St George's Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD: JANUARY 2014

Paper Title:	**Risk and Compliance Report**
Sponsoring Director:	**Peter Jenkinson** Director of Corporate Affairs
Author:	**Sal Maughan** Corporate Risk and Assurance Manager
Purpose:	To update the Board on compliance related issues/risks and related developments occurring across the Trust and provide assurance about the management of risk.
Action required by the board:	For information and discussion as required
Document previously considered by:	Quality and Risk Committee

Executive summary

Key messages

- The significant risks on the Board Assurance Framework are presented following review at Executive Management Committee and Quality and Risk Committee
- An overview of the programme of work underway to prepare for re-inspection and to sustain on-going compliance with CQC standards is provided.

Recommendation

The Board is asked to note:

- The update to the CQC action plan in response to areas of non-compliance
- The updated analysis of the Intelligent Monitoring Report and the significant level of assurance this provides, resulting in the Trust being placed in the lowest risk banding nationally.

The Board is asked to agree:

- The quarterly Board governance statement for self- certification

Risks

The most significant risks on the Board Assurance Framework are detailed in the report

1. Risks - Board Assurance Framework (BAF):

This report identifies the extreme risks on the BAF, new and closed risks during the reporting period and significant changes made following regular review at Executive Management Team. Table 1 details the highest rated risks on the BAF, the risk score for two risks have reduced. Details of these risks are included at Appendix 1:

Table one: highest rated risks

Ref	Description	C	L	Rating (prev)
A534	Failure to provide adequate supporting evidence for all the CQC Essential standards of Quality and Safety	**5**	**3**	**15**
A602	Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year.	**5**	**4**	**20**
3.2-05	The Trust does not deliver its cost reduction programme objectives	**5**	**3 (4)**	**15 (20)**
A509-O8:	Trust unable to achieve readiness for FT status by planned authorisation date as per agreed TFA	**5**	**3 (4)**	**15 (20)**
A513	Failure to achieve the National HCAI targets	**4**	**4**	**16**

1.1 Closed Risks

There has been one risk closed during the reporting period. The rationale for closure is detailed in Table two.

Table two: closed risks

Domain	Risk	Rationale
Patient Safety	A608-O8 - Strategic clinical decisions made without sufficient input from clinician	Proposal to close risk as there has been evidence of full engagement on several large projects including hybrid theatre, OPD, Helipad & 5th Floor SJW works.

1.2 New Risks

There have been four new risks included on the BAF during the reporting and review period as detailed in Table three:

Table three: New risks

Domain	Risk
Patient Safety	01-03 Lack of embedded process for use, provision and maintenance of bed rails
Patient Safety	01-04 Risk to patient safety should the organisation fail to meet its statutory duties under Section 11 in respect of number and levels of staff trained in safeguarding children.
Patient Safety	01-05 Risk to patient safety arising from a lack of standardised and centralised decontamination practice across several areas of the Trust.
Finance	3.7-05 Minimise financial impact of Better Care Fund

In addition to the above, following review by the Executive Management Team, a further risk, which escalated from the Medicine and Cardiovascular Divisional Risk Register is proposed for inclusion on the BAF:

- Patient Safety: Patients may not be effectively monitored due to the telemetry system within cardiology wards being in need of urgent replacement.

2. Assurance Map

The Trust Assurance Map is a schedule of all external visits / inspections which captures actions on-going in response to external visits and those underway to prepare for forthcoming visits. The assurances received from these external inspections help inform the Board as to continued compliance with regulatory requirements including Care Quality Commission Essential Standards of Quality and Safety. The following section provides a summary of all external visits and inspections during the reporting period.

2.1 Care Quality Commission (CQC)

2.1.1 CQC Unannounced Inspection

The CQC carried out an unannounced inspection on 15th – 17th August and in response, the Trust submitted an action plan on 6th November to address issues of non-compliance. A significant proportion of actions are complete with good progress against those which remain on-going. An update to the action plan is attached at Appendix 2.

2.1.2 Action on-going to prepare for CQC Chief Inspector of Hospitals inspection: Feb 2014

A steering group has been established to oversee preparations for re-inspection, its membership includes both Executive leads and Divisional Directors of Nursing and Governance.

