Governance

Annual Report

2008-09

July 2009

Contents

Sections	*Description of contents*	*Page no.*
	Introduction	1
Section 1	Governance Framework	2
Section 2	Risk Management (including Health & Safety)	6
Section 3	Patient Safety	11
Section 4	Governance Support Unit	13
Section 5	Patient Liaison Services	19
Section 6	Developments for 2009/10	25
Appendices		
Appendix 1	Governance Structure	29
Appendix 2	Directorate Governance Group Structure	30
Appendix 3	Incident Reporting	31
Appendix 4	Patient Safety Structure	36
Appendix 5	Report on NICE Guidance 2008-09	37
Appendix 6	National Audit Projects 2008-09	38
Appendix 7	National Service Frameworks	41
Appendix 8	You Said, We Did	42

Introduction

The purpose of this report is to update the Board regarding the activities undertaken on its behalf, of the Governance Committee in 2008-2009. This report will demonstrate that the Trust manages governance in an effective manner and seeks approval of plans for 2009/10. It does not cover areas of financial governance which is dealt with via the audit committee. Regular Board reports and reports to Monitor (the independent regulator for Foundation Trusts) also include financial issues.

The overall responsibility for managing governance within the Trust rests with the chief executive. Operational responsibility for key components of the governance agenda is delegated to the director of nursing and patient care for patient governance and the director of human resources for health and safety.

The report is broken down into a number of distinct areas designed to cover the full range of both the corporate and patient governance agenda. These areas are

- The governance framework (including patient and corporate governance)
- Risk Management (including health and safety)
- Patient Safety
- Governance Support Unit (including clinical audit), and
- Patient Liaison Services (including PALS and complaints).

Where sections overlap, this is indicated in the report. Appendices offer further information on each section.

Throughout the report, examples have been included to illustrate the effectiveness of structures or systems.

Section 1

Governance Framework

Governance Committee

1.1 The Trust manages its governance activities via the Governance Committee. This committee is a committee of the Board of Directors and met nine times during 2008-09. The committee covers both patient and corporate governance activities. A non-executive director chairs the committee and three other non-executive directors are also members. Representation is also drawn from the executive team, chairman of reporting committees and directorate managers.

1.2 Decisions made by the committee on behalf of the Board of Directors are highlighted via a quarterly decision briefing to the board made by the chairman of the committee.

1.3 Various specialist committees report their work to the Governance Committee. These committees all have agreed terms of reference and are chaired by senior members of staff. In 2008-09 further committees have been included as direct reports to the Governance Committee to improve links and communication with governance activities. These committees are: Involving People Steering Group, Patient Safety Steering Group, Safeguarding Adults Steering Group and the Information Governance Committee. The chairmen of these committees also sit on the Governance Committee. Appendix 1 illustrates the committee structure.

1.4 An internal review of the Governance Committee was undertaken in 2008-09. This review consisted of obtaining the views of the committee from its members and a review by Internal Audit. The findings of these reviews were positive in that members felt that the committee worked well and was meeting its terms of reference. Internal audit also reviewed the terms of reference of the Governance Committee and found that the committee structure was well designed and well controlled.

1.5 Areas examined by the committee include:

Area	Outcome
Strategy and policy approval	Approved Patient Safety Strategy; policies approved across corporate and clinical areas
Reviews against national reports, e.g. Safer Births: Everybody's Business	Approved and ongoing monitoring of action plan
Changes in clinical practice, e.g. use of ketamine for anaesthesia in the emergency department (ED); vascular access team (VAT) competencies	Ketamine now approved for use in the ED Approved VAT team competencies
Compliance with national alerts, e.g. Right Patient, Right Blood; Correct Site Surgery	Confirmed compliance and ongoing monitoring of action plans
Measurement of patient experience	Approved the use of handheld computer tablets to measure *'real time'* views of patients
Root Cause Analysis (RCA)	Approved/monitored RCA action plans

The Assurance Framework and Risk Register

1.6 The assurance framework details the Trust's high-level objectives to ensure that there is adequate assurance at board level on its business processes. The Governance Committee is charged by the Board to examine the process in detail.

1.7 Internal Audit examined the assurance framework to ensure a positive sign off for the statement on internal control. The framework was considered fit for purpose. The framework covers all areas of Trust business, including healthcare standards, Monitor requirements, strategic directions and new and existing targets. Any area where a high risk is identified is recorded on the Trust risk register.

1.8 The Trust has continued to develop the corporate risk register over the year. Both the Board and Governance Committee undertake a quarterly review of the register, which highlights the changes made within that quarter. Internal Audit also assessed the validity of the register in assessing the overall statement on internal control.

Examples of issues raised on the risk register	Outcome
Infection Control – meeting the hygiene code Flu pandemic planning – ensuring systems in place to manage a pandemic Management of external alerts – ensure compliance	Hygiene code met via external assessment Plans are in place and being reviewed on a regular basis All alerts have been met with the exception of two which have been risk assessed and discussed via the committee
Noted areas of good practice	Linked to directorate risk registers Directorate managers review register via Governance Committee to ensure corporate overview

Directorate Governance Groups

1.9 Directorate governance groups are key committees involved in embedding the governance and risk management frameworks in the organisation.

1.10 Directorate governance groups cover all aspects of governance from a directorate perspective. Some larger directorates have split their structure into sub-directorates to allow greater focus on the issues at hand. There has also been investment in some areas in dedicated staff to help manage the governance agenda. The chart in Appendix 2 illustrates the clinical directorate governance structures that are in place.

NHS Litigation Authority (NHSLA) Assessment

1.11 The Trust underwent NHSLA assessment at Level 1 for both acute and maternity services in February 2008. The acute services review was undertaken using the new NHSLA Risk Management Standards for Acute Trusts. The Trust was successful in attaining Level 1 status for both services.

1.12 NHSLA standards ensure that trusts have robust policies and systems in place across a wide range of services and offer discounts on insurance premiums dependant on levels achieved.

1.13 Work has continued throughout the year in order to maintain the levels reached in February 2008. Further assessment will take place in February 2010 against the acute services.

1.14 The maternity service underwent assessment at Level 2 against the pilot new maternity standards in February 2009. The service was successful in this assessment and has now become one of the first services in the country to reach Level 2. This was a real achievement as the new standards are more demanding than in previous years. The maternity service will not need to be reassessed for a further three years.

Other External Assessments

1.15 The Trust is subject to a number of inspections throughout the year covering various topics. The following assessments also took place or were reported in 2008/09. Any action plans arising from external inspections are monitored by the governance committee.

Title	Covering	Overview of results
Human Tissue Authority	Mortuary and associated pathology department.	Overall Trust rating – suitable. Two conditions put on license – now removed following actions.
Ionising Radiation (Medical Exposure) Regulations 200	Radiation safety issues in the radiotherapy service	No areas of concern were highlighted in the inspection
Medicines and Healthcare products Regulatory Agency, (MHRA)	Review of the blood transfusion unit	No critical failures highlighted. Action plan developed to cover areas highlighted in report.

The Healthcare Standards and Annual Declaration

1.16 The Healthcare Commission (HC) was the statutory body responsible for performance managing the NHS on quality improvements for the benefit of patients. This has been replaced by the Care Quality Commission (CQC). A major part of HC activity is assuring compliance with the core national healthcare standards.

1.17 Lead managers have been assigned to each of the standards with directors taking a lead on each of the domains.

1.18 The National Standards, Local Strategy (NSLS) Committee, chaired by the Chief Operating Officer, oversees the implementation of action plans relating to the national standards. The NSLS Committee reports to the Governance Committee.

1.19 During 2008-09, Internal Audit conducted an extensive review of evidence relating to each of the core healthcare standards. This enabled the Board to sign the annual declaration and state that all standards had been met.

1.20 The Trust was not selected for a random inspection in 2008-09. The Trust scored Excellent for Use of Resources and Excellent for Quality. This is the highest rating that can be achieved.

Section 2

Risk Management (including Health and Safety)

Policy Reviews

2.1 All the existing policies are currently up to date and have been monitored to ensure they reflect new legislation and current best practice.

2.2 A new Management of the Bariatric Patient Policy was developed and received approval in 2008-09. This now incorporates all the new equipment and lifting techniques required when dealing with this group of patients.

Learning from Errors

2.3 Investigation of incidents and the sharing of learning have increased in 2008-09. The Trust has improved the process for undertaking root cause analysis (RCA) investigations which have proved extremely beneficial in making changes and informing good practice. These principles have been rolled out across a greater category of incidents and a total of nine RCAs were conducted during the year. Three RCAs relating to serious incidents that occurred in 2008-09 remain outstanding for completion as at 31-03-09.

2.4 Changes have been made to the RCA reporting template to ensure greater consistency in the quality of the reports. In addition to the governance committee monitoring RCA Action Plans on a six monthly basis, an additional reporting structure to increase Trust-wide learning from incidents has been put in place by the Patient Safety Steering Group through the Adverse Events Forum and Trust-wide directorate governance groups.

2.5 The Trust continues to report incidents via the National Reporting and Learning System (NRLS) to the NPSA and is recognised as a good reporter. The DATIX Risk Management System interfaces directly with the NRLS system and incidents are uploaded every 2 weeks.

Serious Incidents in 2007-08 for RCA investigation		Serious Incidents in 2008-09 for RCA investigation (3 to be completed)	
Total number for year	7	Total number for year	12
♦ Medication errors	2	♦ Medication errors	2
♦ EWS	1	♦ EWS	2
♦ Treatment delays	1	♦ Treatment delays	2
♦ Falls	3	♦ Falls	4
		♦ Other	2

Health and Safety Action Plan

2.6 The Trust developed a health and safety action plan for 2008-09, in liaison with staff side representatives. This action plan has been monitored by the Health and Safety Committee and received formal approval from the Board of Directors. The action plan is seen as good practice by the Health and Safety Executive (HSE) and ensures continual improvements of health and safety.

