Barking, Havering and Redbridge University Hospitals NHS Trust

CLINICAL GOVERNANCE ANNUAL REPORT 2009/10

(1 APRIL 2009 – 31 MARCH 2010)

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EXECUTIVE SUMMARY

Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT) takes clinical and corporate governance issues seriously. Indeed, without strong governance processes it would not be possible to provide safe and effective care for our patients, protect our staff and be able to demonstrate that the organisation continuously strives for improved performance and value for money based on the implementation of best practice.

This year's Clinical Governance Annual Report, looks similar to those of previous year's but has been refined to make it more readable; concentrating on shorter sections that hopefully provide more visual 'quick glance' tables and graphs.

The topics covered take the reader through the senior level reporting on clinical governance, where decisions are taken on high level risks and issues, through to the smaller sub committee information about specific topics.

Over the past year, the Clinical Governance Department has continued to drive the clinical governance agenda through the Divisional structures at a time of considerable change, especially the changes from Standards for Better Health to Registration. The regulatory aspect of the Care Quality Commission's Registration process will undoubtedly generate considerable challenges for the department, but more especially for the whole organisation, as it will be imperative that senior staff understand and cascade those responsibilities if the evidence is to be available when required.

The continued refinement of the Risk Register and Board Assurance Framework have met with approval by the Trust's internal Auditors, and the Board can be assured that these governance tools are robust and able to underpin and enhance the Trust Board's decision making.

The internally set 'stretch' targets for both infection control and complaints continues to demonstrate the Trust's commitment to driving down healthcare acquired infections and improving the patient experience. The growth and effective involvement of our patient representatives are also providing an invaluable contribution to ensure patient experiences of the services we offer are of a high standard.

Our clinical governance Committees work hard on behalf of our patients and staff ensuring that new techniques and procedures are safe and meet best practice and, where there are risks and safety issues, these are fully acknowledged, discussed and addressed.

The importance of undertaking and learning from audit is being regularly reinforced and strengthened as can be demonstrated by the number and variety of audits reported within this report. However, it is recognised that audit is a cyclical process and it is just as important to ensure there is 'learning' and 'improvement' if the audit process is to be meaningful.

The economic and political climate within which the NHS has to function, will undoubtedly bring new challenges which will require strong clinical governance structures to ensure safe, high quality patient care is delivered. These challenges provide the opportunity to review and revise our clinical governance systems within the Trust to simplify and streamline the processes in place to support and protect staff in delivering high quality patient care.

Pam Strange
Clinical Governance Director

1.0 INTRODUCTION

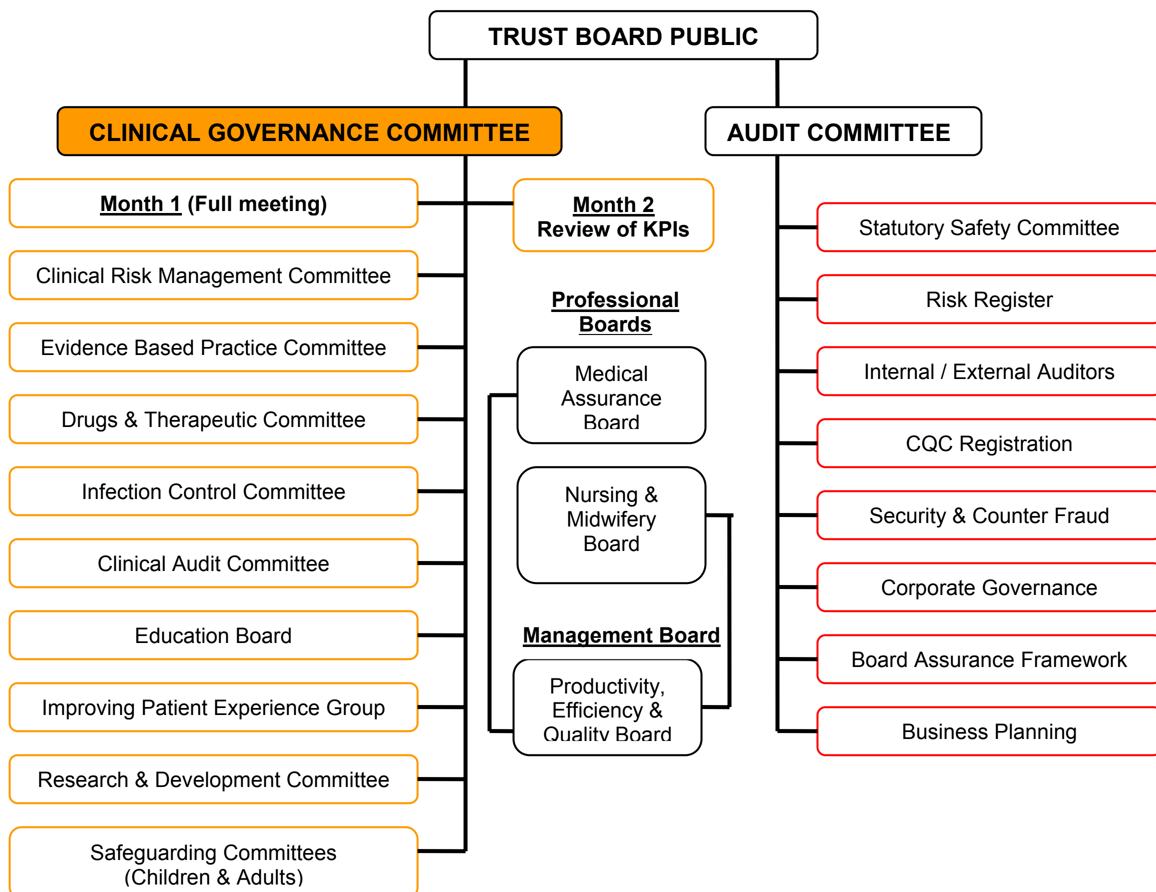
This year the clinical governance annual report has been completely overhauled to both shorten it, and make its content more user-friendly. By using tables and graphs wherever possible, it is hoped that the information is more easily understandable. The period covered is 1st April 2009 to 30th March 2010.

2.0 CLINICAL GOVERNANCE COMMITTEE

The Trust Board delegates responsibility for monitoring clinical governance activity across the organisation to the Clinical Governance Committee (CGC), with the Audit Committee responsible for corporate governance issues (see **Diagram 1**).

Each Trust Board meeting receives a variable number of individual reports relating to clinical governance in both Part I (the public meeting) and Part II (the confidential section). In addition, the minutes from the Clinical Governance Committee are always sent to Trust Board for noting. A number of clinical governance topics are also covered at the Audit Committee meetings, whose minutes are monitored under Part II of the Trust Board meeting. The diagram below shows the current committee reporting structure into the Trust Board meetings.

Diagram 1 Trust Board Reporting



Sub Committees of the CGC submit reports on current topics of note and areas of identified risk via exception reports; other clinical governance topics such as the Risk Register, Care Quality Commission (CQC) Registration and the Board Assurance Framework feed into the Audit Committee that also receives the minutes from the Statutory Safety Committee.

The CGC evolved over the past year and now meets each month; one month is dedicated to a full meeting and the second month to a review of patient safety key performance indicators. **Table 1** below demonstrates the frequency of CGC sub committee meetings and the number of concerns that have been escalated to them for discussion and resolution:

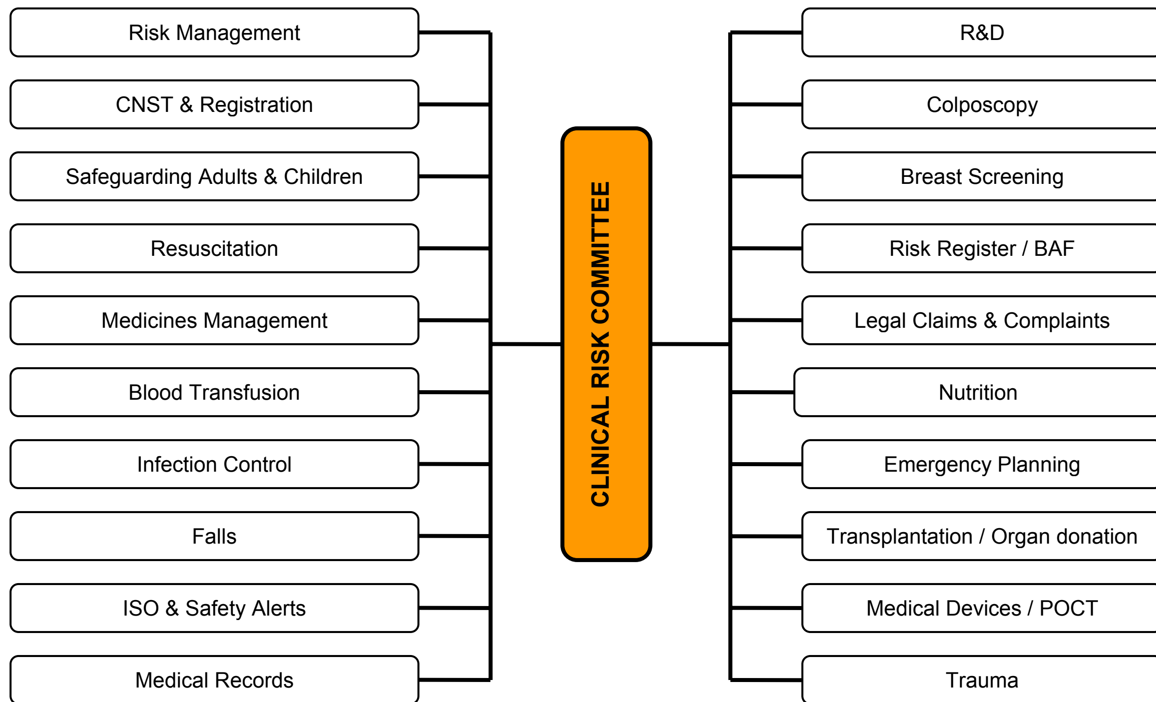
Table 1 Clinical Governance Committee Sub-Committees