The programme of work overseen by the steering group includes several work-streams:

- Oversight and monitoring of corporate CQC action plan
- A detailed programme of actions to address issues identified through a detailed gap analysis of corporate quality inspections and divisional self-assessments
- An overarching communications plan to raise awareness and prepare staff for re-inspection
- A focussed programme of spot checks on wards, clinics and departments including community settings
- Oversight of estates and facilities programme of works in relation to issues identified
- Oversight of information provision to CQC
- Logistical planning to support the CQC team in ensuring a cohesive and balanced inspection across all sites.

2.1.3 Divisional CQC assessment and declarations of compliance

Throughout quarter three, divisions have undertaken self-assessments of compliance across all wards and areas, using a standardised audit tool. These assessments are intended to inform a divisional declaration of compliance with the CQC standards. The divisional declarations will be agreed at the Divisional Governance Board in January 2014 and this declaration will be a quarterly requirement of all divisions going forward. This requirement will be reflected within the Trust Compliance Framework which is currently under review.

2.1.4 CQC Process – Internal Audit outcome

In December 2013, an internal audit was undertaken to provide assurance in respect of the following:

- There is a governance structure which provides assurance to the Trust Board of on-going compliance with the requirements of the CQC; and
- There is a robust and consistent process for regularly assessing and assuring compliance against the requirements of the CQC within the divisions.

The final report has been considered at the Trust Audit Committee in January and an overall reasonable level of assurance was determined. Recommendations for medium priority actions are included within the final report.

2.2 Summary of external assurance and third party inspections Nov - Dec 2013

2.2.1 Shared Services – Speciality Focused Visit

The shared services, speciality focused visit took place on 19 and 20 November 2013. Haematology, ICU, Core Surgery, Trauma and Orthopaedic, and Cardiology were all subjected to an inspection.

The Trust has been sent the final report, checked it for factual inaccuracies and returned it to the GMC (on 10.01.2014). There are no serious/patient safety concerns – although the Trust has been issued a series of recommended and mandatory action points.

2.2.2 Sterile Services: Re-accreditation ISO 13485:2012; ISO 9001:2008; and CE (Annex V)

The United Kingdom Accreditation Service (UKAS) audited the Trust's sterile services between 27.11.2013 – 29.11.2013. The objective was to ensure compliance with three essential standards: ISO 13485:2012; ISO 9001:2008; and CE (Annex V).

Only three minor non-conformities were identified. An action plan was submitted to UKAS before deadline of 29.12.2013. On 09.01.2014 the Trust received formal confirmation that all non-conformities have been cleared. Certificates of accreditation should be received very soon.

2.3 Pending inspections Jan – Mar 2014

2.3.1 UNICEF Baby Friendly - Stage 3

UNICEF UK Baby Friendly assessment at Stage three is scheduled for February 2014, the Trust is fully prepared for this assessment.

2.3.2 G4S – UKAS Quality Management Certification (9001)

The United Kingdom Accreditation Service (UKAS) will be auditing G4S' capacity to deliver patient transport services that conform to nationally recognised standards and the Trust's own policy objectives. This is scheduled to occur in March 2014. The G4S Quality Standards Manager has provided assurance that they are well-prepared for this accreditation.

2.4 External Assurance - conclusion

In conclusion, there has been good progress and positive assurance received by the CQC Steering Group as to the effectiveness of actions underway to address the areas of non-compliance and issues of note identified in the most recent CQC inspection. A robust programme of work to prepare for re-inspection in February continues, which has been further strengthened by a full programme of divisional self-assessments. Several additional items of positive external assurance have been received resulting in a reduction in the levels of risks currently captured on the Board Assurance Framework. There are no other significant issues of concern arising from other external visits/inspections.

3 Intelligent Monitoring Report

The monthly Quality Risk Profile (QRP) report has now been replaced by the Intelligent Monitoring Report, a quarterly report, the first of which was published on 22nd October 2013, to date there has been no updated report released.

It is the CQC's intention to use the Intelligent Monitoring Report to make better informed decisions around the risks present within a Trust which will, in turn, inform the focus of inspections.

Based upon this report, each Acute Trust has been placed in a Risk banding commensurate with the level of risk identified through this data monitoring. This Trust has been placed in band 6 - the lowest category of risk as judged by the CQC. The bandings are based on the risk that people may not be receiving safe, effective, high quality care with band 1 being the highest risk and band 6 the lowest.