Incident Reporting

2.7 Incident reporting is a fundamental requirement of good risk management and safety practices. All staff are required to complete incident forms when they are involved in or witness any incident or near miss within 48 hours or directly by telephone if of a serious nature. The incident forms are then graded centrally with an actual impact and a future potential risk should the incident occur again. The level of investigation is dependent on this grading.

2.8 The total number of incidents reported in 2008-09 was 7851, an increase of 6.7%. This is a good indication that the Trust has a positive incident reporting culture. Appendix 3 sets out the top 5 patient and top 5 employee incidents.

Incidents	Outcome
Patient slips, trips and falls	Falls Steering Group formed, Falls Policy is being updated, intentional rounding introduced in the Directorate of Medicine, all falls resulting in fracture have a full RCA investigation undertaken
Medication Administration	Governance Pharmacist has been appointed to improve the systems for gathering and learning from medication incidents
Staff Shortages	All incidents are reported to the Director of Nursing and Patient Care and reviewed by directorates
Violence and aggression	Business case for 24/7 security approved to be implemented later in 2009, new Security Manager appointed

Manual Handling

2.9 The moving and handling advisor is responsible for ensuring compliance with all manual handling legislation and ensuring good practice.

2.10 All new staff receive an overview presentation at induction on moving and handling and spinal awareness from the moving and handling advisor. During their induction period within their ward/department they receive full practical training commensurate with their work activity from ‘key trainers’.

2.11 Key trainers are trained by the moving and handling advisor and are responsible for providing annual manual handling updates for staff on their ward/department as well as on induction. This role is fulfilled alongside their normal duties.

2.12 Any incident relating to moving and handling is reported via the incident report system and is investigated by the manual handling advisor. In 2008-09 there were 116 reported incidents. Of these 23 were reported to the HSE under the Reporting of Injuries, Diseases & Dangerous Occurrence Regulations (RIDDOR). There were no discernable trends from these reported incidents.

Environmental Monitoring

2.13 The Control of Substances Hazardous to Health Regulations specifies the circumstances where hazardous substances are used and environmental monitoring is required. This also includes dust monitoring. The Noise Regulations also specify noise exposure limits which need to be monitored.

2.14 Environmental monitoring is carried out by the Health and Safety Technician. Monitoring takes place in all areas where the exposure to any of the above hazards could cause harm should they be above acceptable levels. In 2008-09, monitoring highlighted that one laboratory has levels of formaldehyde above the exposure levels.

Substance monitoring	Outcome
During 2008/09 one area of the labs was found to have higher exposure levels	New cut-up tables were purchased. Extraction systems were improved. The area is now fully compliant.

Violence and Aggression

2.15 The Counter Fraud and Security Management Service (CFSMS) is a co-signatory to the concordat with the Health and Safety Executive (HSE). Violence and aggression therefore remains high on the health and safety agenda and certain incidents of physical violence are reportable to both to the HSE under RIDDOR and to the CFSMS via the Physical Assault Reporting System (PARS).

2.16 Violence and aggression incidents are reported via the incident reporting system and these figures are monitored by both the Health and Safety Committee and the Security Forum. The Security Forum is charged with policy development in this area.

2.17 The total number of incidents reported for violence and aggression in 2008-09 was 353. Of these, two were reported to the HSE under RIDDOR.

Violence, aggression and security	Outcome
The need for better management of dealing with violent incidents and co-ordination of security team.	Appointment of Security Manager – start date June 2009
With violence and aggression being nationally on the increase a business case was put forward for 24/7 security	Business case approved and this will be implemented later in 2009.

Health and Safety Committee

2.18 The Health and Safety Committee meets on a quarterly basis and is chaired by the Director of Human Resources who is the executive with delegated responsibility for heath and safety. The Committee discusses general health and safety issues, ratifies health and safety policies and analyses staff incident data.

2.19 The Trust has a duty to consult with safety representatives and the Health and Safety Committee provides a forum for this consultation. The membership of the committee includes both trade union and appointed safety representatives.

Dealing with the Health and Safety Executive (HSE)

2.20 The Trust received a visit from the Health and Safety Executive in February 2009 to inspect the new sonography area within Child and Women's Health. The reason for the visit was that they had been informed of good practice by an external person and they wanted to come and see how the Trust had tackled this issue. The visit was undertaken by two HSE Inspectors and was extremely positive. The HSE acknowledged that there was very good practice within this area.

2.21 The HSE were also due to carry out a full two-day audit of the Trust in March 2009. However, this was postponed by the HSE and will now be conducted in June 2009.

2.22 The Trust is also required to report certain incidents to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). In 2008-09 the Trust reported a total of 46 incidents under RIDDOR out of 7,842 total reported incidents. All RIDDOR incidents are fully investigated by the Risk Team.

RIDDOR Incidents	Totals
Manual Handling	23
Slips, trips and falls	9
Struck by, or against something	4
Muscular skeletal	6
Violence and Aggression	2
Burn, scald, laceration	2

Safety Alert Broadcast System/Central Alert System (SABS/CAS)

2.23 The Central Alert System (CAS) was launched on 1 September 2008 and this replaced two previous systems, Public Health Link (PHL) and Safety Alert Broadcast System (SABS). This electronic system managed by the Department of Health (DH) disseminates alerts relating to Medicines and Healthcare Products Regulatory Agency (MHRA), National Patient Safety Agency (NPSA) and NHS Estates. These alerts are sent to the Trust's CAS Officer who disseminates the alerts to relevant staff and coordinates a response back to the Department of Health on compliance with each alert by within given timeframes. In 2008-09, the Trust received 110 alerts.

2.24 Trusts are also required to report to the MHRA any actual or potential failures of products used by the Trust. The MHRA investigates these reports and takes appropriate action which may result in an alert being sent out nationally via CAS. In the year 2008-09, the Trust made 26 reports to the MHRA.

2.25 Patient Safety Alerts received from the NPSA are managed by the Patient Safety Coordinator who ensures appropriate action is being taken Trust-wide via the NPSA Working Group chaired by the Medical Director. In addition, progress towards compliance is reported to the Patient Safety Steering Group.

Alert/Number	Compliant/closed	Outstanding
MHRA 89	89	
NPSA* 14	9	3 open / 2 not compliant
DH 6	6	1 alert awaiting guidance from DH
NICE 1	1	

* 2 non-compliant are review of radiological images and chest drain insertion. Both have been reported to the Governance Committee and are on the Trust risk register.

Section 3

Patient Safety

Patient Safety Strategy

3.1 Ensuring patient safety is one of the key responsibilities of the Board of Directors. Following the success of the Trust's participation in the Leading Improvement in Patient Safety (LIPS) programme in 2007-08, the Trust continued its commitment to make patient safety the highest priority by approving the patient safety strategy and subsequently signed up to the national campaign – Patient Safety First on 01-09-08.

3.2 A patient safety structure was established (Appendix 4) and funding approved for the recruitment of a Patient Safety Coordinator, additional IM&T analyst capacity, communications and training to support the Trust's participation in Patient Safety First.

Patient Safety First Campaign

3.3 The new patient safety structure provided individual teams with the support needed to introduce a number of interventions to make improvements in patient safety. Measures for each of the interventions are reported to the Patient Safety Steering Group on a monthly basis and six-monthly to the Governance Committee.

3.4 Three patient safety interventions were actively introduced and the progress achieved between October 2008 and March 2009 is summarised below:

Intervention	Achievements in 2008-09
Boards on Board with patient safety (leadership)	• Pledge made to staff that the safety of patients is the Board's highest priority. • Executive Walkrounds established and database created to record key themes and actions taken. • Improved understanding of the scale and type of harm in the Trust via the creation of the Adverse Event Forum and the weekly casenote review via the Global Trigger Tool. • Review and monitoring of the hospital's HSMR rates. • Development of a Quality Dashboard. • Improved communication of patient safety issues via RD&E News, foundation trust membership and Comex.
Reduction of harm to acutely ill deteriorating patients	• Embedding of processes to ensure Trust-wide under-standing and staff training in EWS observations. • Introduction of visual prompt, graded EWS response and twice-daily updating of electronic ward whiteboard to show location of unwell patients. • Resus Committee providing data on number and location of cardiac arrests and peri-arrests per month.

Intervention	Achievements in 2008-09
Reducing harm from inpatient falls	• Falls Project Group established to oversee revision of Trust's Falls Management Policy • Falls Working Group actively piloting improvement work across high risk medical wards • The concept of Intentional Rounding Checklist rolled out across 8 medical wards with a resultant decrease in number of falls recorded. • Intentional Rounding Checklist regional finalist for Health & Social Care Awards. Poster accepted for National Patient Safety Congress in May 2009. Abstract accepted and full paper written and will be presented at EUROMA 2009 conference in Sweden. • Decision taken to complete Root Cause Analyses (RCAs) on all incidents of falls resulting in a fracture to gain clear learning in order to achieve the Strategic Directions target of a reduction in serious inpatient falls by 75%.

3.5 The Patient Safety Steering Group recommended that two additional interventions be undertaken:

- ♦ Critical care bundles (central lines, ventilator care)
- ♦ Reducing surgical harm, prevention of surgical site infections and WHO safe surgery checklist

Scoping work has been undertaken, including audit, to determine the Trust's position in these areas and has been reviewed by the Infection Control Committee to determine how best to take this work forward and in which areas of the Trust. Robust plans will be developed in 2009-10.