COMMITTEE	CHAIR	MEETINGS FREQUENCY	NO. RISKS ESCALATED
Clinical Risk Management Committee	Medical Director / Clinical Governance Director	Bi-monthly	3
Evidence Based Practice Committee	Consultant General Surgeon / Consultant Emergency Medicine	Bi-monthly	5
Drugs & Therapeutic Committee	Divisional Director Women & Children	Monthly	2
Infection Control Committee	Medical Director / Director of Nursing	Bi-monthly	7
Clinical Audit Committee	Consultant Neurosurgeon	Bi-monthly	2
Education Board	Director of Education	Bi-monthly	6
Improving Patient Experience Group	Patient Representative / Non Executive Director	Bi-monthly	0
Research & Development Committee	Director of R&D / Director of Nursing	Monthly	3
Safeguarding Children Committee	Director of Nursing	Bi-monthly	0
Safeguarding Adults Committee	Director of Nursing	Bi-monthly	2
Other risks escalated by Clinical Governance Committee members			
Colposcopy			2
Nursing: Visible leadership			1
Medical records			1
Divisions			13
TOTAL			**54**

3.0 CLINICAL RISK COMMITTEE

Diagram 2 below details the range of topics covered by the Clinical Risk Management Committee (CRC):

Diagram 2 Clinical Risk Committee Reporting



Detailed below (**Table 2**) are a few of the topics covered by the CRC during 2009-10. A number of the topics are covered in more detail later in this section, but the following have been extracted from the exception reports to provide a flavour of the discussions. The full minutes of the CRC can be found on the Trust's intranet.

Table 2 Clinical Risk Committee Topics

TOPIC	ISSUES
Policies for approval or ratification	• Managing the Trust Formulary • Medicines Management Policy (Strategic Overview) • Resuscitation Policy • Retention & Disposal Policy (medical records) • Medical Devices Policy • Audit sections in policies strengthened, tighter version control, compliance with equality and diversity legislation and the introduction of Chair's Approval Forms to improve Trust policy development and implementation.
Protocols and guidelines for noting	• Protocol developed relating to drugs for patients to take away on discharge (TTAs) • Protocol revised for 'never events' investigations.

Table 2 (continued)

TOPIC	ISSUE
Policy non-compliance issues	• Extensive work underway to develop a medical device inventory to rectify non-compliance.
External visits / review of a service feedback	• MHRA accreditation of Blood Transfusion Service • External review of resuscitation services completed. • Decontamination expertise commissioned. • CNST accreditation and CQC registration updates standing agenda items.
Safety issues / alerts	• NPSA Safety alert re use of NHS numbers as primary patient identifier implemented. • 117 safety alerts received via the Central Alerting System (CAS), 46 were relevant to the Trust. • Revised process agreed for the management of NPSA alerts which require multi-disciplinary implementation. • BHRUT in top 5 London Trusts for acknowledgement, implementation and closure of safety alerts (often the best). • All CAS safety alerts placed on intranet.
Funding issues	• Agreement reached for 38 new defibrillators for King George Hospital • Funding issues for the procurement of medical records folders identified and subsequently resolved.
Training for staff / competencies	• Technician training on TTA – pilot scheme • Blood tracking system introduced • Resuscitation training action plan implementation • Medical records workshops being well received by staff. • Medical Device Competency forms developed for all clinical staff.
Audit outcomes	• Loose filing audit • Medical records 'Tracker' system audit reports
Incidents, SUIs (serious untoward incidents) and Never Events	• 25% reduction in SUIs reported for first quarter. • Local never events defined • The introduction of a weekly review of intrauterine deaths made significant improvements in the number of clinical incidents.
Quality systems / problems	• The Trust hold more ISO quality system accreditation than any other Trust nationally ie: » Theatres (Queen's), » Medical Physics, » Radiotherapy, » Chemotherapy Day Unit (Queen's), » Radiology Ultrasound, » Victoria Breast Screening, » Clinical Engineering (King George), » Supplies Logistics, » Supplies Procurement, » Cashiers. • Assistance given where ISO accredited areas outsourced during reporting period ie: sterile services, laundry, security and transport and maintenance. • Quality system processes applied to support QA visits.

4.0 EVIDENCE BASED PRACTICE COMMITTEE

The Evidence Based Practice Committee (EBPC) is the principle committee for ensuring clinical practice within the Trust is based on evidence and proven best practice. All new clinical guidelines, procedures and technologies must receive EBPC approval before being implemented within the Trust. EBPC also reviews Trust compliance to national guidance and recommendations. **Table 3** below summarises the work of the EBPC for the reporting period:

Table 3 EBPC Reviews

Process	Nos. in 2009/10
New Technology Procedures & Interventions	10
Local guidelines	14
NCEPOD reports	2
NCEPOD studies	4
NICE guidance *(not all relevant to the Trust)*	73
CMACE *(previously CEMACH)*	2
Royal College guidance	7

The Trust's in-house developed dedicated evidence based practice database not only records information but provides evidence of review and levels of compliance. Reports can be requested to show approved new guidelines, procedures and technologies, but also published guidance received by the Trust, to whom it was disseminated, and the current evidence supplied to demonstrate compliance. The database can be accessed by all members of the Clinical Governance Quality team and has been submitted to NHS Innovations London, to consider its potential for use by other Trusts.

5.0 CLINICAL AUDIT COMMITTEE

As with the evidence based practice database, the Trust's Clinical Audit Database records all registered audits by specialty and type. The Clinical Audit Team assist with retrieval of medical notes and transference of data collection sheets into 'Formic' a programme that allows completed data sheets to be scanned and results presented in Excel format for ease of analysis. Information and assistance on how to conduct audit, analysis and presentation are also available from the team who also deliver training sessions to all staff and junior doctors on how to conduct high quality audit. Recommendations from completed audits are now routinely sent in an Action Plan format to Clinical Leads and General Managers to ensure improvements and change of practice as a result of audits; these are recorded on the database. The audit outcomes are playing a contributory part in the development of business cases.

A. Registered Audits

Table 4 details the breakdown of the 347 registered audits carried out at the Trust between 1 April 2009 and 31 March 2010 by Division:

Table 4 Registered Audits

Division	Nos. of Audits
Women & Children	45
Medicine	65
Surgery	139
Clinical Support	73
Other	25
TOTAL	**347**

B. National Audit Activity 1 April 2009 to 31 March 2010 (= 41)

All Directorates are expected to participate in new key national audits to optimise the impact of clinical audit. In particular, those audits that form part of the DH centrally funded National Clinical Audit Patient Outcomes Programme (NCAPOP) which are set by the National Clinical Audit Advisory Group (NCAAG) and reflect priorities set by central government, along with various other factors such as the incident/prevalence of a condition and the impact of the condition on the NHS and social services. The Trust is participating in the following NCAPOP studies:

- National Lung Cancer Audit
- Mastectomy and breast reconstruction
- Epilepsy 12
- MINAP Myocardial Ischaemia
- Diabetes
- National Joint Registry
- Inflammatory Bowel Disease
- Stroke
- Services for people who have fallen.
- Continence
- Dementia

C. Corporate Audit (= 53)

Trust Corporate Audit topics are updated annually to reflect high priority issues which affect the entire organisation. Increased uptake of corporate topics has continued during the reporting period. Data collection tool templates are now available for the majority of corporate audit topics to assist auditors. Corporate audits were registered under the following topic headings during this period.

