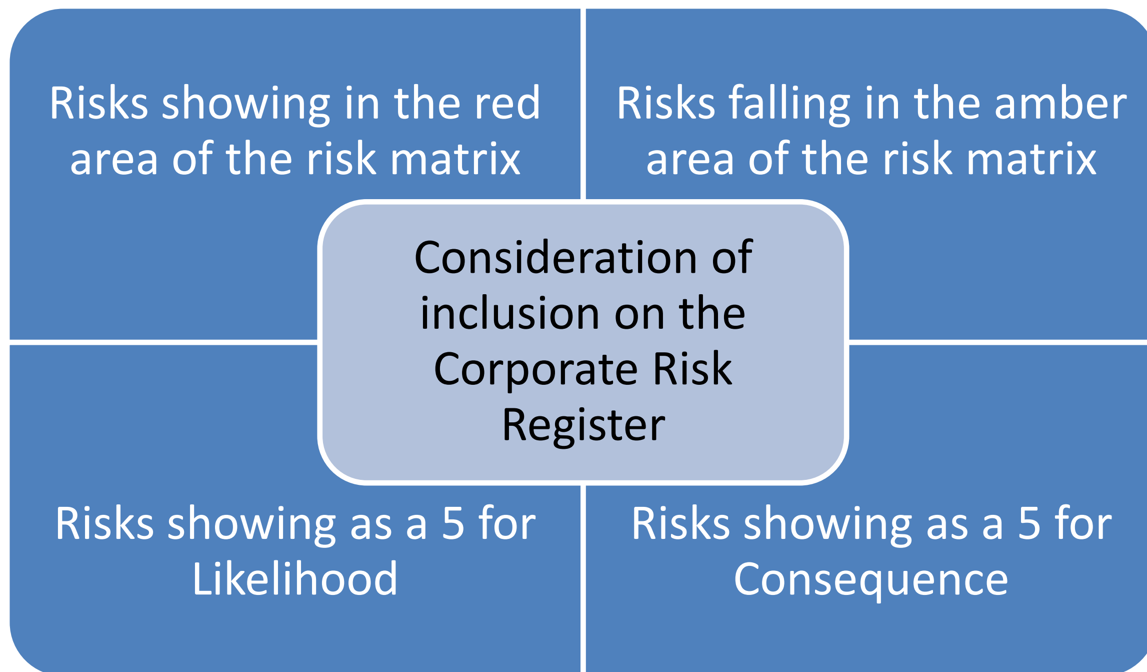
level as set out in the Risk Grade Matrix above. Further guidance is contained in the risk management handbook.

5.1.5.1 Process for risk escalation and de-escalation of risks

- The risk owner should discuss and seek approval from the Risk Register owner and the relevant risk forum for that level before risk escalation to the next level.
- A risk will then be referred to the relevant risk forum for the next level and reviewed and either agreed or returned to the risk owner to review and rescore as appropriate.
- Where risks are escalated to the next level they will be reassessed against the objectives at that level, ie a risk rated 25 at ward level will be re-evaluated and may not be rated 25 at Divisional level.
- With effective controls in place (or a change in the nature of the risk), a risk score should generally start to reduce. Where a risk is de-escalated this must be communicated to the Risk Register owner at the level below and the risk monitored at the appropriate risk forum.
- Risk registers at Divisional/Functional level will also be reviewed, including by the Operations Board to ensure that any common risks across areas are identified and aggregated to ensure that the full risk profile of the Trust is available. This will aid in identifying lower risk issues which may be common across many areas. Registers will also be reviewed to identify high impact but low frequency risks which may pose a threat. These will be considered for inclusion in the Corporate Risk Register reports by the Management Board before being reviewed by the Board

Diagram of escalation process

Risks that fall into any of the following areas of the risk matrix need to be considered at the appropriate risk forum for inclusion into the register above. As a result risks at Divisional/functional level will be considered in relation to the risk matrix for inclusion onto the Corporate Risk Register and considered at the Operations Board and by the Management Board for inclusion on the Corporate Risk Register



5.1.6 Stage 6 – Management of Risk at the appropriate level

The Risk Owner is responsible for the management of risks assigned to them. A risk that has been escalated will appear on more than one risk register and it is the responsibility of the Risk Owner to ensure that all relevant registers are kept updated. Information should be identical on the registers with the possible exception of scoring which will reflect the impact at the different level (see escalation process above).

5.1.7 Risk Profile

A risk profile is a visual mechanism which can be used in reporting, to increase the visibility of risks. It is a graphical representation of information normally found on a Risk Register. It shows all key risks as one picture to enable the Board to understand its total exposure to risk.

Example of a Risk Profile showing the numbers of risks falling into each category

Likelihood					
Almost Certain (5)	6	3	4	1	2
Likely (4)	3	3	3	4	0
Possible (3)	9	2	2	3	1
Unlikely (2)	2	6	2	4	6
Rare	2	3	2	6	2
Consequence	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)

5.1.8 Review of Risks

The Trust recognises that risk management should be embedded within all that the Trust does. Risk should be an ongoing iterative process which is part of day to day work. As part of the assurance process the Trust requires that risks are reviewed by the risk owner monthly partly:

- to enable key controls to be reviewed for effectiveness
- to identify at an early stage that the current risk score is increasing
- to enable, additional contingency plans to be put in place if appropriate
- to enable the Board to be aware of its risk profile and its total exposure to risk.