Training

3.6 A number of staff have attended patient safety events and/or undertaken training and development in the use of tools and techniques to implement and measure safety improvements.

Event/Training	No. staff
A Systems Approach to Patient Safety, masters module at Warwick University	5
Global Trigger Tool training	10
Annual Patient Safety Congress (April 2009)	12
Webex and online support on a variety of topics relevant to the campaign, e.g. Measurement, leadership, deterioration	6
Patient Safety Manager's course	1
South West SHA Patient Safety Cluster group workshop	8

Section 4

Governance Support Unit

Introduction

4.1 During the past year there have been major changes in the status of clinical audit nationally which has culminated in a change of working within the Governance Support Unit and across the Trust. There has been a drive nationally to focus clinical audit activity around outcomes and changes in practice. This has been lead by the Healthcare Quality Improvement Partnership. An additional indicator which focuses on participation in clinical audit by all clinical directorates across the Trust has been added to the Annual Health Check.

4.2 In October 2008 the Governance Support Unit took part in a Rapid Improvement Event which looked at the processes operated within using Lean and 5S principles. This was invaluable and has lead to

- the introduction of new, more robust processes for NICE Guidance to ensure that responses on compliance are received in a timely manner and include action plans for non-compliance
- clinical audit – to ensure that high quality audit projects which lead to improvement in practice are conducted, and
- the refurbishment of the department.

4.3 The Governance Support Unit continues to lead on audit activity throughout the Trust. It provides the coordination of the Trust-wide Clinical Audit Programme and the collation of clinical audit activity across the Trust. All known audit activity is recorded on a departmental database from which quarterly reports on audit activity are disseminated to directorates via their directorate governance groups and the quarterly review process. The last year has seen an increase in the number of national and local clinical audit projects undertaken within the Trust. (See Appendix 6).

Examples of project results and recommendations

Project title	Results	Recommendations
Audit of Management of Surgical Patients with Diabetes	More patients started on peri-operative insulin, more patients had blood sugar checked intra-operatively and 90% had a pre-operative blood sugar measure. Overall glycaemic control in recovery was improved from 2007 audit.	Staff education to be implemented on use of intra-operative insulin and blood sugar measurement during long operations. Re-audit 2011.

Project title	Results	Recommendations
NICE Guideline TAG 10 – Use of Inhaler Systems (Devices) in Children under the Age of 5 Years with Chronic Asthma	Overall results very positive	Use of asthma self-management plans Measuring heights Communication of contents of self management plan to GPs More consideration of using a dry powder device in over 3's, if not using spacer well Re-audit of patients admitted to ward rather than Respiratory OPD
National Sentinel Audit of Stroke	Organisational Audit results in top quartile nationally with an overall score of 82%. This includes a score of 100% for the Daily Stroke Clinic Service and in top 10% nationally by activity for the provision of thrombolysis.	Stroke Management Group to focus on maintaining national position

Clinical Audit and Effectiveness Committee (CAEC)

4.4 The Clinical Audit and Effectiveness Committee continue to coordinate, promote and oversee multidisciplinary clinical audit activity, monitor NICE Guidance implementation throughout the Trust and provide strategic direction for the clinical audit programme. The committee met quarterly at which presentations and reports on outcomes from national and local clinical audit projects were presented.

4.5 An additional meeting of Directorate Audit Leads was held in January 2009 to clarify the role of the Audit Lead with regard to the 're-invigoration of clinical audit'. The co-ordinating role of the Audit Lead for clinical audit within the directorates is key to the Trust being able to meet the target for the national requirements.

Examples of issues raised by CAEC	Outcome
Routine antenatal anti-D prophylaxis Audit (NICE TAG 41) – consent forms not available in all cases	New procedure-specific consent form being introduced
Monitoring of Epidural and PCA Controlled Analgesia 2008.	Surgical nursing teams to monitor compliance and re-audit in six months

Examples of issues raised by CAEC	Outcome
Noted areas of good practice	All reports and action plans on recommendations from national audits presented to CAEC Action plans from national audit projects monitored six monthly via CAEC Exceptions to NICE Guidance compliance monitored through CAEC

NICE Guidance

4.6 NICE Guidance is issued in a number of forms and encompasses the following:

- **Clinical Guidelines** (CGs) – appropriate treatment and care of patients with specific diseases and conditions within the NHS in England and Wales. Healthcare organisations should ensure they take into account NICE Clinical Guidelines when planning and delivering care, as appropriate.
- **Technology Appraisals** (TAs) – the use of new and existing medicines and other treatments within the NHS for example medicines, medical devices, diagnostic techniques, health promotion activities and surgical procedures. Technology Appraisals must normally be implemented and funded within three months from the date of their issue (unless specifically exempted).
- **Interventional Procedures** (IPGs) – the safety and efficacy of surgical procedures. The Trust policy on the Introduction of New Clinical Procedures should be read in conjunction with this guidance.

4.7 Appendix 5 summarises NICE Guidance received during 2008-09.

Examples of NICE Guidance issues	Outcome
Poor completion of feedback template on compliance with NICE Guidance from clinical leads	NICE Initiators introduced within each directorate Electronic system of dissemination and feedback on compliance introduced
Receipt of action plans for areas on non-compliance with NICE Guidance	New action plan template introduced and process of monitoring via CAEC
Noted areas of good practice	Increase in compliance with NICE Guidance

National Confidential Enquiries and National Audit Projects

4.8 There are a number of national audits and confidential enquiries that have been undertaken within the Trust. These audits and enquiries cover a wide range of services. Some are outcome based where others feed into national trend analysis. The Governance Support Unit leads on a number of audits and enquiries. Other projects are managed by specialty leads. All are reported to either the Clinical Audit and Effectiveness Committee or the Governance Committee.

4.9 Appendix 6 lists the national audit projects and confidential enquiries undertaken in 2008-09.

Examples of National Confidential Enquiry and National Audit Project issues	Outcome
NCEPOD Process – assurance around compliance with recommendations	Process to be reviewed and re-designed
Action Planning following reports of National Audit Projects	Rolling programme of presentations on findings/recommendations from national audit projects to CAEC and introduction of new action plan template
Noted areas of good practice	Local audit projects conducted to continue monitoring of specific issues raised by reports of national audit projects which lead to changes in practice, i.e. National Sentinel Stroke Audit

National Service Frameworks (NSFs)

4.10 National Service Frameworks (NSFs) set national standards and define service models for a specified service or care group, put in place strategies to support implementation and establish performance milestones against which progress within an agreed timescale will be measured. Working parties have been set up to implement the recommendations of the following National Service Frameworks: Cancer, Coronary Heart Disease, Diabetes, Older People, Renal Services, Children and Long Term Conditions. The NSFs are monitored through the National Standards Local Strategy (NSLS) Committee. Audits have been undertaken as part of the NSF action plans.

4.11 Appendix 7 lists the Trust's position at 31 March 2009 with regard to NSFs.

Clinical Integrated Document (CID) and Integrated Care Pathways (ICPs)

4.13 In April 2007 a standardised Clinical Integrated Document (CID) for medical admissions was introduced across the Medical Directorate. Compliance was reviewed in 2008 and amendments made to the original version to increase use.

4.14 A new admissions document for Surgery and Orthopaedics has been developed and implemented. Compliance was reviewed in 2008 and amendments made to the original version to increase use.

User Involvement

4.15 Under the Trust's User Involvement Policy all projects involving contact with staff, patients or users of a service by telephone, face-to-face or questionnaire are reviewed by the Patient, User, Staff Involvement Group (PUSIG). The Group review the projects for ethical content and quality.

4.16 In 2008-09 the PUSIG reviewed 33 projects.

Project title	Objective	Directorate/Specialty
Clinical Support Technician Questionnaire	To evaluate this new post and identify potential areas for improvement.	Professional Services. Prosthetics.
Sedation during flexible bronchoscopy Questionnaire	To look at patient satisfaction in the different methods used for sedation and also look at the patients experience as a whole.	Medicine. Respiratory.
Retinal Screening Service Questionnaire	To assess patient satisfaction	Medicine. Diabetes & Endocrinology.
Parent & Carers experience of waiting times	To get parent/carer feedback on the suitability of waiting areas provided for their children and look at the results against national guidance.	CWH. Paediatrics
Vascular Access team electronic patient satisfaction questionnaire.	To evaluate this new service.	Critical care. Intensive care unit.
Multiple Sclerosis Specialist Nurse Questionnaire	To evidence whether the MS Nurse service is fit for purpose and benchmark against national standards.	Medicine. Neurology.
Catering & House keeping services questionnaire	To ascertain patient feedback on the catering and cleaning service provided within the hospital.	Commercial Services/ Facilities. Catering/ Housekeeping.

Education and Training

4.17 Training sessions on clinical audit have been provided to junior doctors and allied health professionals across the Trust. This has led to a greater understanding of clinical audit, raised the profile of the department and brought about an increase in the number of audit outcomes reported. Junior doctors are being requested to undertake meaningful audit projects as part of teams, which could lead to improvements in care. Audits of NICE guidance currently being implemented within the Trust have been given to junior doctors to audit as part of their training.

Section 5

Patient Liaison Services

Introduction

5.1 The Patient Liaison Services team incorporates the following services:

- Complaints Department
- PALS (Patient Advice And Liaison Service)
- Health Information Centre
- Communication support (interpretation, translation and other formats)
- Patient Affairs (adult bereavement service)
- Patient and public involvement

5.2 During the past year the team continued to contribute to processes to ensure compliance with the Healthcare Standards (particularly core standards C14a,b,c, C16, C17) and the NHSLA Risk Management Standards for Trusts (Standard 4.2, 5.3, 5.4).