- Quality of Healthcare Records
- Consent
- Heart Failure
- Medicines Management
- Blood and blood products
- Infection Control
- Mortality

D. NICE Guidance Audit

Table 5 gives an overview of the number of audits carried out as a direct result of NICE guidance; the audit activity is shown by Division:

Table 5 NICE Audits

Division	Nos. of Audits
Women & Children	11
Medicine	15
Surgery	20
Clinical Support	4
Other	4
TOTAL	**54**

E. Trust Mortality & Morbidity Review Audits

The process of undertaking mortality and morbidity review audit is becoming more robust across the Trust with Clinical Leads signing up to agreed routine processes for reviewing mortality and morbidity (M & M) within their specialties. A dedicated Clinical Governance Facilitator for M & M ensures that relevant case notes are sent to Consultants for review with tailored data collection templates accompanying them. Details of review activity is collated and recorded and reported to Divisions and Clinical Governance Committee.

F. Pneumonia Mortality Review

It was identified that the Trust was an outlier in relation to the number of patients who died as a result of community acquired pneumonia. Price Waterhouse Coopers were commissioned to carry out a review of the mortality rates to support learning and increased quality of care. On receipt of the report the trust developed a timed action plan in response to the recommendations which fell into 8 categories:

- Use of guidelines
- Documentation
- Management of Pneumonia
- Pathways for the acute patient
- Inappropriate admissions and Primary Care pathways
- Nursing observations
- Patient Care
- Clinical Governance

The implementation of the action plan was monitored through the Clinical Governance Committee and the Trust Board. In February 2010 a further audit was carried out to measure compliance with the action plan which identified some further issues compliance with the antibiotic policy. From this work further developments have occurred to improve the patient pathway of patients who require urgent and timed treatment for a range of conditions including sepsis, on admission to the A&E Department. These patients are 'red flagged' on admission to ensure that treatment is timely and monitored. Prospective audit of these patients occurs with the consultant managing the post take ward round to provide immediate feedback to junior staff.

G. Miscellaneous Audit Activity

A number of other audits were carried out between 1st April 2009 and 31st March 2010; these are detailed in **Table 6** below:

Table 6 Miscellaneous Audits

Audit Type	Nos. of Audits
Customer Care	38
National Service Frameworks	10
National Patient Safety Agency Alerts	14
Operational Audit	6

6.0 INFECTION CONTROL COMMITTEE

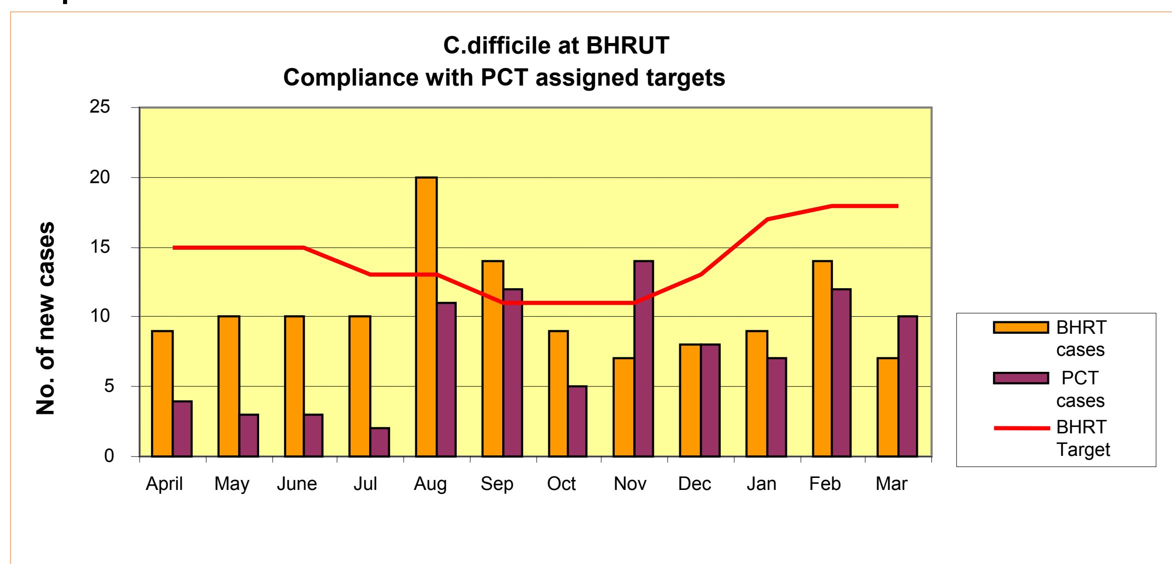
The Infection Prevention and Control Committee met three times during the year and have always received good support from PCT colleagues. The Committee regularly reviews progress against mandatory and local surveillance targets, receives reports of infection outbreaks, reviews educational activity and audits, ratifies new and updated policies and considers reports from external bodies such as the Care Quality Commission. Major issues discussed during the year were:

A. Clostridium difficile

Cases arising 48 hours or more after admission are attributed to the Trust. There were 82 cases in 2009/10, compared with 127 cases the previous year. Our assigned target for 2009/10 was not more than 128 cases. This was an excellent result for our patients as Clostridium difficile infection causes significant morbidity and prolongs hospital stays.

Of interest is the rising number of cases which appear in community patients (PCT cases), some of whom will require admission. All cases diagnosed in our laboratory are shown in the **Graph 1**:

Graph 1 Clostridium Difficile



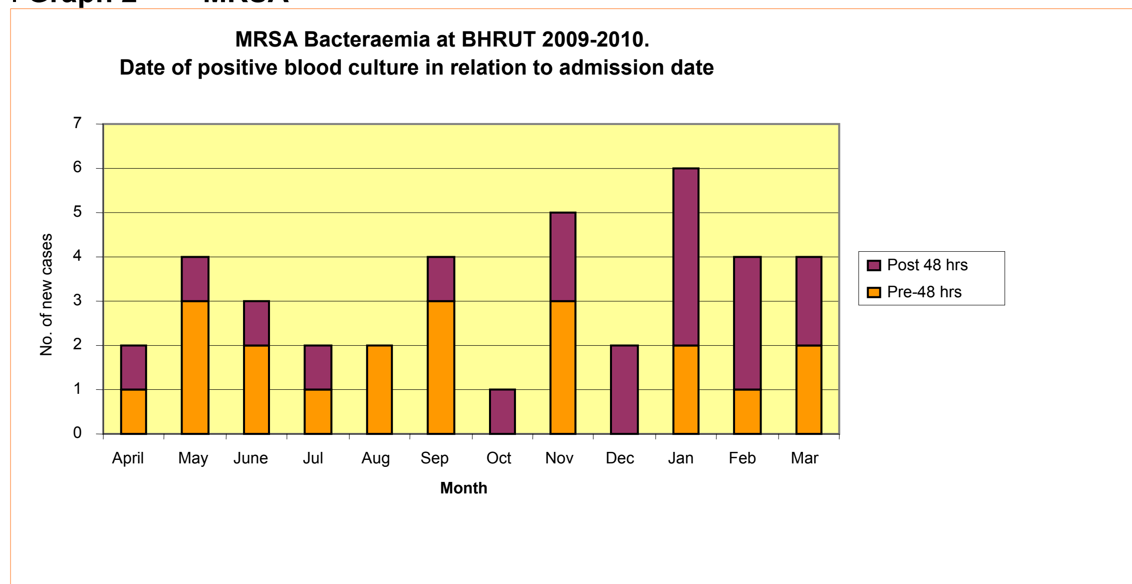
B. MRSA Bacteraemia

All cases of MRSA bacteraemia diagnosed in 2009/10 were assigned to the Trust. Although our 'official target was not more than 54 cases, we had agreed a 'stretch' target of not more than 36 cases.

During the first half of the year the Trust remained below trajectory, however an increase in cases during the winter months led to a final year total of 39 cases, 19 of which occurred at least 2 days after admission (see **Graph 2)**. Root cause analysis of all cases is undertaken and the following preventable causes have been identified:

- An outbreak of MRSA in orthopaedic trauma wards
  Once recognised, close management ensuring strict adherence to standard guidelines brought this outbreak under control
- General lack of compliance with admission screening for 'high risk' patients
  Implementation of screening for all emergency patients is scheduled for 2010/11
- Failure to follow guidelines for the insertion and care of central venous catheters
  This has been incorporated into mandatory and induction training for doctors