6. Training

To enable the successful implementation and maintenance of the risk management strategy, all staff, including Board Members must be appropriately trained. A regular training programme will be provided, based on training needs and linked to the Trust's mandatory training programme to enable attendance to be recorded and non-attendance followed up.

The Head of Corporate Governance will have day to day responsibility for the training programme and will put in place systems to monitor compliance with training requirements and provide an annual training report to the Audit & Risk Committee.

7. Responsibility for Document Development

This strategy has been developed in the light of currently available information, guidance and legislation and may be subject to review. The Director of Governance and Assurance is responsible for the development and maintenance of this strategy which will be reviewed on an annual basis.

8. Identification and Consultation with Stakeholders

Key stakeholders involved in the development of the strategy include members of the Audit & Risk Committee, Directors and those who have specific duties for the risk management process on a day to day basis.

9. Equality Impact Assessment

As part of its development, this strategy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

10. Approval and Ratification

10.1 Approval

The strategy will be approved by the Procedural Documents Approval Group (PAG).

10.2 Ratification

The strategy will be ratified by the Trust Board.

11. Dissemination and Implementation

11.1 Dissemination

The Risk Management Strategy will be launched via the Trust's regular on-line communications and promoted in corporate induction.

An executive summary will be published on the intranet.

Communication with external bodies will be the responsibility of the Director of Governance and Assurance

11.2 Implementation

The strategy will be implemented through a cascade communication system and included in Trust Corporate Induction sessions.

12. Document Control including Archiving Arrangements

12.1 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 when 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. 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.

12.2 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_01404). The intranet automatically shows the new version and archives the old version. (When this happens Stellant records the date, times and author).

A spread sheet 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.

13. Monitoring Compliance

The overall responsibility for monitoring compliance for the Risk Management Strategy lies with the Director of Governance and Assurance.

An annual compliance review against the strategy and process will be carried out with results presented to the Audit & Risk Committee and if required an improvement plan will be monitored by that Committee.

14. Standards / Key Performance Indicators (KPIs)

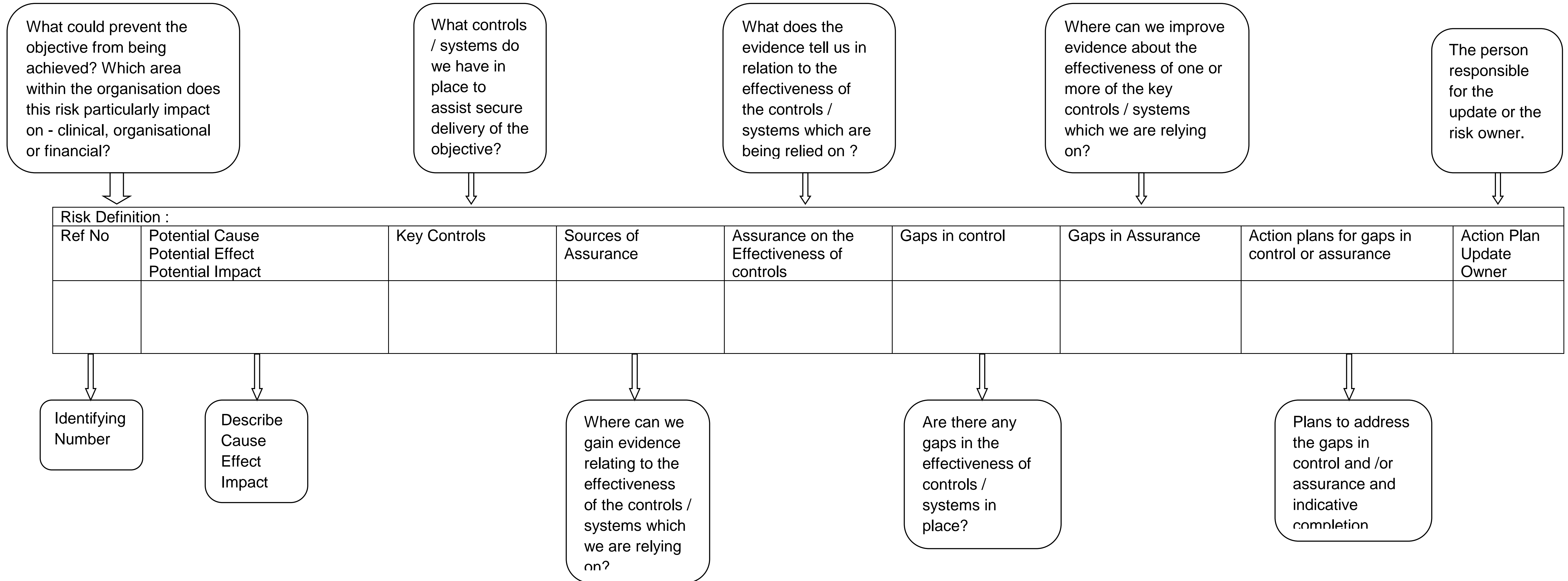
KPIs provide an objective means of measuring the Trust's success in managing aspects of risk. In addition to national and local essential duties to manage risk the following KPIs will be introduced:

- All Division and Function Directors assess local risks and develop and monitor local risk registers
- Adverse events will be reported on Datix and reflect the full range of the Trust's activities
- Staff survey results meet national average results for knowing how to report an incident and for being treated fairly
- Achievement of NHSLA Risk Management Standards