5.3 Policies and procedures for complaints, PALS and the production of patient information were reviewed prior to the NHSLA assessment (see 1.11) with positive feedback being received from the assessor.

Compliments and complaints

5.4 The Trust response to all formal complaints is coordinated via the complaints department. Activity is reported quarterly to the Board of Directors, the Governance Committee and to Directorates via the Quarterly Review process.

	2008/09
New complaints received	351
Complaints received as a % of overall patient activity	< 0.06
% acknowledged in 2 working days	75%
% receiving written response in 25 working days	39%
% receiving written response within agreed timescale	66%
Overall compliance figure *(those achieved within 25 days and agreed extensions met)*	72%
Written commendations received	7,075

5.5 Appropriate staff review all complaints received and make changes to services where possible. Feedback from directorate staff to the Complaints Department about these changes is monitored on a quarterly basis.

Patient Advice and Liaison Service (PALS)

5.6 PALS provide a central point of contact for people needing information, or help with a problem or concern. Collation of information on the DATIX risk management system and subsequent reporting enables the Trust to gather useful information on developing trends, or identify areas where improvements may be necessary. This information is fed back to the departments concerned, ensuring that feedback directly contributes to service improvements.

5.7 PALS contacts remained high. In 2008/09 there were 1,334 cases (1,567 in 07/08). Most cases were resolved so that no further action was needed, with the remainder of clients requiring advice, information or onward referral.

5.8 The following table shows a breakdown of the type of issue dealt with via PALS.

Type of Issue	Number of contacts
Advice and Information	202
Issues for Resolution	466
Negative Feedback	54
How to make a complaint	7
Signposting to other PALS services	605
Total	**1334**

5.9 In order to monitor the satisfaction of the PALS service, feedback is obtained from a random selection of users. Due to the PALS lead leaving within the period this task was only undertaken for the first six months of the financial year. Of those asked for feedback, 100% of respondents said that PALS had listened to and understood their concerns. All of them reported that they had been kept informed of progress, were satisfied with the outcome and would use PALS again.

5.10 The method of feedback for PALS is currently being reviewed in line with the changes to the PALS and complaints processes.

Complaints & PALS divided into Patient Experience headings

5.11 The following table illustrates the 5 top areas of importance to a patient's experience with the number of complaints or issues for resolution received through PALS for each topic. Reporting upon these areas reinforces the importance of acting upon patient experiences. These priority areas comprise:

	Complaint	PALS issues (excl signposting to other PALS services)
Access and Waiting	50	221
Clean, safe place to be	7	39
Information, Communication and Choice	65	268
Building Relationships	37	32
Safe, High Quality Care	192	168
Total	**351**	**729**

5.12 The following table illustrates the top areas of concern raised through PALS and complaints for the above areas of patient experience:

Top area of concern for Complaints	
Patient Experience Area	**How this relates to the Trust**
• Access and Waiting **(50)**	Waiting lists **(29)**
• Clean, Safe Place to be **(7)**	Facilities (4)
• Information, Communication, Choice **(65)**	Information provided **(46)**
• Building Relationships **(37)**	Attitude of staff **(21)**
• Safe, High Quality Care **(192)**	Clinical Care **(153)**
Top area of concern for PALS Issues (excluding signposting to other PALS services)	
Patient Experience Area	**How this relates to the Trust**
• Access and Waiting **(221)**	Length of wait for appointment **(71)**
• Clean, Safe Place to be **(39)**	Patient's Property **(19)**
• Information, Communication, Choice **(268)**	Request for Information **(166)**
• Building Relationships **(32)**	Attitude of staff **(27)**
• Safe, High Quality Care **(169)**	Quality of Care **(54)**

Changes arising as a result of feedback

5.13 Both the PALS service and the complaints function routinely recorded the outcome of the issues that are managed and investigated. The following table identifies the top outcomes for both functions.

Top outcomes for Complaints	Top outcomes for PALS
• Service Improvement **(33)**	• Service Improvement **(20)**
• Staff action required **(30)**	• Issues escalated to a complaint **(12)**
• Meeting offered **(19)**	• Issue forwarded to Matron for local resolution **(8)**
• Further training required **(8)**	• Loss and compensation claim **(6)**
• Improvement in Communication **(7)**	• Forwarded to another PALS service **(4)**
• Changes to Appointments **(7)**	• Suggestions forwarded to Service Manager **(3)**
• Meeting arranged or held **(7)**	• Improvement in Communication highlighted **(2)**
• Information leaflet being reviewed **(4)**	• Led to further Patient and Public Involvement work **(1)**
• Procedural change **(1)**	

5.14 Further details of impact on service improvement and continuous learning being applied across the Trust are reported at 8 on the patient experience diagram, 'You Said, We Did'.

Health Information/Communication Support

5.15 The health information team coordinate the production of patient information leaflets, details of which are available to all staff via the trust intranet system (ComEx). The patient information manager is responsible for the process of ensuring leaflets are regularly reviewed, liaising with authors to ensure that information is up to date, evidence based and written in plain English.

5.16 **Trust Patient Information** – The database for patient information is viewable on the Health Information Centre (HIC) ComEx page. The Trust has now **464** live leaflets, **205** in the process of being produced and another **176** waiting to be reviewed by the authors.

5.17 The table below shows the activity for the HIC, with a list of the top five topics, along with the number of cancer enquiries (this figure is shown because of a request by the Cancer Services & User Group).

Health Information Centre Activity	2007/2008	2008/2009
Enquiries and information given	**52,562**	**41,876**
Average per week	**1011**	**805.30**
Cancer enquiries and Force referrals	**2839**	**1437**
Average Cancer enquiries per week	**55**	**28**
Top five enquiries for whole year		
General medical	**12,905**	**8346**
Heart/blood pressure	**4869**	**3200**
Back pain and arthritis	**3106**	**2209**
Cancers and Force referrals	**2839***	**1437**
Cholesterol, stroke and neurology	**2359**	**1542**

5.18 General information (health promotion – Sun, Flu, Healthy Eating, Smoking etc) was made available in the Concourse for anyone to take 24/7 in 2007/2008. The information taken was recorded at 12,088. In readiness for the relocation it had been decided not to offer this service this year.

5.19 Reasons for the decrease in numbers could be due to:

- Norwalk (hospital closure)
- Change of visiting times
- Information not available in the concourse when the centre is closed.
- More wards are now holding their own information

5.20 Requests for information in a variety of different languages/formats and provision of interpretation continue to increase. During the last year communication support was provided via a range of services including:

- face-to face interpretation
- interpretation (Polish) for Parent Craft classes (ongoing)
- translations of medical records
- provision of appointment letters and information leaflets in languages other than English
- information in large print and audiotape format
- over 300 calls to Language Line (telephone based interpretation service) totaling approximately 66 hours of dialogue. 40% of calls were Polish.

Patient Affairs Bereavement Service (PABS)

5.21 Activity increased slightly in the patient affairs bereavement service, with support provided to the relatives of 1405 patients who died (on a ward) at the RD&E during the year. The service responds to the needs of families and friends, ensuring that the registration process is dealt with in a sensitive, empathic and efficient way.

5.22 The checklist and reporting system devised jointly with Devon Doctors ensures that GPs are informed of a patient's death in a timely fashion. Activity is monitored regularly with any notable exceptions reported directly to the clinical teams.

5.23 **Changes to the Service:** A Mortuary Database has been running since 2006 – PABS are now inputting data on the system including next of kin details, recordings of the process for completion of the certificate and any correspondences with the relatives of the deceased. This has enabled the provision of a comprehensive record of care post death which can be accessed at any time in the future should the need arise.

5.24 The Department of Health have implemented changes (January 2009 and ongoing) to improve the process of death certification in England and Wales. One of the changes was to develop an improved system of death certification to improve the quality and accuracy of medical certificates of cause of death (MCCDs), enable more effective and consistent scrutiny and provide improved information for clinical governance and the surveillance of public health. New cremation forms have been introduced with few changes of which noticeably a higher requirement is made on making sure we have included the occupation of the deceased. This has been quite a big learning curve for both doctors and PABS.

5.25 PABS are trialling a new appointment system for relatives of the deceased in readiness for the relocation of the service (concourse refurbishment). This is working well.

Patient and Public Involvement/Patient Surveys

5.26 The Patient and Public Involvement (PPI) Steering Group and the Disability Equality Action Group (DEAG) merged at the end of 2008 to become The Involving People Steering Group. The group has met three times and are working on finalising their action plan.

5.27 Both the Disability Equality Action Group and Carers Issues sub group continue to report into the Involving People Steering Group quarterly on the progress of their action plans.

5.28 The Involving People Steering Group submit a decision briefing every quarter to the Governance Committee.

5.29 A new Involving People Strategy has been developed.

5.30 A new Involving People Procedure has been developed along side the Involving People Toolkit to support staff in carrying out PPI projects.

5.31 The Trust continues to partake in the annual national survey programmes (devised by the Healthcare Commission).

5.32 An electronic survey system has been successfully introduced throughout the hospital. This system is mainly being used to support the new Electronic Nursing Quality Assessment Tool (NQAT), which is an ongoing audit based around the Essence of Care (DOH) core standards. 40% of the Nursing Quality Assessment score is informed by a real-time patient survey. All acute wards will have conducted their first audit by July 2009 and it is planned for a tool to be designed for theatres and in patient/daycase areas which will also be conducted electronically.