Table four details the three potential risks identified in the current Intelligent Monitoring Report. The relevant Trust lead is identified for each and an update has been provided as assurance regarding the highlighted risks as at Jan 2014:

Table four: identified risks

Level of Risk	**Indicator**	**Observed**	**Expected**	**Description of data & source**	**Assurance**
Risk	**Incidence of MRSA**	10	3.59	Count of MRSA Bacteraemia during the period: **Aug 2012 to Jul 2013**. (Numerator - total person bed days). Data Source: Public health England	YTD data demonstrates a continually improving trajectory in relation to HCAI infections.
Risk	**Potential under reporting of patient safety incidents resulting in death or severe harm**	0.4	1.49	Count of severe harm or death incidents: **July 2012 – June 2013**. (Numerator - total person bed days). Data Source NRLS	The Trust's process for identifying, considering and declaring potential incidents in this category has been externally validated by the CCG and is found to be robust. The Trust has high level s of reporting which is indicative of a positive safety culture.
Elevated Risk	**Whistle-blowing**	9 (One or above = elevated risk)	0	High level details of 9 whistleblowing alerts have now been received. Some alerts are generic in their terminology making it difficult to ascertain specific services/areas.	Where identifiable, all issues highlighted through alerts have been fed back to relevant Trust leads and have been incorporated into programme of preparedness for CQC re-inspection.

3.1 Conclusion

In conclusion, the Intelligent Monitoring Report, low risk banding and improved CQC report in August 2013, when considered in conjunction with other external assurances, provide a significant level of assurance around continued Trust compliance with regulatory requirements. In addition, where necessary appropriate actions are in place to improve and sustain compliance.

4 Board Governance statements for self-certification

This section of the report sets out the quarterly Board Governance Statement required by Monitor as set out in the document Applying for NHS Foundation Trusts Status: A Guide for Applicants (April 2013).

Detailed assurances were considered when agreeing the Trust's self-certification at the previous Trust Board in November 2013. There has been no material change in the assurances underpinning each statement and the reporting position remains unchanged. Where a risk remains the rationale is provided. The statements of compliance are correct as at November 2013.

The Board is asked to consider each statement detailed in table five and confirm whether they agree with the proposed self-certification, or require any revisions to be made prior to submission to the NTDA.

Table five: Board Governance Statements for self-certification

1	**The board is satisfied that plans in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements.**	**YES**
2	**The board is satisfied that processes and procedures are in place to ensure all healthcare professionals providing care on behalf of the trust have met the relevant registration and revalidation requirements.**	**YES**
3	**Issues and concerns raised by external audit and external assessment groups (including reports for the NHS Litigation Authority assessments have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner.**	**YES**
4	**All recommendations to the Board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned.**	**YES**
5	**The necessary planning, performance management and risk management processes are in place to deliver the integrated business plan, including but not restricted to:** **a) obtaining and disseminating accurate, comprehensive, timely and up-to-date information for board and committee decision-making;** **b) the timely and effective scrutiny and oversight by the board of the trust's operations;** **c) effective financial decision-making, management and control; and** **d) taking appropriate account of quality of care considerations.**	**YES**
6	**An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).**	**YES**
7	**The board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets (after the application of thresholds) as set out in appendix B of Monitor's Compliance Framework; and all known targets going forwards.**	**RISK**
	Updated assurance/rationale: **MRSA:** The Trust has had 4 cases *of MRSA by the end of Q3*. The Monitor Compliance Framework 2013-14 confirms the Monitor annual *de minimis* limit for	

	cases of MRSA as 6. The Trust is within this and therefore considers itself to be compliant for Q1 - Q3. **C-Diff:** The Trust has had 26 C-diff cases to date against a YTD trajectory of 39, making the trust compliant for this measure. **Cancer**:-The Trust was non-compliant against the 62 Day target in November with 80.8% of patients seen against a target of 85%. This underperformance follows an improvement in Augusts' which has since proved challenging to maintain. The year to date position is 83.6%. All other cancer targets are being met. **ED Performance:-**Performance has improved for the month of December with 95.0% of seen within 4hours, for both Type 1 and Type 3 performance and 94.4%. for Type 1 only. For Quarter 3 (October-December 2013) performance stands at 94.2% for all Types and 93.5% for Type 1 only. The Trust is on YTD trajectory for all other compliance framework requirements.	
8	**The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance (IG) Toolkit.**	**YES**
9	**The board has in place a register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans to ensure any Board vacancies are filled.**	**YES**
10	**The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.**	**YES**
11	**The selection process and training programmes in place ensure that non-executive directors have appropriate experience and skills.**	**YES**
12	**The management team has the capability and experience necessary to deliver the integrated business plan**	**YES**
13	**The management structure in place is adequate to deliver the integrated business plan, including but not restricted to:** **a) Effective board and committee structures** **b) Clear responsibilities for the board, for committees to the board and for staff reporting to the board and those committees** **c) Clear reporting lines and accountabilities throughout its organisation**	**YES**
14	**The Board has considered all likely future risks to compliance with the NHS Provider Licence and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach of conditions occurring and the plans for mitigation of these risks to ensure continued compliance.**	**YES**