. Graph 2 MRSA



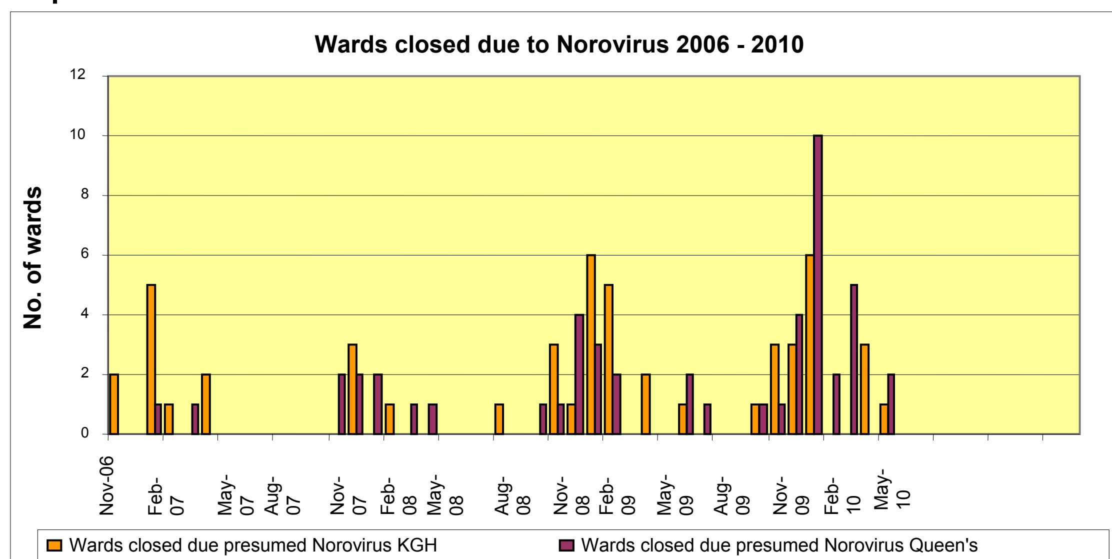
During 2010/11 only 'post 48 hours' cases will be assigned to BHRUT, but the target set of not more than 11 cases will be tough to meet without considerable improvement in practice.

C. Other outbreaks of infection

Norovirus

The major issue for the Trust was the large number of diarrhoea and vomiting outbreaks due to Norovirus that occurred mainly during the winter. This necessitated many ward closures (See **Graph 3**).

Graphs 3   Norovirus



This was part of a nationwide outbreak that occurred on an even larger scale elsewhere. To the credit of the Trust the situation was managed without major impact on activity and the infection and prevention team were able to offer practical support to a neighbouring Trust that were even more severely affected.

Panton-Valentine Leukocidin MRSA (PVL-MRSA) in Neonatal Intensive Care

Investigation of a baby with MRSA bacteraemia led to the discovery of a small outbreak of this organism in NICU (neonatal intensive care unit) at Queen's Hospital, involving 4 babies and 1 health care worker. Although few babies were affected, this organism has considerable pathogenic potential, and full containment measures, including staff and patient screening were applied. All affected babies recovered.

Multi-resistant Acinetobacter in Critical Care

An outbreak which eventually involved 22 patients occurred over a 3 month period from August to November 2009. Although not normally pathogenic, it can cause severe infection in critical care patients and, because it is resistant to all commonly used antibiotics, treatment is problematic. Strict isolation criteria and repeated high level cleaning eventually brought the outbreak under control.

D. Visits from the Care Quality Commission (CQC)

During 2008/09 a non-compliance with isolation procedures in critical care areas was declared by the Trust. Revision of our *Isolation Policy*, staff education and ongoing surveillance were implemented and following an inspection by the CQC in July 2009 the non-compliance was revoked.

An unannounced visit took place on 9th December 2009. Major issues highlighted included lack of induction of locum staff, inadequate cleaning of ward areas and equipment and non-compliance with 'bare below the elbows'. Although most issues are not directly the responsibility of the infection prevention and control team, they are considered under the heading of prevention of healthcare associate infection by the CQC. Following considerable activity by many Trust staff, sufficient progress was demonstrated to satisfy the CQC in a subsequent visit. Implementation of weekly 'visible leadership' activities from February onwards by the Director of Nursing & Infection Prevention and Control (DIPC) and matrons will ensure that progress is maintained during 2010/11.

E. ***Change of Director of Infection Prevention and Control (DIPC)***

In November, the Trust's medical director Dr Yasmin Drabu, who had also served as DIPC for 3 years, left the trust. The role has been taken on by Deborah Wheeler, our new Director of Nursing who has brought considerable expertise with her from her previous position and her keenness and innovative engagement with all has already had considerable impact on progress with infection prevention and control.

7.0 STATUTORY SAFETY COMMITTEE

The Statutory Safety Committee meets bi-monthly and is chaired by the Clinical Governance Director and reports to the Audit Committee, the CEO is the executive lead for health & safety in the Trust. A number of committees report into the Statutory Safety Committee such as the Radiation Protection Committee; Fire, Health and Safety Committee and the Violence and Aggression Working Group. The membership of the Committee includes representatives from our Contractors, PFI Partners and a representative from Parkhill (Local Security Management Services).

The Committee were informed that new regulations came into force in September in relation to the absorbent material required for pathology sample packaging; action was being taken to identify a suitable source.

Security issues such as access to Tropical Lagoon Children's Ward were followed up by the Committee with the Trust's partners Sodexo. The importance of ensuring access for paediatric staff, the crash and fire teams was fully recognised, alongside the need to restrict access by other staff.

A Health and Safety Dashboard has been developed to monitor all elements of health and safety, and trend analysis highlights areas for investigation and improvement and a Health and Safety Annual Report was circulated to the members for comments at their July meeting and was subsequently amended to reflect the comments received. The following section provides greater detail on key issues discussed by the Statutory Safety Committee.

A. Risk Management Training

During the past year the team have participated in a total of 168 mandatory training sessions offered for staff. The number of attendees totalled 3581 Trust wide, ensuring 74% of staff were trained in these issues for the period in question

The number of Nurse Refresher training sessions held throughout the period of 2009/2010 totalled 76 sessions. Unfortunately 14 of these sessions were cancelled: 2 due to additional Registered Nurse Induction, 6 for low number of attendees, and 6 due to financial constraints. Other training provided by the Risk Management Team includes:

- Registered Nurses 2 days per week, Tuesday and Thursday.
- General Induction on 1st and 3rd Monday of the month.
- Mandatory Risk training for Midwives 1 Wednesday per month
- HCA Mandatory Training two sessions per month
- ISTC Consultant Training at various times throughout the year.
- Ward/ Department practice Fire Evacuations Trust wide every week.
- Specific Fire Training for satellite sites and departments, regularly.
- Speak at Conflict Resolution Training on various dates throughout the year.
- Dangerous Goods Update Training for Midwifery and Community workers
- Mandatory Risk Management Training Trust wide for non-nursing staff.

- F1 & F2 Doctors Induction including Vulnerable adults
- Paediatric and Gynaecology Doctors' Induction
- Incident Reporting department based
- PFI Partners

B. Health and Safety

The Trust organised an event during October 2009 to coincide with the European Week of Health & Safety. The 2009 campaign focused on risk assessments, risk management and hot topics such as manual handling and infection prevention and control. The stand was organised and manned by members of the Risk Team, with support from PFI partners, Sodexo/Catalyst, who welcomed the opportunity of promoting the health and safety message to their staff.

Various competitions and prizes were offered to both staff and public and the stand proved to be popular with staff and visitors alike.

Over the period two new policies relating to health and safety were produced and approved. These were the *Young Persons at Work Policy* created to protect young persons from general and specific hazards whilst working for the Trust, and the *First Aid Policy* created to support the creation of the new Trust First Aid programme and subsequent training scheduled for next year.

There have been no incidents that have been investigated by the Health & Safety Executive for the period.

C. Fire Safety

Table 7 below details the number of fire activations that have taken place from 1 April 2009 to 31 March 2010:

Table 7 Fire Alarm Activations

Quarter 1	Quarter 2	Quarter 3	Quarter 4
46	61	61	39

During December a member of staff inadvertently activated the building total evacuation alarm. A large proportion of the premises evacuated and in-patient areas prepared for evacuation in many cases, but were stood down when the accidental activation was discovered. It should therefore be considered as a full evacuation exercise for Queen's Hospital.

Earlier this year consultations were held with the management company of the accommodation blocks at King George Hospital, with input from the London Fire Brigade, with a view of making the accommodation block fire alarm system 'stand alone' where the calls to these premises would no long be attributed to King George Hospital figures. This was finally achieved in March and has reduced the attributed numbers of calls by approx 20 calls per month.

There have been no notable fires or fire related incidents for the reporting period and no Regulatory Enforcement Notices have been issued to the Trust for fire related matters

The Trust's *Fire Policies* have all been updated to reflect current status and a *Disaster Evacuation Plan* developed. In addition, all Fire Risk Assessments for Trust occupied buildings have been completed in accordance with the Regulatory Reform Order. Notices of deficiencies have been forwarded to the Trust FM team for rectification.

The Trust was deficient in a vertical evacuation strategy. This has been written and incorporated into the Disaster Evacuation Plan. In order to achieve effective vertical evacuation of non ambulant patients a number of Ski Pads have been purchased and will be installed on fire escape staircases in Queen's and rear corridors of wards at King George Hospital. Training on Ski Pads will be co-ordinated with the manual handling team and a schedule of staff training put in place.