5.33 The Patient Forum was replaced by LINks (Local Involvement Networks) on 1 April 2008.

5.34 A Trust-wide patient and visitor feedback card has been piloted with an aim to introduce throughout the Trust in the summer 2009.

Examples of PPI issues raised	Outcome
Payments policy	Recommendations of change have been put forward by the Involving People steering.
A mechanism for real-time patient feedback.	NQAT
LINks request for information	The Trust responded to LINk's first request for information querying access for people with visual impairments.
Noted areas of good practice	NQAT

Section 6

Developments for 2009/10

Introduction

6.1 Whilst much work has been has been completed in 2008-09, the Trust is committed to continually improving its services, year on year. To this end, a number of strategies and plans have been developed. These are detailed below.

Registration with the Care Quality Commission (CQC)

6.2 The CQC is currently undertaking a consultation on how Trusts should register under the new regulations. Once agreed, the Trust will be required to register and maintain systems to ensure on-going registration.

Health and Safety Action Plan

6.3 The Trust has developed a health and safety action plan for 2009-10, in liaison with staff side representatives. This plan has been agreed by the Health & Safety committee and was presented to the Board in June 2009.

Patient Safety

6.4 The following table highlights the key plans in place for 2009-10 for the development of the Trust's participation in the Patient Safety First campaign:

Intervention	Development Plans for 2009-10
Boards on Board with patient safety (leadership)	• Determine improvement workstreams required as a result of understanding the Trust's Top Five adverse events via the work of the Adverse Event Forum and the use of the GTT. • Review and monitoring of specialty HSMR rates. • Implementation of a Trust-wide Quality Dashboard. • Development of Never Events reporting • Development of an annual Quality Report/Accounts.
Reduction of harm to acutely ill deteriorating patients	• Development of the Electronic Whiteboard to record the use of SBAR to generate monthly reporting on compliance. • Redevelop observation chart is to include the graded response strategy. • Take actions to ensure data shows decrease in cardiac arrest and increase in peri-arrests.
Critical care bundles (central lines, ventilator care)	• Continue use of CVC care bundles in renal dialysis • Implement use of CVC care bundle in cancer services • Implement use of CVC care bundles on ITU • Establish definition of VAP to enable monitoring of VAP rates in ITU
Reducing harm in peri-operative care/WHO safe surgery checklist	• Implement Patient Safety First care bundles in Gynae Theatres and measure results • Re-audit use of safe surgery checklist and time out • Develop clear protocols for surgical antimicrobial prophylaxis

Intervention	Development Plans for 2009-10
Reducing harm from inpatient falls	• Use Days Between Falls at ward level as a measure • Target Surgery, followed by Orthopaedics, as next areas for falls reduction work. • Complete review and implementation of Falls Policy and Falls training package. • Pilot use of NPSA multi-incident RCA investigations for similar falls incidents. • Trust-wide roll out of Intentional Rounding Checklist.
Venous Thromboembolism	• Establish new committee to manage implementation of national guidelines. • Commit to new intervention of Patient Safety First Campaign when launched.
Reducing Harm from High Risk Medications	• Carry out scoping work to consider feasibility of formal implementation of the Patient Safety First intervention in conjunction with existing workstreams.

6.5 In addition, the Patient Safety Steering Group will:

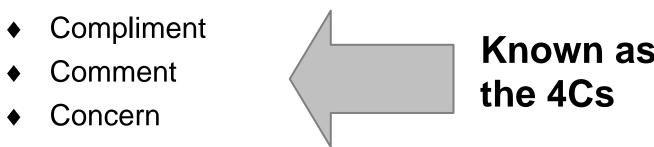
- Ensure that patient safety improvement initiatives are aligned with Trust Strategic Directions.
- Oversee the revision of RCA Guidelines, Tools and Templates in line with the requirements of the NHSLA Risk Management Standards for Acute Trusts and Care Quality Commission.
- Facilitate external training provision for a cohort of 20 RCA Facilitators and 20 moderate incident investigators Trust-wide.

Changes to the NHS Complaints Procedure

6.6 On 1 April 2009 the new NHS and Adult Social Care Complaints Regulations came into force. The purpose of this section is to provide an update on the changes within the complaints and PALS department in line with the new complaints regulations.

6.7 All issues that are received by the complaints and PALS department are now being processed and recorded as either a:

- Compliment
- Comment
- Concern
- Complaint



6.8 For all issues brought to the department's attention, staff members are now contacting the individual, where possible, and engaging with them over the best way to manage their issue. If we are unable to contact the individual a letter is sent to them requesting them to make contact with the department. This process was previously undertaken for PALS issues received, and has been introduced for complaints that would have previously been communicated through the written format.

6.9 As part of the changes to the systems and processes within the department all complaints, concerns and comments will be processed and managed in the same way and therefore will have a consistent approach to the management of

issues as detailed below. The new approach will be to address all complaints/comments/concerns as 'issues of concern', in the first instance (these were previously partially captured through the PALS report).

Each issue is assessed to determine the seriousness and most appropriate timescale to investigate and respond

OUTCOME A Up to 15 days to resolve	**OUTCOME B** 15-25 days to resolve	**OUTCOME C** 25 days – 6 months to resolve
• Telephone call/resolution meeting • Dealt by any member of staff/ PALS • Apology or explanation given • Prompt remedy • Written or verbal update • Advocacy support offered is appropriate • Feedback form completed and faxed to 01392 403908	• Discussion with complainant and plan created • Advocacy support offered is appropriate • Requires investigation. Statements and interviews with staff undertaken • Summary investigation template completed with remedial action highlighted • Local resolution meeting, verbal contact or written response dependent on the plan	• Complex complaint. Possibly more than one organisation involved • Patient care or patient safety issue • May require independent review • Detailed investigation template and action plan completed • Response issued from Chief Operating Officer (with copy of report)
Service user unhappy: re-negotiate plan if appropriate	Service user unhappy: re-negotiate plan if appropriate or refer to Ombudsman after sign-off	Service user unhappy: Re-negotiate plan if appropriate or refer to Ombudsman after sign-off

NHS Litigation Authority (NHSLA) Assessment

6.10The Trust will be re-assessed at level 1 of the acute services NHSLA standards in February 2010. Work will continue in maternity services to embed the systems highlighted in the level 2 assessment. This will be particularly important with the new configuration of maternity services planned for 2009-10.

Clinical Audit and Effectiveness Committee (CAEC)

6.11 Clinical Audit Conference will be held on 2 October 2009 at which national speakers will be presenting on 'how to push forward the re-invigoration of clinical audit'.

Clinical Integrated Document (CID) and Integrated Care Pathways (ICPs)

6.12 Compliance in the use of the Medicine, Surgery and Orthopaedics admissions documents will be audited in 2009.

6.13 The format and content of the 14 existing ICP documents will be reviewed. These were developed in a number of formats and with varying degrees of detail.

6.14 Links with PCT colleagues will be established to begin work on the development of cross-boundary ICPs starting with fractured neck of femur.

6.15 The Map of Medicine (MoM) project will be reviewed with the aim of increasing use of MoM. Slow progress due to lack of support from clinicians for MoM but recently increased interest.

Patient and Public Involvement/Patient Surveys

6.16 All acute wards will have conducted their first NQAT audit by July 2009 and it is planned for a tool to be designed for theatres and in patient/daycase areas which will also be conducted electronically.

Sustainable Development

6.17 The Department of Health (DoH) is committed to sustainable development which is in line with the principles of the White Paper "Our health, our care, our say". The environment in which people live and work has a key influence on their health. Environmental considerations need to be taken into account when building or adapting facilities in which NHS services are delivered.

6.18 In 2009-10 the Trust will

- Establish a Board approved Carbon Reduction Strategy by September 2009 setting out how the Trust aims to support the commitment of the NHS to be a leading sustainable and low carbon organisation.
- Establish a governance structure to support implementation of carbon reduction and sustainable development.
- Sign up to the Good Corporate Citizenship Assessment Model as a resource to help assess and improve the Trust's contribution to sustainable development and carbon reduction.
- Establish a Board approved Sustainable Development Management Plan by December 2009, which will include milestones for the Trust's contribution towards the interim targets set by the NHS to meet the provisions of the Climate Change Act.
- Begin to monitor, review and report on carbon.
- Actively raise carbon awareness at every level of the Trust.
- Continue to implement energy efficiency projects, e.g. improvements arising from the findings of a functional audit of all air conditioning systems.