Signed for and on behalf of the Board:

Title: **Christopher Smallwood, Chairman**

Date: 28th November 2013
Trust: St. George's Healthcare NHS Trust

Appendix 1

Principal Risk	A534-O7:Failure to demonstrate full compliance with the CQC Essential Standards of Quality and Safety				
Description	Lack of a sufficiently robust approach to self-assessment and subsequent actions to ensure compliance may lead to a CQC inspection finding of non-compliance. Improvement and/or enforcement action imposed by the CQC with associated reputational risk and risk to the FT application Ref BAF Risk A509. Ultimate risk of loss of licence to operate certain services.				
Domain	**3. Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Current**	**Update**	**Exec Sponsor**	Peter Jenkinson
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	3	3	3	**Date closed**	
Score	15	15	15		

Controls & Mitigating Actions	**Controls:** Quality inspections launched October 2013 with reporting via divisional management and EMT Corporate and Divisional action plans completed with on-going monitoring through divisional governance boards, Patient Safety Committee and QRC. Programme of staff for a re-launched to support wider understanding of issues around compliance. Quality surveillance data monitored and appropriate action ensured in response - reported as part of overall CQC compliance monitoring update to Trust Board via Risk and Compliance Report. Programme of staff briefings to raise awareness of standards and actions required to ensure compliance. Programme of divisional mock-CQC inspections **Mitigation:** Internal and external stakeholder management to highlight excellence in patient safety and clinical effectiveness – clinical outcomes.	**Assurance**	**Negative**: CQC unannounced inspection Jan 2013: 6 out of 8 standards non-compliant with three standards deemed to have moderate impact upon people who use services and three minor. Internal audit report identified gaps in the current evidence collation at divisional level. **Positive**: Final report from August inspection shows significant improvement from January inspection – compliance in 5 out of 8 standards and minor impact in other three standards. Publication of CQC assessment of trusts into risk 'bands' (October 2013), based on quality surveillance data puts trust into band 6 (lowest risk).

Gaps in controls	Monitoring and testing compliance in practice is not embedded – schedule of quality inspections now launched as business as usual, supported by divisional self-assessment Compliance framework requires review in order to support required improvements in achieving, monitoring and sustaining compliance. – Being developed with divisions with completion by December 2013. Gaps in staff understanding of CQC compliance agenda – staff briefings to continue.	**Gaps in assurance**	The Trust is in wave two of CIH inspections so next inspection due January to March 2013
Actions next period:	Review quality inspection programme and audit tool to incorporate further learning around potential new standards and inspection regime. Scope and timescales for review of compliance framework to be finalised and review commenced Project to commence encompassing further training and support from Corporate team to ensure HealthAssure CQC module is embedded within divisional practice to support overall compliance agenda.		

Principal Risk	A602.1-O1 Pressures on internal capacity may result in the Trust being unable to meet demands from activity, negatively affecting quality, throughout the year.
Description	Requirement for high activity volumes in some specialities. Potential for commissioner challenges and financial penalties There is an unlimited demand on A&E which will may impact on increase in emergency admissions A rise in emergency admissions impacts on capacity for elective admissions, time that theatres are not in use and 28 day rebook timeframes. Variable demand may impact on patient pathways and negatively affect patient safety. Delayed transfer of care and repatriation patient delays to host hospitals block beds for emergency/elective activity. Winter pressures relating to Flu, diarrhoea & vomiting symptoms increase demand on side rooms and closure of beds. There are reduced numbers of discharges at weekends and on bank holidays causing capacity problems on the next working day/s Pressure on bed capacity and failure to meet operational targets both emergency and elective Use of bank/agency staff to staff escalation areas Loss of Trust income due to elective cancellations Adverse reputation