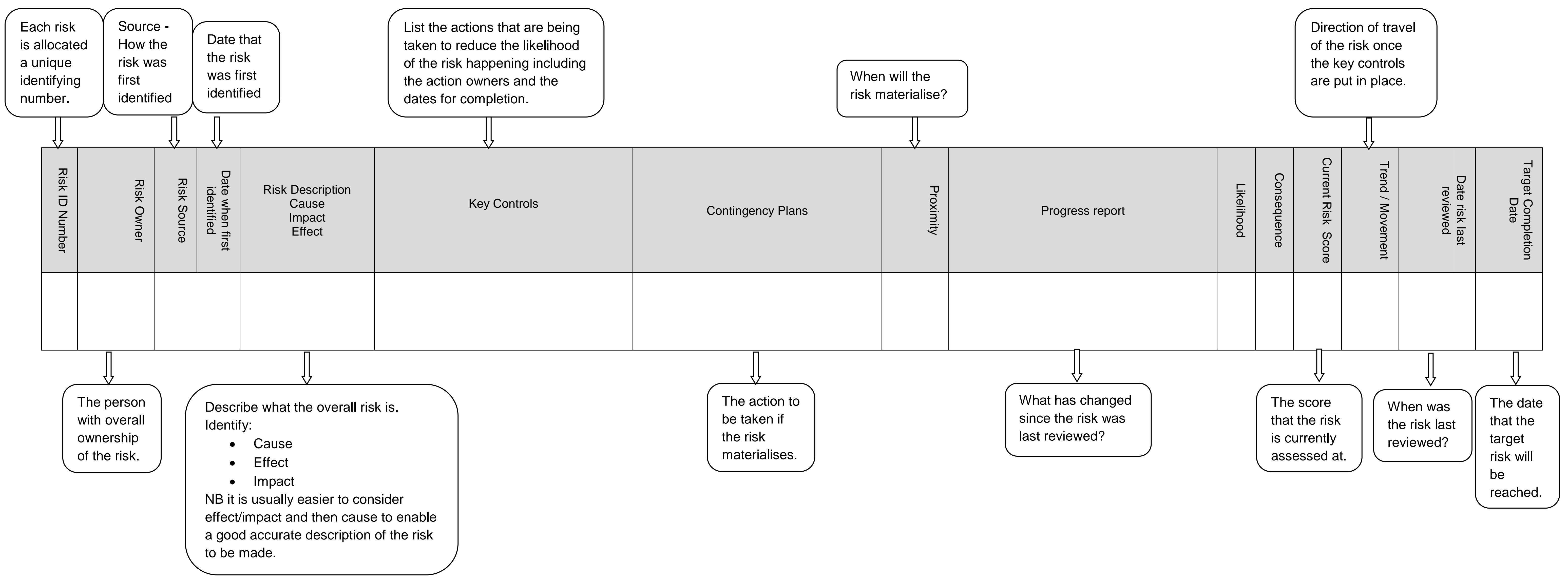
15. References

- NHSLA Risk Management Standards 2012 -13 for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care.
- The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
- Home Office Risk Management Policy and Guidance, Home Office (2011)
- NHS Audit Committee Handbook, Department of Health (2011)
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011)
- UK Corporate Governance Code, Financial Reporting Council (2010)
- Taking it on Trust, Audit Commission, (2009)
- Risk Management Assessment Framework, HM Treasury (2009)
- Understanding and Articulating Risk Appetite, KPMG (2008)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- Audit Commission 2006, Auditor's Local Evaluation
- Department of health 2004. *Standards for Better Health*, Department of Health
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)

Appendix 1 - Board Assurance Framework



Appendix 2 - Template Risk Register



Appendix 3 - Guidance on Risk Scoring

To calculate the risk placement on the matrix , it is necessary to consider both the likelihood of the risk happening and the consequence of it happening.

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
5. Catastrophic					
4. Major					
3. Moderate			X		
2. Minor					
1. Negligible					

For example if you assess a risk as possible with moderate consequences, the overall risk would sit at X on the above table, ie moderate consequence (3) and possible likelihood (3):

If a risk falls in the shaded red or orange area, the risk should be automatically referred to the higher level. If the risk falls within the shaded yellow area, it should be considered for upwards referral taking into account wider factors such as imminence and availability of mitigation measures.

Likelihood and Consequence

The likelihood and consequence of a risk occurring is always a question of judgement.

Likelihood

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency - How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possible frequently
Frequency - timeframe	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected	Expected to occur at least daily
Probability - Will it happen or not?	<0.1%	0.1 - 1.0%	1 - 10%	10 - 50%	>50%

Consequence

Consequence is the term given to the resulting loss, injury, disadvantage or gain if a risk materialises. When considering the likely consequence consider how severe the consequence would be if the risk were to occur.