Appendix 1

Governance Structure

Board of Directors

Management Assurance

Independent Assurance

Audit Committee

Management Assurance committees and groups
Clinical Audit & Effectiveness Committee
Decontamination Committee
Drugs & Therapeutics Committee
Emergency Preparedness Steering Group
Environment & Waste Management Group
Fire Safety Committee
Health & Safety Committee
Hospital Transfusion Committee
Infection Control Committee
Information Governance Committee
Involving People Steering Group
Medical Devices Group
National Standards Local Strategy Committee
Nursing & Midwifery Governance Committee
Patient Environment and Action Group
Patient Safety Steering Group
Radiation Safety Committee
Resuscitation Committee
Safeguarding Adults Steering Group
Security Forum
Directorate Governance Groups

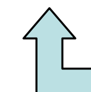
Appendix 2

Directorate Governance Group Structure

Governance Committee

- **Cancer DGG**
  - Chemotherapy Governance Group
  - Oncology Governance Group
  - Haematology Governance Group
- **CWH DGG**
  - Maternity Governance Forum
  - Gynaecology Governance Group
  - Paediatrics Governance Group
- **Medicine DGG**
  - ED Gov. Group
  - EMU Gov. Group
  - Endoscopy Gov. Group
  - Renal Gov. Group
  - Diabetes/Endo Gov. Group
- **Prof. Srvcs DGG**
  - *Diagnostics*
  - Pathology Governance Group
  - Imaging Governance Group
  - Radiology Governance Group
- **Surgery 1 DGG**
  - Specialist Surgery DGG
- **T&O DGG**
  - Critical Care DGG

Reports directly to the Governance Committee


Under development: Respiratory, Stroke and Neurology
Plans to establish: Cardiology and Care of the Elderly

Appendix 3

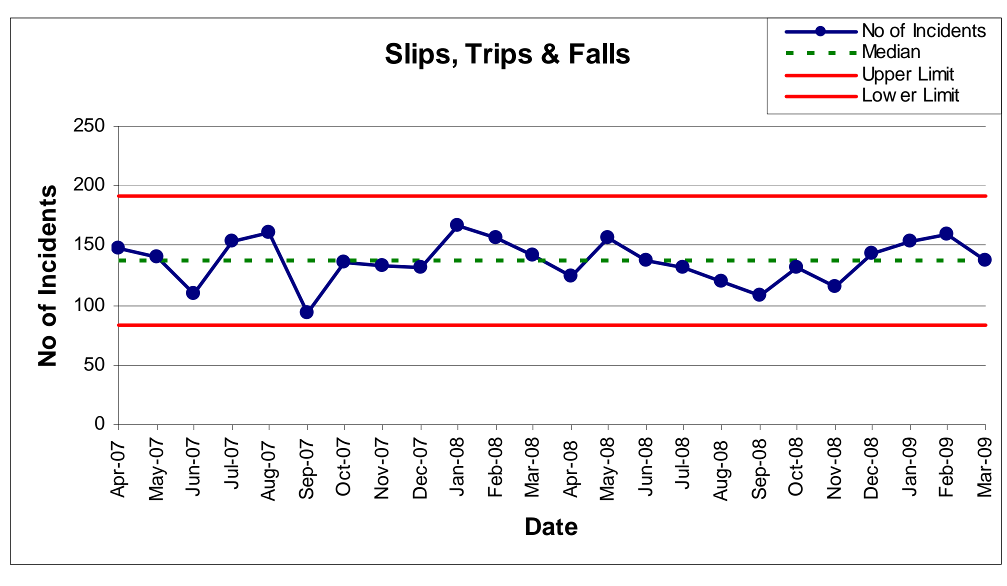
Incident Reporting

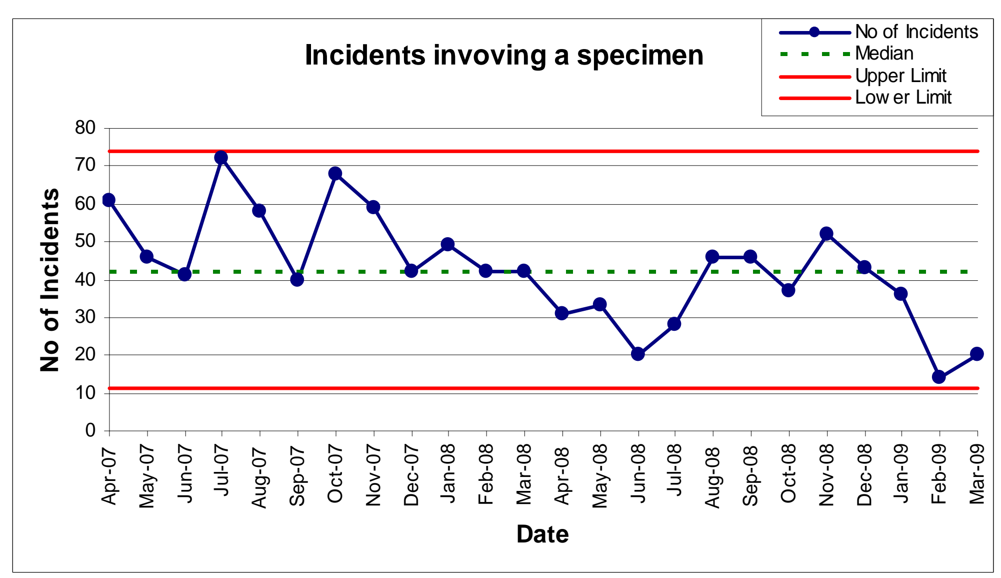
Risk Matrix – ALL Incidents 01/04/08 - 31/03/09

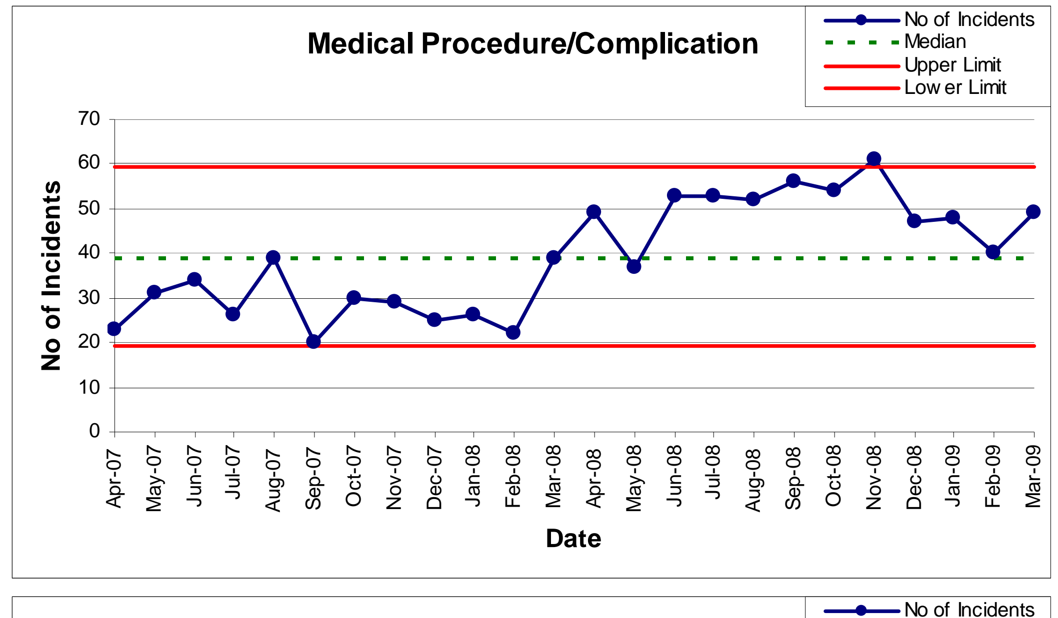
Actual Impact – Patient incidents

None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
3614	1966	78	6	6

Trustwide Top 5 Patient Incidents
April 2008 to March 2009






Medical Procedure/Complication
No of Incidents
Median
Upper Limit
Low er Limit
70
60
50
40
30
20
10
0
No of Incidents
Apr-07
May-07
Jun-07
Jul-07
Aug-07
Sep-07
Oct-07
Nov-07
Dec-07
Jan-08
Feb-08
Mar-08
Apr-08
May-08
Jun-08
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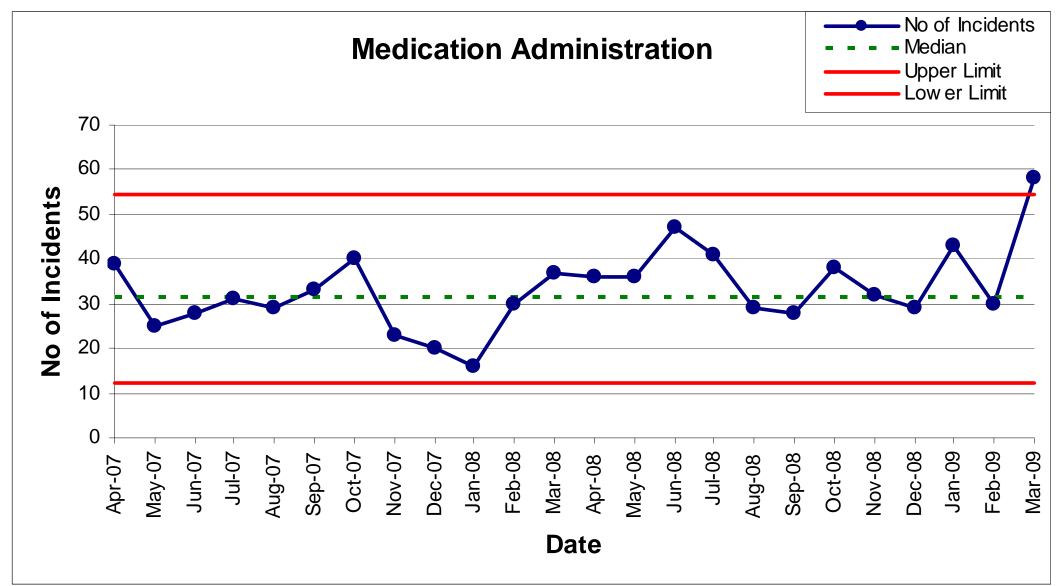
Feb-09
Mar-09
Date