Domain	1. Quality			Strategic Objective	1.1 Patient Safety
	Original	Current	Update	Exec Sponsor	Miles Scott
Consequence	5	5	5	Date opened	01/11/2012
Likelihood	4	4	4	Date closed	
Score	20	20	20		

Controls & Mitigating Actions	**Controls:** Implementation of several schemes to address capacity, encompassing: - Surgical assessment Unit - Grey & Vernon wards - Critical Care - Cardiology Schemes to address capacity issues submitted to NHSE & NTDA. Additional work-streams implemented, assisted by ECIST review recommendations: • Bed management review • ECIST toolkit on internal waits • Opportunities for managing patients elsewhere • 7 day consultant cover • Management of frailty **Mitigations:** • Seek additional external capacity • Cap demand for services	**Assurance**	Internally funded winter plan & externally pursuing with commissioners. Programme of applications for additional winter funding Participation in Urgent Care Board ECIST review (September 2013)
Gaps in controls	The summer period saw a higher level of activity than predicted, and this resulted in bed pressures that exceeded those in the winter. Revised the capacity modeling completed Sep 13 shows the trust is at risk of a difficult winter, even after the additional capacity we have planned has been put in place.	**Gaps in assurance**	
Actions next period:	• Initiating capacity planning for 14/15		

Principal Risk	3.2-O5 Cost Reduction slippage. The Trust does not deliver its cost reduction programme objectives: Objective 3- to detail savings plans for the next two years				
Description	•Opportunities for savings schemes are not identified •Opportunities to save are not sufficiently developed to deliver the value required •Savings identified within schemes are overoptimistic / savings are double counted •Savings are redeployed •Savings schemes are not delivered as planned •Savings identified are only non-recurrent				
Domain	**2. Finance & Operations**			**Strategic Objective**	**2.1 Meet all financial targets**
	Original	**Current**	**Update**	**Exec Sponsor**	Steve Bolam
Consequence	5	5	5	**Date opened**	01/12/2012
Likelihood	4	4	3	**Date closed**	
Score	20	20	15		

Controls & Mitigating Actions	Controls Benchmarking St. George's services to ensure that opportunities for CRP savings are identified through avenues such as: ▪ SAFE analysis of productivity opportunities ▪ Albatross HRG reference cost comparison ▪ Civil eyes Consultant performance comparison ▪ Service Line Management Over-programming ▪ Additional Schemes to be developed above annual requirement as a contingency against under-delivery Programme Management Office (PMO) ▪ Role of PMO in managing CRP programme. ▪ Rigorous PID and POD development to support CRP projects. ▪ Director oversight, review and sign-off of projects to ensure that only projects that have a realistic chance of delivery are agreed and implemented. ▪ Risk assessment of all schemes, challenge on the value of savings achievable and monitoring of scheme progress, with reporting	**Assurance**	Audit Reports Internal review of PMO processes by Governance Team Benchmarked controls against Monitor's guide on "Delivering Sustainable Cost Improvement Programmes" (19-01-2012). Audit Reports Internal review of PMO processes by Governance Team Audit Reports Internal review of PMO processes by Governance Team TDA review of Trust CIP governance

	back to F&P Committee and the Board. ▪ Appointment in 2013/14 of interim Divisional CIP leads. ▪ Future CIP strategy to identify pipeline of future projects. Service Improvement Team GE Organisational change/ Lean (See Programme Plan for Exemplar site) ▪ Development of in-house expertise Development of savings culture Mitigating Actions 1.To develop further in-year non-recurrent CRP projects to offset the non-delivery of the full CRP programme. These would include: ▪ Vacancy freezes ▪ Reductions in procurement spend ▪ Slowing of in-year capital programme 2. Bring forward of future years schemes – with a two year programme of CIP projects in place, the trust will bring forward schemes from future years to offset under-performance in the CIP programme in year TDA CIP review group.		
Gaps in controls	Over-programming yet to be achieved Lack of consistent pipeline of future projects	**Gaps in assurance**	
Actions next period:	Update rolling 2 year CIP programme with detailed PIDs covering 14/15 and 15/16 Develop 'fighting fund' for additional contingency Agree proposal for support on 16/17 to 18/19 programme development		

Principal Risk	A509-O8: Trust unable to achieve readiness for FT status by planned authorisation date as per agreed NTDA Accountability Framework
Description	External economic environment. Failure to achieve performance targets.