	1	2	3	4	5
Descriptor	Insignificant	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical / psychological harm).	Minimal injury requiring no / minimal intervention or treatment. No time of work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days Increase in length of hospital stay by 1 - 3 days	Moderate injury requiring professional intervention Requiring time of work for 4 - 14 days. Increase in length of hospital stay by 4 - 15 days. RIDDOR / agency reportable incident. An event	Major injury leading to long-term incapacity / disability Requiring time of work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.

			which impacts on a small number of patients.		
Quality / Complaints / Audit	Peripheral element of treatment or service suboptimal. Informal complaint / inquiry.	Overall treatment or service suboptimal. Formal complaint (stage 1) Local resolution Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness. Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards. Major patient safety implications if findings are not acted upon.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints / independent review. Low performance rating. Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted upon Inquest / ombudsman inquiry Gross failure to meet national standards
Human Resources / organisation development / staffing / competence	Short-term staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days_ Loss of key staff Very low staff morale No staff	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key

				attending mandatory / key training	training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage - short term reduction in public confidence Elements of public expectation not being met	Local media coverage - long term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation MP concerned (questions in the House) Total loss of public confidence
Business objectives / projects	Insignificant cost increase / schedule slippage	<3 % over project budget Schedule slippage	5 - 10% over project budget Schedule slippage	10 - 25% over project budget Schedule slippage Some key objectives not met	>25% over project budget Schedule slippage All key objectives not met
Finance including claims	Small loss risk of claim remote	Loss of 0.1 - 0.25% of budget	Loss of 0.25 - 0.5% of budget Claim(s) between	Uncertain delivery of key objective / loss of 0.5 - 1.0% of budget	Non-delivery of key objective / loss of >1% of budget

			£10,000 and £100,000	Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Failure to meet specification / slippage Loss of contract / payment by results Claim(s) >£1 million
Service / business interruption Environmental impact	Loss / interruption of >1 hour Minimal or no impact on the environment	Loss / interruption of >8 hours Minor impact on environment	Loss / interruption of >1 day Moderate impact on environment	Loss / interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Appendix 4 – Glossary and definition of terms

The terms in use in this document are defined as follows:

Assurance – confidence based on sufficient evidence that internal controls are in place, operating effectively and objectives are being achieved

Contingency Plan – the action to be taken if the risk materialises

Consequence – the result of a threat or an opportunity

Control – actions taken to reduce likelihood and or consequence of a risk

Current Risk Score – the score that the risk is currently assessed at

Directional Arrow – a visual means of showing the direction of travel after key controls are put in place.

Escalation – the act of advancing an issue to a higher management level for resolution, action or attention

Internal Control – a method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management. If a control is not working effectively then it is not a control

Likelihood – the chance or possibility of something happening

Horizon Scanning – identifying, evaluating and managing changes in the risk environment

Risk – is the uncertainty of outcome, albeit positive opportunity or negative threat of actions and events.

Risk Appetite – the level of risk that the Trust is prepared to accept, tolerate or be exposed to

Risk Management – is the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them and monitoring and reviewing progress

Risk Matrix – the table which allows risks to be viewed visually in the context of extent of both likelihood and consequence

Risk Maturity – the overall quality of the risk management framework

Risk Owner – the person with overall ownership of the risk

Risk Register – the tool for recording identified risks and monitoring actions and plans against them

Risk Tolerance – the boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives

FINANCE AND INVESTMENT COMMITTEE (FIC)
Terms of Reference

Role
The role of the Finance and Investment Committee (FIC) is to undertake on behalf of the Trust Board thorough and objective reviews of financial policy and financial performance issues reviewing the risks to the financial position. In addition the FIC will advise the Trust Board on finance issues and investment strategy, including those relating to the Trust's estate.

The Committee will review the Trust's financial performance and identify the key issues and risks requiring discussion or decision by the Trust Board.

Definitions
"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Finance and Investment Committee
"the Directors" means the Trust's Board of Directors.

1 Membership

1.1 Members of the committee shall be appointed by the Trust Board. The committee shall be made up of six members. These are three non-executive members'/ Designate NED, the Chief Executive, Chief Financial Officer and the Chief Operating Officer.

1.2 Only members of the committee have the right to attend and vote at committee meetings. The committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of the committee will be an independent non-executive director. In the absence of the committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the committee. Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of four scheduled meetings.
- Director of Operational Finance
- Director of Estates and Facilities
- Deputy Director of Finance (rotational basis)

2 Secretary

2.1 The Trust Secretary or their nominee shall act as the secretary of the committee.

3 Quorum

3.1 The quorum necessary for the transaction of business shall be three members, two of which are non-executive directors'/ Designate NED'. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

4 Frequency of meetings and attendance requirements

4.1 The committee will normally meet six times a year at appropriate times in the reporting cycle and otherwise as required.

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of four meetings. The Secretary of the committee

shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

6 Minutes of meetings

6.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

6.3 Minutes of committee meetings should be circulated promptly to all members of the committee and, once agreed, to all members of the Trust Board unless a conflict of interest exists.

7 Annual General meeting

7.1 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

8 Duties

The committee should carry out the following duties for the Trust:

8.1 Financial policy, management and reporting

The Committee shall make recommendations to the Trust Board on financial policies, provide oversight of financial management and reporting with consideration to the overall financial performance of the Trust.

Specifically the committee shall:

- advise the Trust Board on financial policies;
- recommend to the Trust Board the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust Board;
- review the Annual Plan including the annual revenue and capital budget prior to submission to the Trust Board for approval;
- review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust Board;
- review compliance with the self-assessment quality checklist for the annual reference cost submission;
- review at the request of the Trust Board specific aspects of financial performance where the Board requires additional scrutiny and assurance;

- review the Trust's projected and actual cash and working capital;
- approve and keep under review, on behalf of the Trust Board, the Trust's investment and borrowing strategies and policies;
- ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control);
- review the financial risks.