D. Staff and Patient Safety

As part of the Patient Safety First campaign, the Trust held an awareness day at Queen's Hospital on 24th September to provide information about patient safety to staff and visitors alike. The Patient Safety campaigns look at ways of reducing harm to patients by changing practice in specific areas, based on existing evidence and experience.

A new surgical safety preoperative checklist (approved by the World Health Organisation) has been introduced in the Trusts' operating theatres. This has been implemented successfully within the Trust, with praise being received from the Patient Safety Campaign who was leading on this issue. The checklist has also been implemented in Interventional Radiology following an SUI.

The total number of incidents reported for the 2009/10 period, were 9845, (see **Table 8** below) which is up by 1275 from the previous year, the breakdown is as follows:

Table 8 Incident Reports

	2008/2009	2009/2010
Clinical Care	2539	3137
Communication/Staff Attitude	104	172
Facilities/Equipment	448	549
Fire	199	203
Safety Other	343	169
Safety Patient	2293	2583
Safety Staff	967	1096
Security	271	257
Staffing	893	1047
Triggers Obstetrics	493	492

The Risk Team report and discuss incidents at the Clinical Risk Committee, Falls Prevention Group, Statutory Safety Committee and Medication Incident Review meetings to ensure that a thorough analysis of incidents and trends is carried out and that lessons learnt from incidents are identified and action plans are developed to improve patient and staff safety. The 4 highest reported incident causes are: medication errors, quality of documentation, problems with patient transfers and problems with diagnostic tests.

A monthly report is sent to all Clinical Leads and Heads of Departments alerting them to their risks and giving them the opportunity to discuss them with staff, implement control measures to reduce the risk at a local level and record actions taken to change and improve clinical practice. A Clinical Governance Facilitator personally minutes many of the Incident Review meetings and requests minutes of those that are facilitated independently.

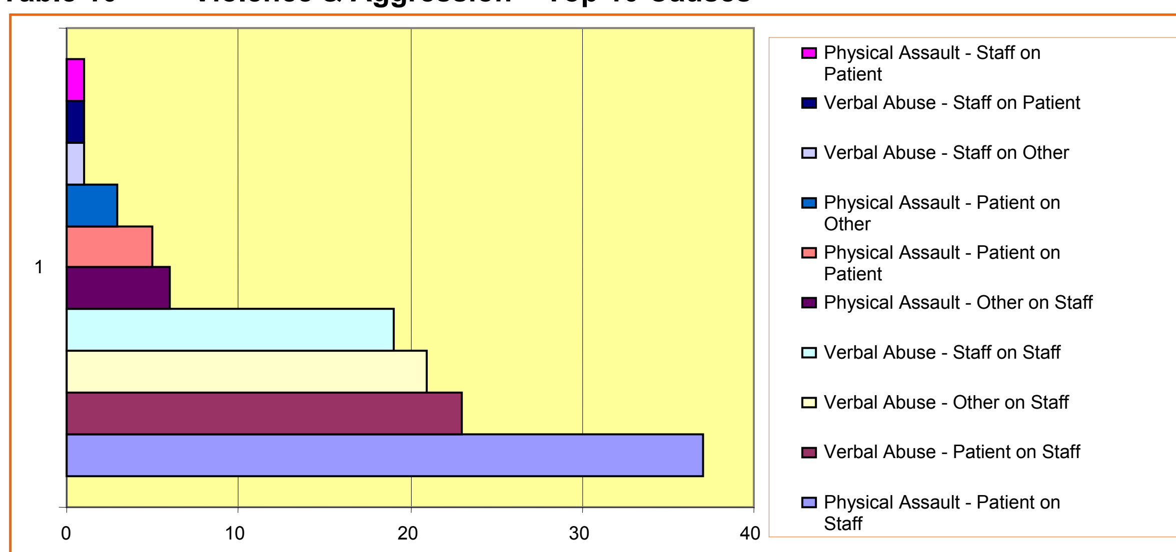
E. Violence and Aggression

The Violence and Aggression Working Group reviews incidents where staff, patients and visitors have been subjected to verbal or racial abuse, verbal or physical threats, or physical aggression.

The group consists of representatives from both the Trust and its partners: The Counter Fraud & Security Services Division of Parkhill Security Management Service, the Metropolitan Police Service, and Sodexo Security Management.

The implementation of the *Violence and Aggression Policy* and its associated 'green, yellow and red card' system allows the Trust to exclude offenders for a period of 12 months; with the exception of emergency medical treatment. Offenders are entered onto the Trust's violence and aggression risk register, and an alert is added to their electronic notes on PAS and SYMPHONY. Over the period there have been 63 green cards (verbal warning), 12 yellow cards (first written warning), and 3 red cards (final exclusion letter) issued. **Table 10** describes the top 10 violence and aggression incident causes.

Table 10 Violence & Aggression – Top 10 Causes



During March 2010 the Trust invested in safety alarms for those staff that work off site, alone. This initiative is fully supported by the Metropolitan Police, who will respond where it is reasonably practicable to red alerts raised in the community by lone workers.

To mark the NHS Security Awareness Month the Trust joined the local Metropolitan Police and the NHS Security Management Service in holding a security awareness day for staff and the public. The police were on hand to offer advice on security and our local Security Management Specialist, together with the Trust Health Safety & Fire Adviser were present to promote the reporting of violence and aggression

F. Emergency Planning

The table top exercise planned for 24th November 2009 was cancelled on the morning of the exercise due to extreme bed pressures. The Trust took part in a Multi Agency CBRN exercise on 28th March 2010 which resulted in the A&E department at Queen's Hospital setting up its decontamination unit and nominated staff wearing the full personal protective equipment.

Contingency planning is underway for the 2012 Olympics.

8.0 SAFEGUARDING CHILDREN AND ADULTS

In autumn 2009, BHRUT approved a business case for additional resources for the safeguarding team. The existing team comprising a Consultant Nurse and Named Midwife for Safeguarding, the Named Doctor for Safeguarding Children and Named Doctor for Safeguarding Adults, have been given to go-ahead to recruit 2 Band 7 nurses; one for children and one for adults, a Band 6 nurse for safeguarding children, two administrative posts and additional PA capacity for the safeguarding adults named doctor. Recruitment is in process.

A number of key documents have been, or are expected to be, issued by external bodies that will have an impact on safeguarding practice within the Trust. These documents are *Working Together to Safeguard Children, 2010* and *Safeguarding Adults Pan London Policy and Procedure*. A full review of the Trust's policies will take account of any changes required to ensure best practice is fully integrated.

A small number of staff have been trained on the *Mental Capacity Act and Deprivation of Liberty Standards* during the past year and further training is planned so that all staff will be familiar with the Act and their roles.

The Trust took part in 4 sserious case reviews (SCR's) that are undertaken when there are concerns about inter-agency working. The purpose of a SCR is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together.
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result, and as a consequence.
- To improve inter-agency working and better safeguard and promote the welfare of children and adults at risk.

9.0 MATERNITY GOVERNANCE

Maternity Services have seen a number of changes in the way it has delivered its services within the last year. One of the significant changes has been the commencement of a robust pathway for managing women with adverse outcomes. This was partly triggered by the NPSA Alert released in November on being open with patients, their families and carers following a patient safety incident.

Women that have raised concerns are being contacted regularly and kept updated with progress of any investigations and feedback; this process acknowledges their concerns and serves to improve their experience and satisfaction with the organisation.

Maternity Services have also increased capacity for the monthly multi-disciplinary training sessions as it was felt lack of capacity could result in some staff not receiving their annual mandatory training. Maternity education has increased, in terms of expectation and demand, and the team was expanded to accommodate the increasing numbers of new staff and existing members who required ongoing support and development.

Staffing levels continue to pose a huge challenge for the department in terms of medical and nursing staff. While further appointments of Consultant Obstetricians/Gynaecologists have been made to comply with the 98 hour Labour ward cover, there remains the continuing challenge of shortage of middle grade doctors. Action is being taken locally as well at Trust level. Recruitment of nurses and midwives is ongoing and the department has worked

extremely hard to reduce waiting times before newly qualified midwives are first interviewed for their first post.

Maternity services participated in CNST Level 2 in December 2009 and were outstandingly successful. This is a huge achievement for such a large Unit that delivers a large volume of women in any one year; there are challenges when deliveries result in adverse outcomes. It must be emphasised that staff are more accepting of the need to learn lessons from incidents, and following root cause analysis, these lessons are distributed by various methods including an extremely popular and effective method: `Message of the Week'.

With the drive towards a Birthing Centre planned for the immediate future, much planning is in place to achieve an environment for women which heavily promotes 'normality in totality', with outcomes that can only be welcomed by communities as the `norm' under the umbrella of childbirth. Safety will remain paramount irrespective of choice!