	Inability to demonstrate implementation of robust quality governance processes in particular CQC compliance. Lack of commissioner support. Lack of support from NTDA for current timescale due to financial performance, including CIPs. Trust's reputation is adversely impacted. Future status of Trust in doubt if FT status is not achieved by 2014				
Domain	**3. Regulation & Compliance**			**Strategic Objective**	**3.1 Maintain compliance with all statutory and regulatory requirements**
	Original	**Current**	**Update**	**Exec Sponsor**	Peter Jenkinson
Consequence	5	5	5	**Date opened**	31/10/2010
Likelihood	3	4	3	**Date closed**	
Score	15	20	15		

Controls & Mitigating Actions	Close monitoring of external economic environment and adaptation of strategy/approach accordingly. CIP/Finance controls as per finance risks. Clear action plan and performance management milestones in achieving Foundation Trust Status & risks managed at programme level. Capacity Risk Management. QGAF assessment and BGAF assessment completed.	**Assurance**	Monthly oversight meeting with TDA covering performance and FT readiness. Reported to Board via CEO report. QGAF assessment score 3.5 confirmed by Deloitte April 2013. IBP checked by TDA & Deloitte (May 2013). Negative:
Gaps in controls	The board to board with the TDA now agreed for March 2014, due to the new CQC inspection regime and the TDA requirement that all aspirant FTs must go through a new style inspection before going into the Monitor phase. Trust submissions to TDA due by 2 January 2014.	**Gaps in assurance**	Exec to Exec meeting with TDA confirmed for 28-Jan-14 Board to Board meeting with TDA to be confirmed, end March 14
Actions next period:	Continue the implementation of the action plans relating to QGAF, BGAF and HDD. Confirm date for completion of CIPs for 14/15 and 15/16, for submission to NTDA. Board approval of submissions in November 2013. Additional letters of support to be obtained.		

Principal Risk	A513-O1: Failure to achieve the National HCAI targets for MRSA and C Diff				
Description	The target for MRSA is set at 0 cases (zero tolerance) and 45 case for C. Diff for year 2013/14 The Trust's reputation is adversely affected Foundation Trust application affected Loss of patient &public confidence in the Trust Risk of patient harm				
Domain	**1.Quality**			**Strategic Objective**	**1.1 Patient Safety**
	Original	**Current**	**Update**	**Exec Sponsor**	Alison Robertson
Consequence	4	4	4	**Date opened**	31/05/2010
Likelihood	3	4	4	**Date closed**	
Score	12	16	16		

Controls & Mitigating Actions	Bi-weekly taskforce meeting and bi-monthly Infection Control Committee meeting Regular reports to the Patient Safety Committee, EMT & Trust Board Infection Control score card used to monitor monthly progress Regular communications sent to support practice and raise awareness to ensure staff adhere strictly to diarrhoea protocol Divisional action plans presented to the taskforce as required Zero Tolerance statement on the Trust intranet Bi-monthly antimicrobial steering group chaired by Medical Director Consultant level information circulated on a regular basis Screening request form on which doctors now confirm patient's working diagnosis – suggestive of infection and requires screening RCA carried out for each infection (MRSA, MSSA &Cdiff) Infection Control Policy in place	**Assurance**	Overall trajectory has now recovered. (26 reported against threshold 45:end of Dec 2013) CQC Compliance with Outcome 8: Infection Control (Aug 2013) Peer review completed in January 2012. - Feedback is positive. Best practice visit to Southampton in May 2013. MRSA – 4 cases, all investigated via RCA – no themes emerging Infection control action plans subject to review by internal audit – reasonable insurance. Peer review of infection control nursing team (By Barts& the London Trust) final report agreed with recommendations
Gaps in controls	BAF risk 01-01 Informatics to support production of real time data	**Gaps in assurance**	
Actions next period:	Continual revision of infection control action plan (last update Oct 13). Increasing number of consultants champions for infection control. Continuing regular cleaning inspections and recurrent themes from inspections circulated		

	Weekly line care rounds & C:diff rounds on-going. Competence assessment document for taking blood cultures developed and now out for consultation – expected to be approved Jan 14 Pack for peripheral line insertion in place (to be considered for blood cultures also) Focus on improving decontamination practice services not utilising TSSU – meeting with Trust De-Con lead (HA) Director of E&F (ND) and DIPC (AR) STNC have since purchased more nasendoscopes Analysis and actions in relation to latest audit of line care.