8.2 **Investment policy management and reporting**

The Committee shall review and recommend to the Trust Board:

- the Trust's Investment Strategy and maintain oversight of the Trust's investments, including:
  - establish the overall methodology, processes and controls which govern the Trust's investments;
  - evaluate, scrutinise and monitor investments;
  - review the capital programme;
  - prepare post project evaluations for capital projects and for revenue projects which have a whole life contract value of £5 million and above. All projects will have a two stage review that will be presented to the FIC; immediately to assess project or contract completion and approximately 12 months later to review whether anticipated outcomes/savngs had been achieved.

- review and recommend to Trust Board the Trust's treasury management, working capital and estates strategies.
- within limits set out in the Standing Orders, Standing Financial Instructions and matters reserved to the Trust Board, the Committee shall approve, evaluate and scrutinise the financial and commercial validity of individual investment decisions, including the review of Outline and Final Business Cases. Business cases will usually be referred to the FIC following initial review by the Investment Management Committee, with input from the others as appropriate. The current delegated limit for the Trust is £5million.

9 Reporting responsibilities

9.1 The committee will report to the Trust Board on its proceedings after each meeting.

9.2 The committee shall make whatever recommendations to the Trust Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

9.3 The committee will produce an annual report to the Trust Board.

10 Other matters

The committee should:

10.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

10.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

10.3 give due consideration to laws and regulations;

10.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust Board for approval, any changes it considers necessary.

11 Authority

11.1 The committee is a non-executive committee of the Trust Board and has no powers, other than those specifically delegated in these Terms of Reference. The committee is authorised:

11.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties;

11.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary;

11.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

12 Monitoring and Review:

12.1 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee might provide.

12.2 The secretary will assess agenda items to ensure they comply with the committee's
responsibilities.

12.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.

12.4 Terms of reference approved 20 June 2013.

12.5 To be reviewed June 2014.

QUALITY COMMITTEE

Terms of Reference

Role

The role of the Quality Committee is to obtain assurance that high quality care is being delivered across Imperial College Healthcare NHS Trust. The committee will also obtain assurance that the quality strategy is being implemented and continuous improvement evidenced.

Quality encompasses the six principles for improvement set out by Donald Berwick: "care that is safe, effective, patient-centered, timely, efficient, and equitable", which in turn are the key elements of the quality strategy.

The committee will ensure that robust Clinical Governance structures, systems and processes including those for Clinical Risk Management and service user safety, are in place across all services and are line with national, regional and commissioning expectations.

The committee will refer appropriate issues to relevant committees including the operational and management boards.

Approval of required annual reports related to quality will be undertaken through this committee for example Quality Accounts, for recommendation for Trust Board approval where required.

Definitions
"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Quality Committee
"the Directors" means the Trust's Board of Directors.

1 Membership

1.1 Members of the committee shall be appointed by the Board of Directors. The committee shall be made up of at least four members. Non-Executive Directors shall be in the majority. Members may not appoint a deputy to represent them at a committee meeting.

1.2 Only members of the committee have the right to attend and vote at committee meetings. The committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of the committee will be an independent non-executive director. In the absence of the committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the Quality committee. Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of 75% scheduled meetings.

2 Secretary

2.1 The Trust Secretary or their nominee shall act as the secretary of the committee.

3 Quorum

3.1 The quorum necessary for the transaction of business shall be two including one Non Executive and one Executive Director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

4 Frequency of meetings and attendance requirements

4.1 The committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of 75% meetings. The Secretary of the committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

6 Minutes of meetings

6.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.

6.3 Minutes of committee meetings should be circulated promptly to all members of the committee and, once agreed, to all members of the Board of Directors unless a conflict of interest exists.

7 Annual General meeting

7.1 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

8 Duties

The committee should carry out the following duties for the Trust:

8.1 Clinical Governance

8.1.1 Obtain assurance that robust Clinical Governance structures, systems, and processes, including those for Clinical Risk Management and service user safety, are in place across all services, and developed in line with national, regional and commissioning expectations;

8.1.2 Approve and assure delivery of the integrated quality governance plan which includes actions related to; Mid Staffordshire NHS Foundation Trust Inquiry (2013), Clinical governance review (2012), Quality Governance Assurance Framework (2013) and QG15;

8.1.3 Obtain assurance that the Divisional Clinical Governance groups are effectively coordinating Clinical Governance activity within the Trust.

8.2 Patient Centeredness

8.2.1 Approve and assure delivery of the Trust's user involvement and patient experience annual plans/ strategy;
8.2.2 Obtain assurance that this is a key element of the work of Clinical Governance across the Trust.

8.3 Effectiveness (Monitoring and improving clinical performance)

8.3.1 Approve and assure delivery of the annual programme of Trust-wide clinical audits;
8.3.2 Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented;
8.3.3 Obtain assurance that NICE Guidelines and Technology Appraisals are implemented;
8.3.4 Obtain assurance that systems are robust for undertaking nationally mandated audits receiving summary results and monitoring the implementation of recommendations;
8.3.5 Oversee the Trust's work on Care Quality Commission's Improvement Reviews.
8.3.6 Report to the Audit, Risk and Governance Committee any ongoing concerns or risks being overseen by the Committee and to refer other matters to other committees as appropriate

8.4 Safety (Managing service user safety and clinical and other risks)

8.4.1 Obtain assurance that the Trust has effective mechanisms for managing clinical risk and improving service user safety, learning from incidents, and taking action to reduce risks and improve clinical quality;
8.4.2 Receive and review trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning;
8.4.3 Obtain assurance that effective channels are in operation for communicating and managing issues of Clinical Governance to relevant managers, staff and external stakeholders;
8.4.4 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults;
8.4.5 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act.