Medication Administration
No of Incidents
Median
Upper Limit
Low er Limit
70
60
50
40
30
20
10
0
No of Incidents
Apr-07
May-07
Jun-07
Jul-07
Aug-07
Sep-07
Oct-07
Nov-07
Dec-07
Jan-08
Feb-08
Mar-08
Apr-08
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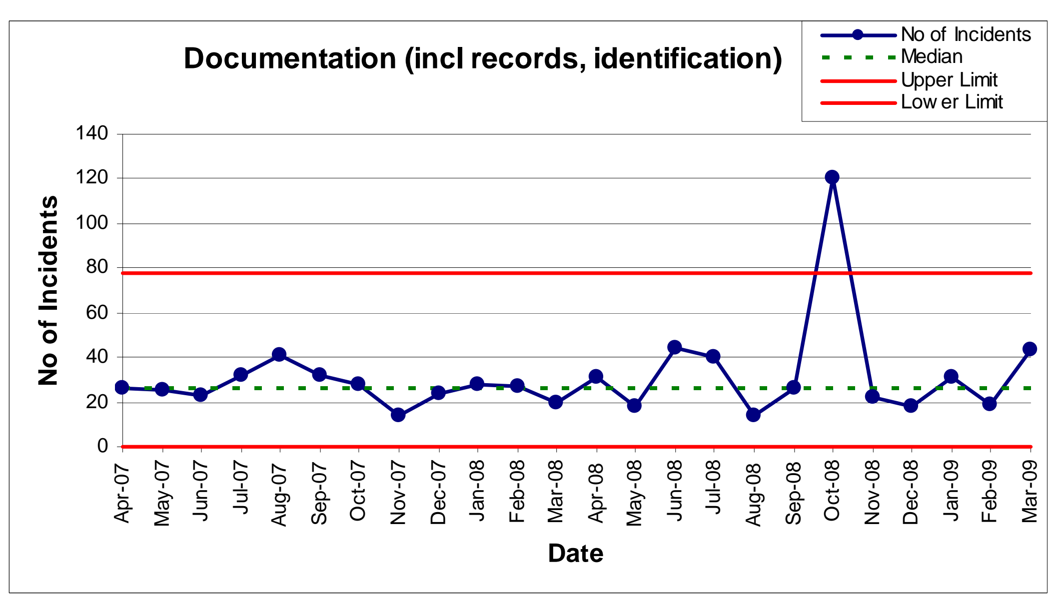
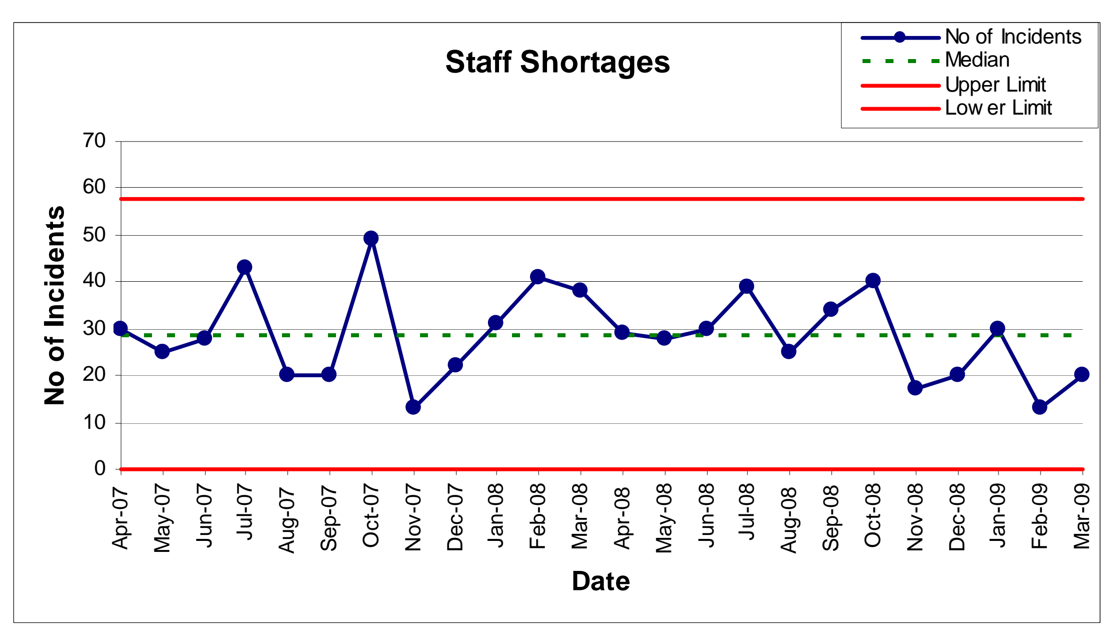
Jan-09
Feb-09
Mar-09
Date

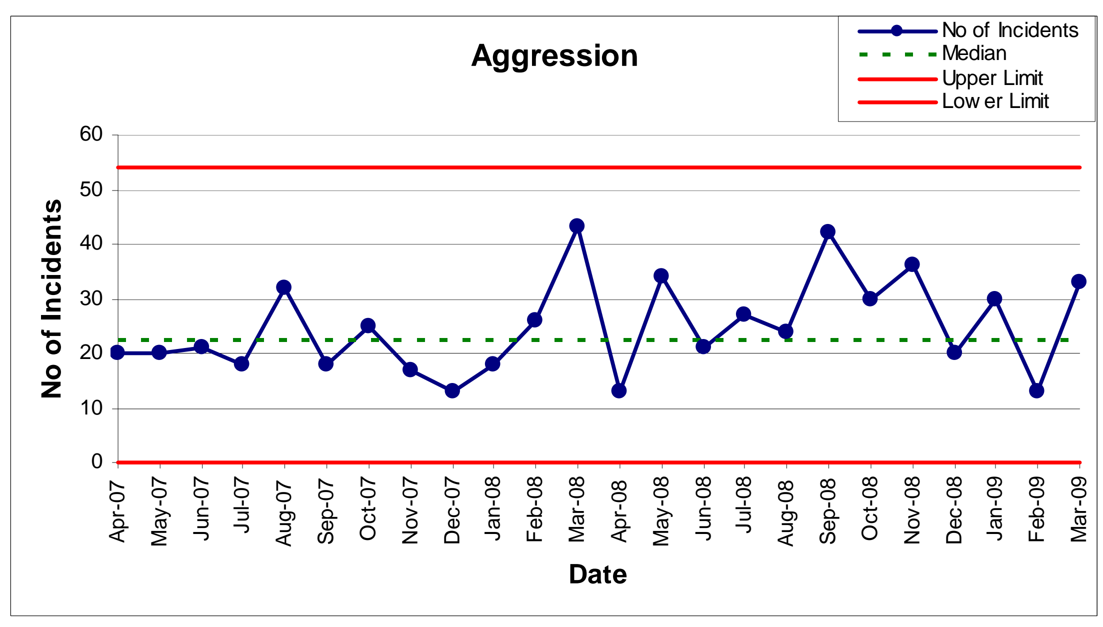

Documentation (incl records, identification)
No of Incidents
Median
Upper Limit
Low er Limit
140
120
100
80
60
40
20
0
No of Incidents
Apr-07
May-07
Jun-07
Jul-07
Aug-07
Sep-07
Oct-07
Nov-07
Dec-07
Jan-08
Feb-08
Mar-08
Apr-08
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Date

Actual Impact – Staff incidents

None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
657	1301	66	0	0

Trustwide Top 5 Employee Incidents
April 2008 to March 2009





Inoculation injury

No of Incidents
Median
Upper Limit
Low er Limit

No of Incidents

35
30
25
20
15
10
5
0

Apr-07 May-07 Jun-07 Jul-07 Aug-07 Sep-07 Oct-07 Nov-07 Dec-07 Jan-08 Feb-08 Mar-08 Apr-08 May-08 Jun-08 Jul-08 Aug-08 Sep-08 Oct-08 Nov-08 Dec-08 Jan-09 Feb-09 Mar-09

Date

Walk into/trap/struck by

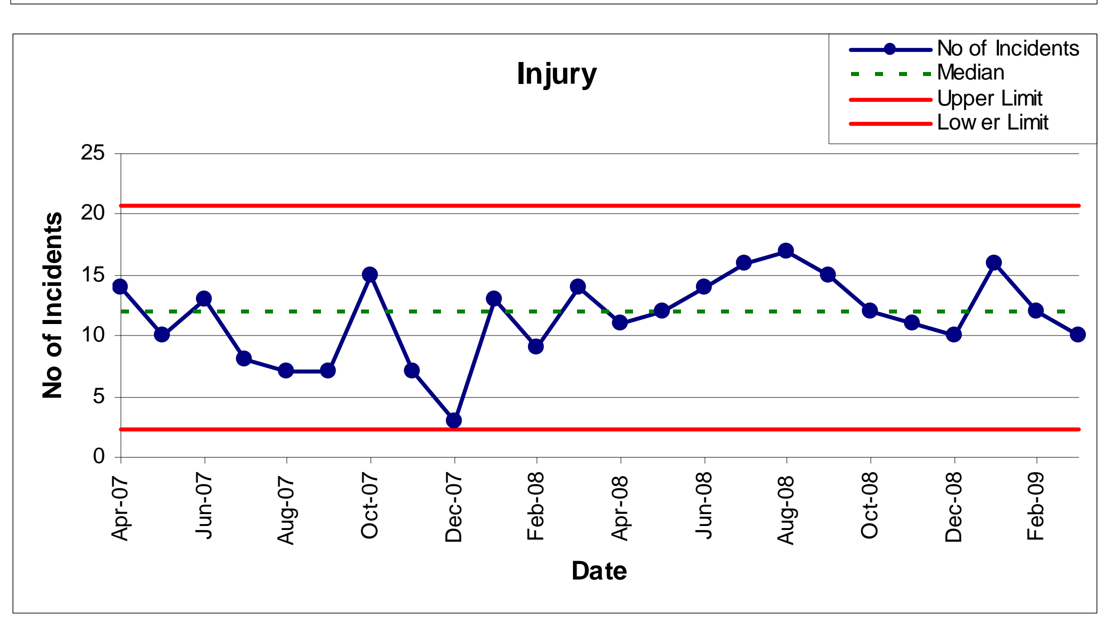
No of Incidents
Median
Upper Limit
Low er Limit