A. Care Quality Commission Alerts

The Care Quality Commission notified the Trust in March 2010 of the CQC analysis into the maternity indicators which showed a significant high rate of emergency maternal readmissions within 28 days of delivery. The maternity department carried out a detailed review using Dr Foster Intelligence covering the period in question, April 2008 – December 2009. This highlighted some new issues for the team and resulted in the following actions:

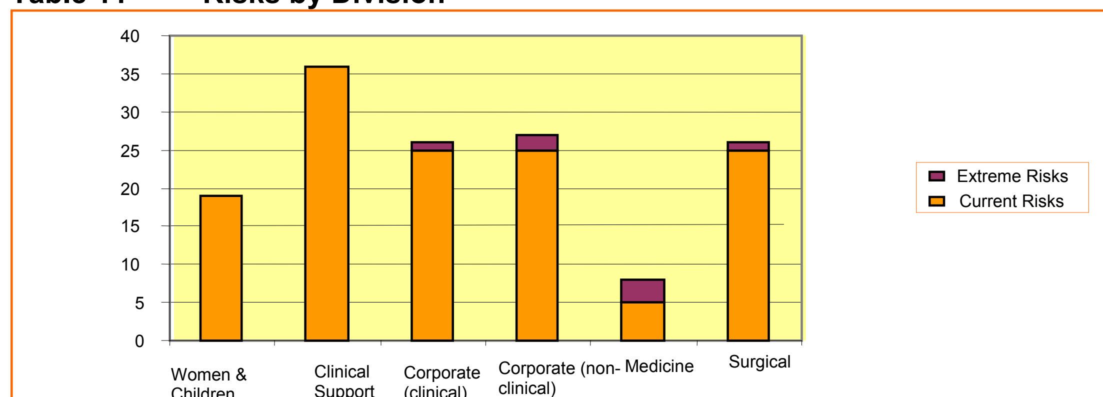
- Timing of discharge from community midwife
- Postnatal information for women
- Seniority of medical personnel admitting women within 1 month of delivery
- Review guidelines for admitting women postnatally
- Documentation for reasons for readmission of women
- Review of surgical and wound management processes for women having caesarean sections
- Inclusion of readmissions to the balanced scorecard to ensure continued monitoring of performance and to ensure effectiveness of actions

The full response was sent to the CQC within the tight timeframe requested.

10.0 RISK REGISTER

The risk register is now on the Ulysses database and quarterly reports are generated to the Divisions who then review their risks and update the register; all extreme risks are then incorporated into the Board Assurance Framework. **Table 11** below details the risks by Division.

Table 11 Risks by Division



11.0 BOARD ASSURANCE FRAMEWORK

During 2009/10 a review of the Board Assurance Framework (BAF) was undertaken to ensure that the principal objectives were linked to the relevant ambition. All extreme risks from the risk register continue to be linked to the BAF.

Prior to submission to the quarterly Audit Committee each Division receive updates via the electronic Safeguard Risk Management system. Divisions are required to undertake a review of their risks for review by the Audit Committee that provides assurance to the Board that risks are managed locally and are regularly reviewed. The BAF is reviewed by the Trust Board at every public meeting. The BAF was reviewed by the Trust's Auditors and was found to provide '**substantial assurance**' to the Trust Board.

12.0 COMPLAINTS

2009/10 represented a third year of full implementation of the Action Plan developed by the Clinical Governance Director to address the problems experienced by the Complaints Department in 2006/07.

The key target of the Plan for 2009/10 was to achieve at least a 40% reduction in the number of formal complaints received as against the total for 2007/08, representing a reduction from 1068 to below 640. This target was more than met (see **Table 12** below) which represented a considerable achievement for all Trust staff. The greatest progress was made in reducing the large proportion of complaints attributable to problems with communication, particularly associated with medical diagnosis and treatment.

Table 12 Combined Complaints

	Number	Status
Complaints - Local resolution	569	79% resolved within 30 days
Ombudsman Cases	1	Recommendations implemented.
Patient Advice & Liaison Service (PALS	9000	90% resolved within 15 working days

During the year the Complaints Department introduced a range of revised investigation and response arrangements to meet changes in the complaint regulations at the national level from April 2009.

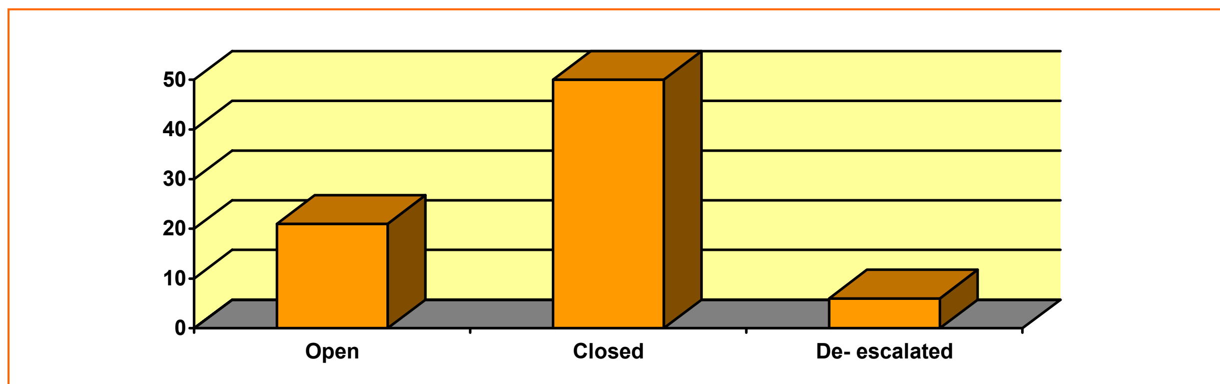
From April 2009 the PALS and Complaints Departments have offered a single seamless service, dividing contacts between them according to the seriousness and complexity of the subject matter and the wishes of the patient, carer or member of public concerned.

Interpreting services within the Trust are contracted in and managed by PALS at a cost of about £100,000 in the year from 1 April 2009 to 31 March 2010. In order to ensure that services are as cost effective as possible a telephone interpreting service is available since it avoids unnecessary costs when patients, for whatever reason, do not attend the appointment. However, many types of clinical activity require face to face interpretation as do many service users such as those requiring signing.

13.0 SERIOUS UNTOWARD INCIDENTS (SUIs)

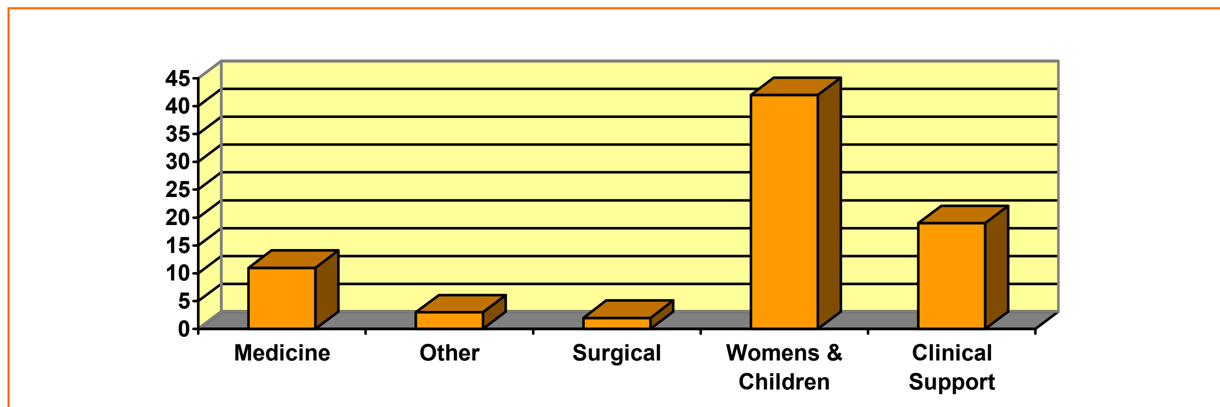
77 serious untoward incidents were reported via the STEIS reporting system during the period 1st April 2009 to 31st March 2010. **Graph 4** shows the status of the SUIs.