8.5 Equity (Equality & Diversity)

8.5.1 Approve and monitor delivery of the Trust's equality delivery system so that essential principles of equality are embedded into the culture, behaviour and decision making process of the organization;
8.5.2 Receive assurance that clinicians, managers and staff promote and advance equality and diversity, whilst working closely with patients, the public, local communities, voluntary organisations, staff and staff side organisations.

8.6 Efficiency and Timeliness

8.6.1 Obtain assurance that efficiency programmes are not having a detrimental effect on quality through the CIP process;
8.6.2 Obtain assurance that patient access targets are being delivered.

8.7 NHSLA

8.7.1 To oversee the Trust's approach to the NHS Litigation Authority (NHSLA) Risk Management Standards assessment.

9 Reporting responsibilities

9.1 The committee will report to the Board of Directors on its proceedings after each meeting.

9.2 The committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

9.3 The committee will produce an annual report to the Board of Directors.

10 Other matters

The committee should:

10.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

10.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

10.3 give due consideration to laws and regulations;

10.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Board of Directors for approval, any changes it considers necessary.

11 Authority

11.1 The committee is a non-executive committee of the Board of Directors and has no powers, other than those specifically delegated in these Terms of Reference. The c committee is authorised:

11.1.1 to seek any information it requires from any employee of the trust in order to perform its duties

11.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary

11.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

12 Monitoring and Review:

12.1 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee might provide.

12.2 The secretary will assess agenda items to ensure they comply with the committee's responsibilities.

12.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.

12.4 Terms of reference approved 15/07/2013

12.5 To be reviewed dd/mm/yyyy

REMUNERATION & APPOINTMENTS COMMITEE

Role

The role of the REMUNERATION & APPOINTMENTS COMMITTEE is to act on behalf of the Trust Board in relation to the appointment, remuneration, terms of service and performance of the Executive Directors; to oversee the process for appointing Non-Executive Directors; for reviewing the structure, size and composition of the Trust Board.

Definitions

"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Remuneration & Appointments Committee
"the Directors" means the Trust's Board of Directors.

1 Membership

1.1 Members of the committee shall be appointed by the Board of Directors. The committee shall be made up of the Trust Chairman and two Non-Executive Directors.

1.2 Only members of the committee have the right to attend and vote at committee meetings. The committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of the committee will be an independent Non-Executive Director, nominated by the Chairman of the Trust Board. In the absence of the committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the Remuneration & Appointments Committee: Chief Executive and Director of People & Organisational Development. Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of 75% of scheduled meetings.

2 Secretary

2.1 The committee shall be supported administratively by the Director of People & OD, who will act as Secretary to the committee, whose duties in this respect will include:

- The agreement of agendas with committee Chair and collation of papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Advising the committee on employment issues and procedures.

3 Quorum

3.1 The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

4 Frequency of meetings and attendance requirements

4.1 The committee will normally meet at least twice a year at appropriate times in the reporting cycle and otherwise as required.

4.2 committee members should aim to attend all scheduled meetings but must attend a minimum of 75% of meetings on a rolling basis. The Secretary of the committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other Non-Executive Directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

6 Minutes of meetings

6.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.

6.3 Minutes of committee meetings should be circulated promptly to all members of the committee and, once agreed, to all members of the Board of Directors unless a conflict of interest exists.

7 Annual General meeting

7.1 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

8 Duties

The committee should carry out the following duties for the Trust:

General

8.1 To act on behalf of the Trust Board in determining the appointment, remuneration, terms of service and performance of the Executive Director members of the Trust Board (Executive Directors) listed in the Appendix.

8.2 To agree and oversee the process for appointing Non-Executive, Executive Directors and direct reports to the CEO

8.3 To agree, on behalf of the Board of Directors, the remuneration and terms of service of the Executive Directors and note the remuneration of all other Directors..

8.4 To monitor the performance and the development of Executive Directors.

8.5 To ensure that effective plans are in place to provide continuity of leadership in the event of extended Executive Director absence or vacancy.

8.6 To approve any severance payments that are proposed for Executive Directors, for other very senior managers (VSMs) and others as maybe required by the DH.

Duties – Specific: Board Composition

8.7 Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.

8.8 Be responsible for identifying and nominating a candidate, for approval by the Board, to fill the position of Chief Executive.

8.9 Before an appointment is made evaluate the balance of skills, knowledge and experience on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the committee shall; use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

Appointment of Executive Directors

8.10 To nominate one or more members to be actively involved with the Chief Executive in the appointment of specific Executive Director posts, and in the design of the selection process on behalf of the committee.

8.11 To ensure that the selection process is based upon:
- An agreed role and person specification.
- The use or other involvement of any third party recruitment professionals.
- An interview panel to include the Chief Executive, an agreed Non-Executive Director or Directors, an external assessor representing the SHA or its successor body and such other persons as may be agreed to be helpful.

8.12 To keep the Trust Board informed of the process, procedures and timetable to which it is working, as appropriate.

Remuneration of Executive Directors

8.13 To agree on behalf of the Trust Board the remuneration and terms of service of the Executive Directors. To ensure that the Executives are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance, and to the provision of any national arrangements or directives for such staff where relevant.