No of Incidents

25
20
15
10
5
0

Apr-07 May-07 Jun-07 Jul-07 Aug-07 Sep-07 Oct-07 Nov-07 Dec-07 Jan-08 Feb-08 Mar-08 Apr-08 May-08 Jun-08 Jul-08 Aug-08 Sep-08 Oct-08 Nov-08 Dec-08 Jan-09 Feb-09 Mar-09

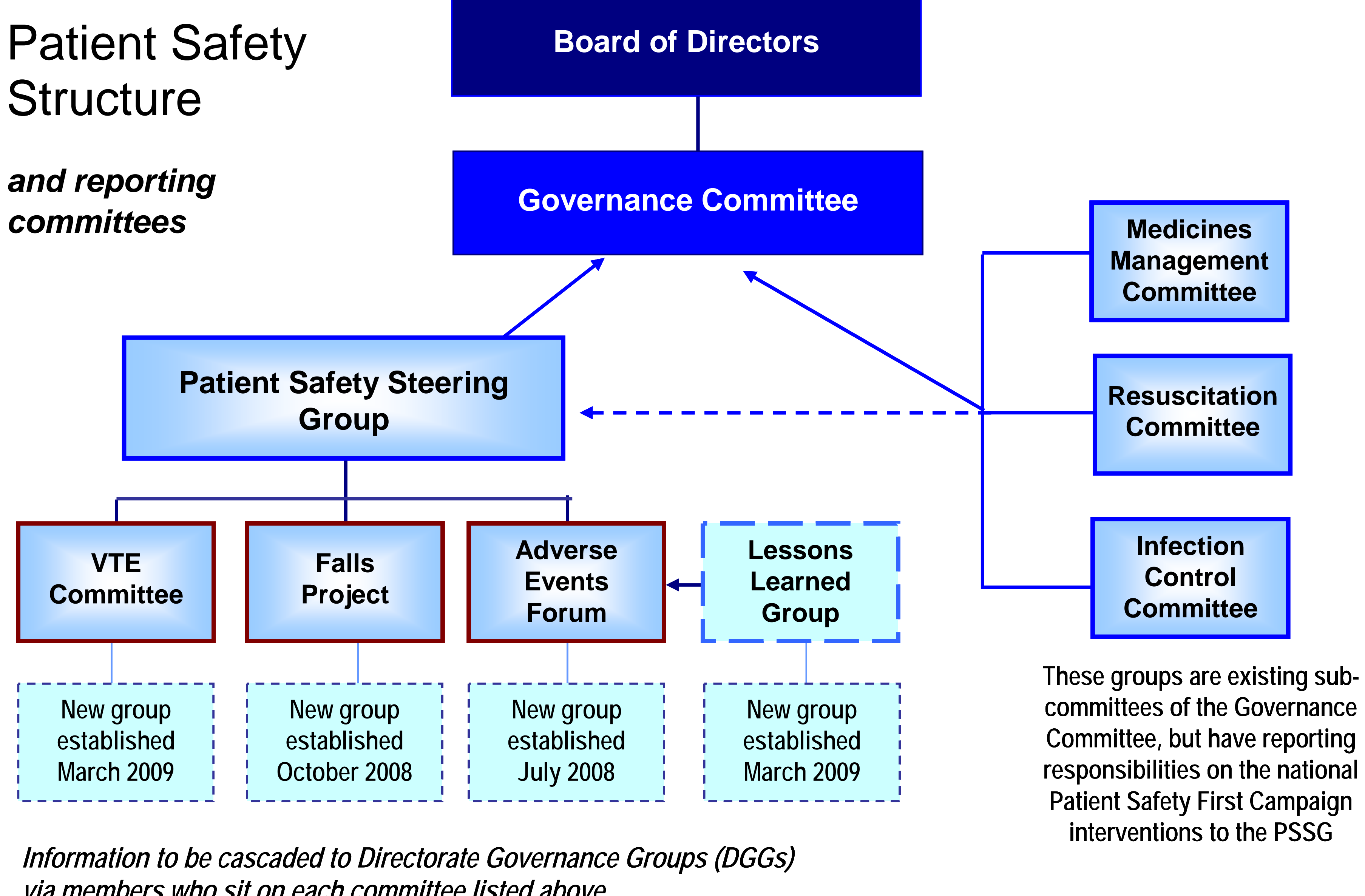
Date



Actual Impact – Visitor/other incidents

None (green)	Minor (yellow)	Moderate (orange)	Major (red)	Catastrophic (red)
87	66	4	0	0

Appendix 4



Appendix 5

Report on NICE Guidance

1 APRIL 2008 – 31 MARCH 2009

	Clinical Guidance	Interventional Procedures	Technology Appraisals
Total applicable guidance issued	15	19	18
Total complied with	6	10	13
Total partially complied with or with some minor exceptions *	2	1	0
Total not in use (due to funding, further research needed etc.) **	2	0	2
Total outstanding ***	5	8	3

* Majority of issues complied with. Action plans in place to ensure compliance with outstanding issues.

** Current discussions with PCT regarding funding arrangements.

*** Currently under review by Directorates

Appendix 6

National Audit Projects 2008-09

SPONSOR	TITLE	Trust Participation	OUTCOMES to Clinical Audit & Effectiveness Committee	Action Plans in place
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Coronial Autopsy Study	Yes	Yes	Yes
NCEPOD	Sickle Cell and Thalassaemia	Yes	No	No
NCEPOD	Severely Injured Patient	Yes	No	Yes
NCEPOD	Emergency Admissions	Yes	No	No
NCEPOD	Systemic Anti-cancer Therapy	Yes	No	No
NCEPOD	Deaths in Acute Hospital Study	Yes	Report release – Nov 09	Awaiting report
NCEPOD	Acute Kidney Injury Study	Yes	Report release – Jun 09	Awaiting report
NCEPOD	Parenteral Nutrition Study	Yes	No – ongoing	Study still ongoing
NCEPOD	Emergency & Elective Surgery in the Elderly	Yes	No – ongoing	Study still ongoing
	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	N/A – ongoing audit
	National Trauma and Research Network (NTARN)	Yes	Yes	N/A – ongoing audit
	Myocardial Infarction National Audit Project (MINAP)	Yes	Yes	N/A – ongoing audit
	National Heart Failure Audit	Yes	No – ongoing	N/A – ongoing audit
DoH	National Primary Angioplasty Audit (NIAP)	Yes	No	No
RCP	National Audit of the Organisation of Falls and Bone Health in Older People	Yes	No – July 2009	Yes
	National Care of the Dying Patient	Yes	Report awaited	Awaiting report

SPONSOR	TITLE	Trust Participation	OUTCOMES to Clinical Audit & Effectiveness Committee	Action Plans in place
RCP/NHSBT	Comparative Audit of Fresh Frozen Plasma	Yes	No	Yes
RCP/NHSBT	Bedside Transfusion Practice 2008	Yes	Awaiting report	Awaiting report
RCP	National Chronic Obstructive Pulmonary Disease Audit	Yes	No – July 09	No
RCP	National Audit of Services for People with Multiple Sclerosis	Yes	Yes	Yes
RC Paeds & Child Health	National Neonatal Audit Project	Yes	Yes	Yes
NCASP	National Diabetes Audit	No	N/A	N/A
NCASP	Lung Cancer (LUCADA)	Yes	Yes - Audit still in progress	Ongoing audit
NCASP	Bowel Cancer (NBOCAP)	Yes	No – audit still in progress	Ongoing audit
NCASP	Head and Neck Cancer	Yes	No – audit still in progress	Ongoing audit
BASO	Breast Cancer Audit	Yes	No – audit still in progress	Ongoing audit
NCASP	National Oesophago-gastric Cancer Audit and Outcomes Project (AUGIS)	Yes	No – audit still in progress	Ongoing audit
BAUS	Urology	Yes	No – ongoing	Ongoing audit
NCASP	Mastectomy and Breast Reconstructive Surgery	Yes	No – audit still in progress	Ongoing audit
NHSBT	UK Comparative Audit of Upper Gastro-intestinal Bleeding and the Use of Blood	Yes	Yes	Yes
RCP	National Sentinel Audit of Stroke - organisational audit	Yes	Yes	Yes

SPONSOR	TITLE	Trust Participation	OUTCOMES to Clinical Audit & Effectiveness Committee	Action Plans in place
RCP	National Sentinel Audit of Stroke - clinical audit	Yes	No – July 09	Yes
RCP	Management of Back Pain and Depression by OH Services	Yes	Yes	Yes
RCP/BSG	UK Inflammatory Bowel Disease Audit	Yes	No – Oct 09	No
	National Hip Fracture Database	Yes	No – ongoing	No

Appendix 7

National Service Frameworks (NSFs)

Title of NSF	Date Released	Lead Directorate	Number of Action Points	PCT-Led Action Points	Actions Points N/A to RD&E	Actions Points met
Diabetes	2001	Medicine	17	3	0	10
Renal	2006	Medicine	53	11	9	26
Children	2004	Child & Women's Health	11	0	0	9
Cancer	2007	Cancer Services	66	3	0	56
Long Term Conditions	2005	Medicine	11	5	0	2
Older People	2001	Medicine	8	1	0	5
Coronary Heart Disease	2000	Medicine	19	0	0	14

Appendix 8

You Said, We Did