Graph 4 Status of reported SUI's

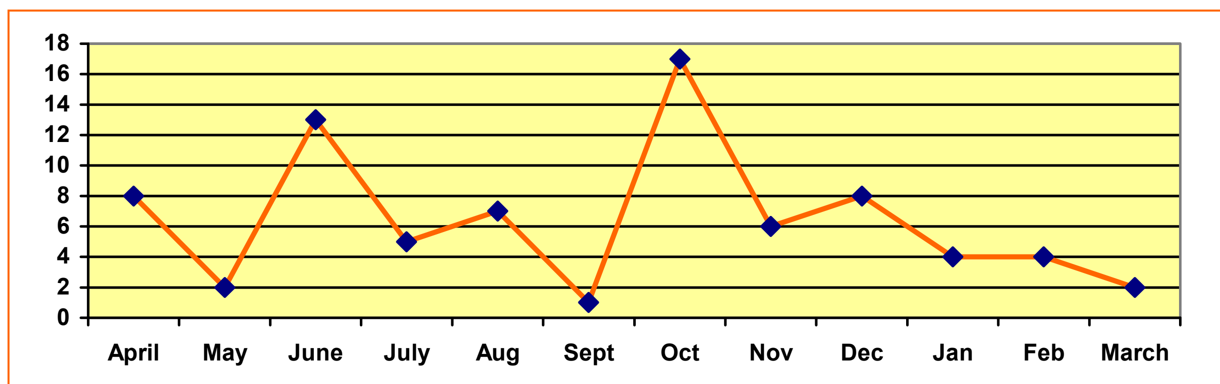


Of the numbers of SUI's reported 50 have been closed and 6 de-escalated after consideration by the Trust and NHS London. Queen's Hospital has been categorised a high risk site for maternal cases therefore are the highest reporters of SUI's. It is a requirement to report maternal intrauterine deaths and also now unexpected transfer of infant to NICU.

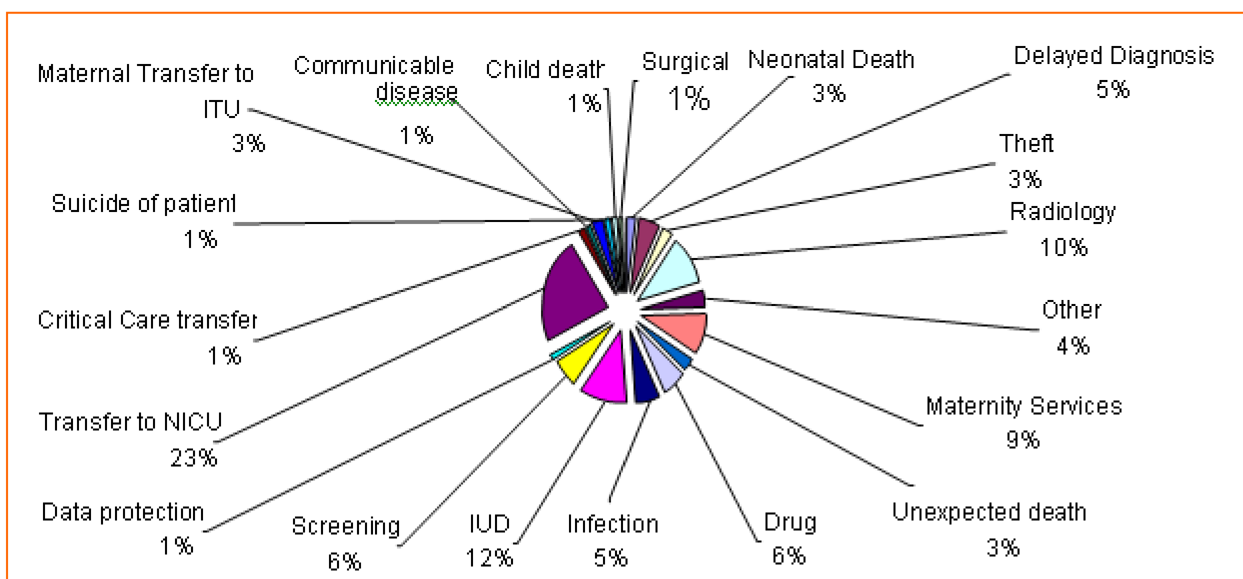
Graph 5 Divisional SUI's



Graph 6 Incidents reported per month



Graph 7 Type of incident



It should be noted that 12% of SUI's reported relate to Intrauterine deaths (this figure has decreased since last year, following greater clarification from NHS London regarding reporting criterion, however 23% of SUI's reported relate to unexpected transfer to NICU which was introduced as a reporting criterion this year

There are a number of issues that have been learned from Root Cause Analysis investigations and a number of actions that are required to be taken by the Trust. The recommendations and action plans are recorded on to the Trust database and followed up to ensure closure. Details are provided via the Safety Score Card to the Clinical Risk Management Committee and also to the Divisions for discussion

14.0 LEGAL CLAIMS AND INQUESTS

Table 13 highlights that clinical negligence claims have increased by 50% from Quarter 1 and remained at the higher level for Quarters 2, 3 and 4. This is consistent nationally with other NHS Trusts as the NHSLA have also reported a dramatic increase in the number of clinical negligence claims, which is likely to be a consequence of the economic situation.

Table 13 Clinical Negligence Claims

Case Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
CNST	21	46	44	44	155
Inquest	32	14	31	20	97
Total	**53**	**60**	**75**	**64**	**252**

At present the Trust has 313 clinical negligence claims being pursued. 37% of these are 'open' claims, which indicates that the formal legal process has begun and the Trust is in receipt of a 'Letter of Claim' and/or court proceedings. 63% of these are potential claims which are requests for medical records from Claimant's Solicitors in order to investigate a potential claim against the Trust. These do not always materialise into an 'open' claim and some claims are withdrawn.

The Directorates where most claims are received are Obstetrics, General Surgery and A&E. The common trends in cases mainly relate to failures / delays in treatment, failures / delays in diagnosis and inappropriate treatment being provided to patients. The costs to the Trust of these claims are shown in **Table 14**.

Table 14 Cost of Claims

Cost Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Damages	43,901	840,100	227,561	83,530	**1,195,092**
Defence Costs - Other	8.090	302,535	65,394	1,392	**377,411**
Plaintiff Costs	30,341	629,742	108,658	27,075	**795,816**
Total	**82,332**	**1,772,377**	**401,613**	**111,997**	**2,368,319**

15.0 CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)

In February 2010 the Trust was reviewed by the NHS Litigation Authority. The Trust retained its Level 1 accreditation status, but despite a huge amount of work was unsuccessful in its aim of achieving a Level 2 pass. Four areas were zero-rated under the NHSLA's concordat arrangements, which had increased the pressure on the remaining areas to achieve 100% compliance. It is well recognised that success at Level 2 is hard to achieve, especially for such a large organisation.

The Trust now has to be reassessed at Level 1 in 2010/11 before it can attempt a further Level 2 review in 2011/12. However, the impetus gained to move the Trust to a Level 2 organisation will be maintained to facilitate a better outcome at the next attempt.

16.0 STANDARDS FOR BETTER HEALTH

Core standards ceased to exist from the end of March 2010, as the new Care Quality Commission's (CQC) Registration process came into force. As there was a period of double-running of the two systems, and in order to minimise the workload for Trusts, the CQC required a mid-year declaration to be made, followed by an end-of-year update if there had been any changes.

BHRUT declared itself fully met with the core standards in December for the mid-year declaration but, following CQC unannounced visits and internal concerns, declared 'insufficient assurance' for two areas in April for the final declaration.

The first area identified was C11b – Mandatory training, where delivery against the existing action plan fell behind during the winter months in some areas. The revised action plan required a comprehensive training needs analysis to be revisited by each of the Trust's Divisions to ensure complete clarity around the numbers of staff that require mandatory training, at which level and the timescales for ensuring compliance.

The Trust also felt that for C11c – Appraisals there was also insufficient evidence that they had been taking place for all grades of staff on an annual basis. A subsequent review highlighted that staff felt the existing paperwork was confusing and a simplified version has now been developed and reintroduced through an intensive campaign to raise awareness of the changes made.

17.0 CARE QUALITY COMMISSION - REGISTRATION

The CQC required all NHS Trusts to register with them by the end of January 2009 under their new system as a 'Regulatory Body'. The registration process was extremely complex with clarity around some aspects delayed by the Parliamentary approved process that took place in December 2009.

The registration procedure required the Trust to identify its main locations and these were considered to be Queen's, King George and Victoria Hospitals and the Sydenham Centre in Barking. Details of the services offered on each site needed to be incorporated into a 'Statement of Purpose' that was also recommended for public consumption, and is available on the Trust's website. Information about nominated individual senior staff members for each location was also required and any changes to this information must be notified to the CQC for any absences over 28 days.

The actual standards against which the organisation is now measured have been refocused. Whilst policies and procedures are still important, the emphasis is now, quite correctly, on the patient experience, quality and outcome of their care. Each Division was asked to review their compliance against the new Regulations, by specialty, and to report back where it was felt there were concerns. These concerns were discussed at the Trust's Strategy & Service Improvement Board and the decision taken, endorsed by the Trust Board, that the Trust was compliant with all areas except:

Regulation 15	Safety and suitability of premises at the Sydenham Centre
Regulation 16	Safety, availability and suitability of equipment at the Sydenham Centre
Regulation 22	Staffing at Queen's (medicine and maternity / midwifery) and at King George Hospital (medicine).

Since that initial declaration, forms to vary the Sydenham Centre registration have been submitted to the CQC. The concerns identified have been rectified as the services provided from the Sydenham Centre move into the new building at Barking Community Hospital.