8.14 To agree and review annually a policy framework for the pay of VSMs not on national contracts, including Executive Directors.

8.15 To establish the parameters for the remuneration and terms of service for the appointment of Executive Directors, with delegated authority of the Chief Executive to agree starting salaries within the agreed parameters.

8.16 Responsibility for the determination of the salaries of VSMs other than Executive Directors is delegated to the Chief Executive or relevant Executive Director advised by the Director of People & OD and working within the agreed policy framework. The committee will review annually the earnings of the VSMs including senior clinicians and clinical managers.

8.17 To agree the Termination of Contract of Executive Directors and the payment of any redundancy or severance packages in line with prevailing DH or SHA guidance.

Performance and Succession Planning

8.18 To monitor and evaluate the performance both individually and collectively of the Executive Directors in the context of their responsibilities and objectives.

8.19 To ensure the capability of potential or nominated deputies for Senior Executive Directors to effectively deputise during periods of extended absence on the part of the Executive Directors.

8.20 To oversee an assessment of the capability and succession potential of the top 100-150 Trust leaders in order to identify any strategic gaps requiring appropriate intervention.

9 Reporting responsibilities

9.1 The committee will report to the Board of Directors on its proceedings after each meeting.

9.2 The committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

9.3 The committee will produce an annual report to the Board of Directors.

9.4 The committee shall produce an annual report of the Trust’s remuneration policy and practices which will be part of the Trust’s Annual Report.

10 Other matters

The committee should:

10.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

10.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
10.3 give due consideration to laws and regulations;
10.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Board of Directors for approval, any changes it considers necessary.

11 Authority

The committee is a Non-Executive committee of the Board of Directors and has no powers, other than those specifically delegated in these Terms of Reference. The committee is authorised:

11.1 The committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee with relevant responsibility and knowledge of the matter and all employees are directed to cooperate with any request made by the committee.
11.2 The committee may commission such external professional advice or services as is deemed appropriate to enable it to fulfil its responsibilities.
11.3 In order to ensure the business of the committee is not unduly held up between meetings, the Chair may take Chair's action between meetings. Any such decisions thus taken will be reported to the next meeting. This may include authorisation of contractual severance payments to staff other than Executive Directors as required by the DH. Where substantive or sensitive decisions are required outside of scheduled meetings then the Chair may convene an extraordinary meeting of the committee.

12 Monitoring and Review:

12.1 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee might provide.
12.2 The secretary will assess agenda items to ensure they comply with the committee's responsibilities.
12.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.
12.4 Terms of reference approved dd/mm/yyyy
12.5 To be reviewed dd/mm/yyyy

Audit, Risk & Governance Committee

Terms of Reference

Role

The role of the Audit, Risk & Governance Committee is to provide the Trust Board with the assurance that an adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively.

Definitions

"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Audit, Risk & Governance Committee
"the Directors" means the Trust's Board of Directors.

1 Membership

1.1 Members of the committee shall be appointed by the Board of Directors. The committee shall be made up of a minimum of three members. Only non-executive Directors shall be members of the Committee. Members may not appoint a deputy to represent them at a committee meeting. The Chairman of the Trust is not a member of the Committee.

1.2 Only members of the committee have the right to attend and vote at committee meetings. The committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of the committee will be an independent non-executive director. In the absence of the committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the committee. Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of 75% scheduled meetings.

1.4.1 Internal and External Audit representatives will normally attend meetings at least once a year. The committee shall meet privately with the Internal and External Auditors;

1.4.2 The Chief Executive will be invited to attend any meeting and should attend at least annually to discuss with the committee the process for assurance that supports the Annual Governance Statement.

2 Secretary

2.1 The Trust Secretary or their nominee shall act as the secretary of the committee.

3 Quorum

3.1 The quorum necessary for the transaction of business shall be 2 members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

4 Frequency of meetings and attendance requirements

4.1 The committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of 75% meetings. The Secretary of the committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

6 Minutes of meetings

6.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.

6.3 Minutes of committee meetings should be circulated promptly to all members of the committee and, once agreed, to all members of the Board of Directors unless a conflict of interest exists.

7 Annual General meeting

7.1 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

8 Duties

The committee should carry out the following duties for the Trust:

8.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

8.2 In relation to the management of risk, the Committee will:

- 8.2.1 Review the process under which the trust sets its risk appetite;
- 8.2.2 Oversee and advise the Board on the current risk exposures of the Trust, and the effectiveness of the Trust's risk management systems;
- 8.2.3 Keep under review the effectiveness of the Trust's risk management and risk assessment processes ensuring the use of both qualitative and quantitative measures in assessment;
- 8.2.4 Refer to the quality committee any clinical risks that require further scrutiny by its membership;
- 8.2.5 Review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions;
- 8.2.6 Review the statements to be included in the Annual Report concerning risk Management;
- 8.2.7 Review the process and effectiveness of learning from incidents trustwide.

8.3 The Committee will monitor due diligence on any integration or partnership arrangements, reviewing the risk assessment and decision-making processes to ensure all control issues are addressed.

8.4 The Committee will seek assurance on behalf of the Board that the design and application of the control environment in core financial processes are fit for purpose and reflect both public and commercial sector best practice.

8.5 In particular, the Committee will review the adequacy and effectiveness of:

- 8.5.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with CQC Standards), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;
- 8.5.2 an effective system of management of performance and finance across the

whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

8.5.3 the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

8.5.4 the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

8.5.5 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by the Counter Fraud and Security Management Service.

8.6 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

8.7 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

9 Internal Audit

9.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Chief Executive and Board of Directors. This will be achieved by:

9.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

9.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

9.1.3 consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

9.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

9.1.5 annual review of the effectiveness of Internal Audit.

10 External Audit

10.1 The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

10.1.1 consideration of the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit;

10.1.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;

10.1.3 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Organisation and associated impact on the audit fee;

10.1.4 review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

11 Whistleblowing and counter fraud

11.1 The Audit Committee will review the adequacy of the trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern including patient care and safety.

11.2 In particular the committee will:

- 11.2.1 review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the counter fraud and security management service;
- 11.2.2 approve and monitor progress against the operational counter fraud plan;
- 11.2.3 receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity;
- 11.2.4 monitor progress on the implementation of recommendations in support of counter fraud;
- 11.2.5 receive the annual report of the local counter fraud specialist.

12 Other Assurance Functions

12.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

12.2 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (for example the NHS Litigation Authority), professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies).

12.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work.

13 Management

13.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

13.2 They may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

14 Financial Reporting

14.1 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

14.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Board of Directors.

14.3 The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgmental areas; and
- significant adjustments resulting from the audit.

15 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

15.1 The committee will review on behalf of the Board proposed changes to the Standing Orders and Standing Financial Instructions;

15.2 The committee will examine the circumstances of any departure from the requirements of Standing Orders, Standing Financial Instructions;

15.3 The committee will monitor the policy on standards of business conduct for members of staff with reference to the codes of conduct and accountability thereby providing assurance to the Board of probity in the conduct of business;

15.4 The committee will review proposed changes to the Scheme of Delegation before presentation to the Trust Board for approval;

15.5 The committee will review schedules of losses and compensations annually.

16 Reporting responsibilities

16.1 The committee will report to the Board of Directors on its proceedings after each meeting;

16.2 The committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed;

16.3 The committee will produce an annual report to the Board of Directors.

17 Other matters

The committee should:

17.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

17.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

17.3 give due consideration to laws and regulations;

17.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Board of Directors for approval, any changes it considers necessary.

18 Authority

18.1 The committee is a non-executive committee of the Board of Directors and has no powers, other than those specifically delegated in these Terms of Reference. The committee is authorised:

18.1.1 to seek any information it requires from any employee of the trust in order to perform its duties;

18.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary;

18.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

19 Monitoring and Review:

19.1 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee might provide.

19.2 The secretary will assess agenda items to ensure they comply with the committee’s responsibilities.

19.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.

19.4 Terms of reference approved dd/mm/yyyy

19.5 To be reviewed dd/mm/yyyy

IMPERIAL COLLEGE
HEALTHCARE NHS TRUST
ALMANAC / PROGRAMME OF MEETINGS AND VENUES FOR 2013/14

MONTH	Apr 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014
TRUST BOARD	24 April (Seminar)	29 May (in Public)	26 June (Away Day)	24 July (in Public) 10:00 – 13:00 W12		25 September (in Public) 10:00 – 13:00 NBRCX	30 October (Seminar) 10:00 – 13:00 NBRCX	27 November (in Public) 10:00 – 13:00 CWB	18 December (Seminar) 10:00 – 13:00 NBRCX	29 January (in Public) 10:00 – 13:00 NBRCX	26 February (Seminar) 10:00 – 13:00 CWB	26 March (in Public) 10:00 – 13:00 NBRCX
FOUNDATION TRUST PROGRAMME BOARD		16 May	20 June	16 July 15:00 – 17:00 CWB	16 August 12:00 – 14:00 CWB	20 September 12:00 – 14:00 CWB	22 October 15:00 – 17:00 CWB	19 November 15:00 – 17:00 CWB	17 December 15:00 – 17:00 CWB	21 January 15:00 – 17:00 CWB	18 February 15:00 – 17:00 CWB	18 March 15:00 –17:00 CWB
QUALITY COMMITTEE		15 May		8 July 12:00 – 14:00 CWB		11 September 10:00 – 13:00 CWB	8 October 10:00 – 13:00 CWB	13 November 10:00 – 13:00 CWB	5 December 10:00 – 13:00 CWB	8 January 10:00 – 13:00 CWB	12 February 10:00 – 13:00 CWB	6 March 10:00 –13:00 CWB
AUDIT, RISK & GOVERNANCE COMMITTEE	18 April		05 June	22 July Extraordinary 11:30 – 14:00 CWB		4 Sept 10:00 – 12:30 CWB			11 December 10:00 – 12:30 CWB			12 March 10:00 – 12:30 CWB
FINANCE & INVESTMENT COMMITTEE			20 June			19 September 15:00 – 17:00 SMR 1/6		21 November 15:00 – 17:00 SMR 1/6		23 January 15:00 – 17:00 SMR 1/6		20 March 15:00 – 17:00 SMR 1/6
REMUNERATION & APPOINTMENTS COMMITTEE			June									

Key			Key	
Clarence Wing Board Room	**CWB**		HH W12 Conference Centre	**W12**
New Board Room CXH	**NBRCX**		MR1, 6th Floor – Salton House	**SMR 1/6**