Actions to address staffing levels are being led by the Executive Director of Nursing, with workforce plans reviewed and recruitment drives are underway locally and in Europe.

Following the submission in January the CQC placed conditions on the Trust's registration in a number of areas, giving deadlines when full compliance must be achieved. The areas are:

- Resuscitation training
- Appraisal
- Discharge planning
- Staffing levels
- Child protection training
- Nurse mandatory training
- Use of treatment rooms

Comprehensive action plans, led at Executive level are in train to ensure the deadlines on these conditions can be met, and the conditions removed.

18.0 CARE QUALITY COMMISISON - SURVEYS

A. Inpatient Survey 2009

The Trust participated in the Care Quality Commission National Inpatient Survey and Outpatient Survey. For both surveys the Trust commissioned contractors 'Quality Health' to undertake the survey on their behalf.

Data of 850 patients for both surveys was supplied by the Trust, with additional data cleaning carried out by National Statistical Tracing Service to ensure removal of deceased patient data. Data was required to fulfil the criteria and time period laid down by the Picker Institute who co-ordinate national surveys on behalf of the Care Quality Commission. Results from both surveys were presented to the Trust Board and disseminated across the organisation.

The five priority areas selected for demonstrating improvement are:

1. Medication management and information provision
2. Respect, dignity and confidentiality
3. Nutrition (assistance with meals)
4. Pain management (including diversity of pain)
5. Hand hygiene (adherence to the Hygiene Code)

Short term subgroups have been formed to focus on the priority areas. The membership is multi-disciplinary, including patient representative from The Improving Patient Experience Group. The Commissioning for Quality and Innovation (CQUIN) related questions from the national survey have been incorporated into the relevant subgroups.

The subgroups report on their progress monthly to the Patient Experience Committee which reports quarterly to the Nursing and Midwifery Board.

B. National Outpatient Survey 2009

A multi-disciplinary implementation group has been established to monitor progress against the action plan for 2010.

The action plan has been drafted with the following priorities areas:

- Customer care skills training of front line staff
- Communication and the provision of information
- Dignity and privacy during consultation
- Cleanliness of the environment

C. Improving Patient Experience Group

The Improving Patient Experience Group (IPEG) works under joint chairmanship of a patient representative and a Non-executive Director of the Trust. It has agreed Terms of Reference and is developing a wide reaching work programme. The Co-Chair of IPEG attends the Patient Experience Committee and the Clinical Governance Committee and IPEG members attend the public section of the Trust Board meeting. Some of the activities for 2009/10 include:

May 2009: An IPEG led patient satisfaction survey of the outpatient clinic areas at both Queen's and King George

Aug 2009: Freshwater Healthcare Focus Group - IPEG invited.

Sept 2009: Health4NEL Consultation - IPEG invited.

Oct/Nov 2009: Promotion of IPEG in Atrium at Queen's Hospital.

Nov/Dec 2009: via email, members assisted Darzi Fellow, Dr Rahul Seewal in reviewing the patient considerations in developing a Back Pain pathway.

Feb 2010: Tour of Queen's, Asst. Director & 2 Co-Chairpersons and Patient Environment and Action Team (PEAT) Inspections.

Ongoing: Membership on four of the five subgroups of the Patient Experience Committee. The represented subgroups are:

» Medication management and information provision
» Respect, dignity and privacy
» Hand hygiene
» Pain management

March 2010: Attendance at Design for Patient Dignity Event, Co-Chair and Review of Patient Information Booklet on behalf of the Communication department.

D. The Patient Experience Committee

The Patient Experience Board was established in November 2009. There has since been a change in the name to Patient Experience Committee (PEC) to more accurately reflect the purpose and terms of reference of the group.

The Committee includes representatives from patient forums, internally and externally, multi-disciplinary clinicians, chaplaincy, PALS, Communications, Clinical Governance, IPEG, Facilities Services and User Volunteer Sector.

The Committee identifies from the National Patient Experience Action Plan issues requiring improvement within the Trust ensuring these are owned and embedded within relevant staff and departments and benchmarked against National Survey. Real time surveys and feedback from patients is being driven by the Committee so that meaningful quality data can be obtained to inform changes in practice and service and provide positive outcomes.

E. Local Surveys

In addition to the national surveys, the Trust completed a dignity survey in March 2010 which incorporated questions on same sex accommodation; the results have been forwarded to NHS London. A declaration regarding the virtual elimination of same sex accommodation is available on the Trust website.

The Trust is currently tendering for a supplier of an electronic system to enable it to introduce real time patient surveys. The selection process is due to be completed in August 2010 with surveying to start in September. More information on progress with this initiative will be included in the 2010/11 Clinical Governance Annual Report

To improve the information provision and accessibility for patients with learning disabilities, the following improvements have been made:

- Easy read leaflets have been introduced into the Trust. An article has been placed in *The Link* e-magazine outlining the 'easy health' website.
- Membership on the Health subgroup of the Learning Disability Partnership Group.

- The Trust has been represented at The Learning Disability 'Big Health Check' activities in which patients and their carers, providers and commissioners of services collaborate to determine the agenda for the local population
- Introduction of Learning Disability staff resource packs.

Future plans include membership of Learning Disability Partnership in Barking & Dagenham and Redbridge and the introduction of a mechanism to flag vulnerable patients, including those with a learning disability.

19.0 PROGRESS WITH 2009/10 OBJECTIVES

Table 15 below outlines progress with the 2009/10 objectives laid down in the 2008/09 Clinical Governance Annual Report.

Table 15 Progress with 2008/09 Objectives

Objective	Progress
Governance	
Ensure mid-year S4BH self-assessment is completed and declaration made.	Mid-year and full year declarations made within timescales for core standards. Declaration available on Trust website.
Achieve CNST Level 2	CNST level 2 was not achieved, but Level 1 status retained. Four areas assessed under Concordat arrangements were zero-rated (ALE KLOE 4.1 and PMETB scores)
Facilitate Care Quality Commission's new Registration system that replaces Standards for Better Health from April 2010.	Staff guided through registration process. Registration deadlines fully met and on-line documentation submitted to CQC.
Development of best practice for BHRUT using NICE guidance, national audit data and internal intelligence to achieve robust clinical safety.	EBPC extremely active in monitoring implemented new technology
To meet infection control targets and maintain HCAI registration.	Met.
Establish Divisional benchmarking using internal KPIs to improve clinical quality	Each Division has clinical governance data on a monthly basis and has agreed local 'never events'.
Safety	
Develop and implement Patient Safety First campaign.	Strategy developed and initiatives included e.g. WHO checklist.
Nominate patient safety champions to further support the Safety Strategy.	Clinical Leads to be nominated in Divisions – in progress.
Improve staff safety through raising awareness.	Staff awareness through a range of internal media.

20.0 KEY CLINICAL GOVERNANCE OBJECTIVES FOR 2010/11

The following governance objectives are shown in **Table 16** and will underpin the work of the department for the coming year.

Table 16 Objectives for 2010/11

Objective	Milestones	Reporting Mechanism	Achievement Measure
Governance			
Develop and publish the Trust's Quality Account in line with Dept. of Health guidance.	June 2010	PEQ / Trust Board	Publication of Quality Account and submission to the Secretary of State.
Maintain CNST Level 1 in 2010/11 and progress towards Level 2 achievement in 20011/12.	Informal Review – Oct 2010 Formal Review – Feb 2011	PEQ / Trust Board	Level 1 retained with good score. ALE KLOE 4.1 score = 3 PMETB score = 2 Evidence collection for Level 2 maintained.
Reduce HSMR to be in-line with National Standards	Red bells & high level indicators developed	Clinical Governance Committee	Dr Foster tool
Facilitate full compliance with the CQC conditions to Registration placed on the Trust by 31st December 2010.	Treatment Rooms – 30.4.10 Discharge Planning / Pressure Damage 30.6.10 Staffing / Child Protection / Mandatory Training – 31.7.10 Appraisal / Resuscitation – 31.12.10	PEQ / Trust Board	Conditions removed from CQC Trust Registration to deadline. Improvements maintained and monitored.
Review and implement use of CQC self-assessment tool for maintaining Registration evidence database	Compliance tool introduction – 31.7.10 Key initiatives identified across the Trust for 'hotspots' Location compliance forms completed – 31.8.10 Evidence folders – 30.9.10	PEQ / Trust Board	Understanding of CQC compliance requirements by SROs Location evidence listed and evidence folders in place.
Safety			
Zero tolerance for infections	Full RCA for each case	Infection Control Committee	Staying below trajectory
Implement Global Trigger Tool	June 2010	Clinical Governance Committee	Trust Board approved in June Implement over Q 2/3
Develop rigorous internal scrutiny processes.	Awareness of shortfalls	Clinical Governance Committee	No external assessment surprises
Develop NHS Innovations trigger tool for use within Trust	Action plan described through CQUIN	Clinical Governance Committee	Increased patient safety