Appendix 2

Issue identified by CQC	Area	Action to be taken and what you intend to achieve	How to ensure this is sustainable / Measure or test of Effectiveness	Who is responsible for this action?	Date for completion	Update 15th January 2014
Outcome 9: Management of Medicines						
Patients were not protected against the risks associated with medicines, because the temperatures of some medicine storage areas were not monitored consistently. Staff were not monitoring the minimum and maximum temperatures of the drug fridges on most of the areas we visited.	All	Pharmacy Dept to lead and manage a thermometer calibration service for all drugs fridges. Standard Operating Procedures to be implemented to cover temperature monitoring, action in response to out of range readings, de-frosting, Ward Manager sign-off and escalation process. Existing quarterly meetings between Pharmacy and Ward Managers to have drug fridge monitoring on their agenda.	This will become embedded into everyday clinical practice. Compliance will be monitored through existing medication safety visits, audit of safe and secure handling of medicines and included in the quarterly review meeting between the ward manager and ward pharmacist.	Chris Evans, Chief Pharmacist.	End of Jan 2013	• Standard operating procedures implemented Roll out staff training including ward manager sign off • Implementation of service and audit has been done. • Compliance with drug fridge monitoring through existing medication safety visits, audit of safe and secure handling of medicines and included in the quarterly review meeting between the ward manager and ward pharmacist • Current out-standing actions include: -training of staff at audit of process at some community service clinics (including Doddington clinic, Tooting health clinic, Stormont and Eileen Leckie) -audit of process at HMPW • Ward pharmacy staff to continue in-going training and audit of process , as part of the overall medicines management

Issue identified by CQC	Area	Action to be taken and what you intend to achieve	How to ensure this is sustainable / Measure or test of Effectiveness	Who is responsible for this action?	Date for completion	Update 15th January 2014
Outcome 13: Staffing						
There were not always enough qualified, skilled and experienced staff on the Trevor Howell In-patient Ward and the Trevor Howell Chemotherapy Day Unit to meet patient needs. Patients experienced delays in their treatment and staff felt under pressure due to staff shortages. Staffing numbers for the ward were also not always filled.	Med & Cardio	Co-ordinated and prioritised recruitment campaign to fill all vacancies developed. Recruitment actions now all completed but on-going actions as part of a retention plan.Status at 6.11.13:Trevor Howell Day Unit: one outstanding post - to be filled by end of Nov 2013Trevor Howell ward: 3 band 6s still vacant but to be filled by end of Jan 2014.	Staffing levels assessed and recorded daily and reported to Head of Nursing. Monitoring of PALS enquiries / comments, complaints, friends & family test, vacancy levels, staff turnover.	Alison Hughes.Divisional Director of Nursing.Medicine & Cardiovascular.	End of Jan 2014	• Trevor Howell Day Unit now fully established to current levels. • Trevor Howell Ward - 3 of 7 band 6 posts currently vacant. • Agreement to add recruitment and retention premium to chemotherapy trained band 6 nurses.

Issue identified by CQC	Area	Action to be taken and what you intend to achieve	How to ensure this is sustainable / Measure or test of Effectiveness	Who is responsible for this action?	Date for completion	Update 15th January 2014
Outcome 21: Records						
Patients on Brodie Ward were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.	Surgery, Theatres, Neuro& Cancer	Daily review of 6 sets of nursing records at 14.00 by nurse in charge. In the event that a patient has triggered on Early Warning Score (EWS) the nurse in charge will review the medical notes to ensure appropriate escalation has occurredWard sister reviewing nursing documentation on a daily basis as part of the handover processQuality ward rounds completed regularly by senior staff which includes a review of EWS scores and documentationEWS competencies to be re-assessedEWS to be a regular item on the neurosciences education programmePerformance management of staff who fail to meet competency	Trust EWS auditsDisplay of daily results on ward performance indicator board.% of staff reassessed against EWS competencies% of staff attending EWS education session	Helene AndersonDivisional Director of Nursing. Surgery, Theatres, Neuro& Cancer	End of Dec 2013	20/01/14 update: • Brodie Stroke = October 2013 training= 92% of relevant staff - process of reassessment will be 100% by end of January 2014. • Brodie Neuro = 100 % October 2013 - process of reassessment now in progress

Issue identified by CQC	Area	Action to be taken and what you intend to achieve	How to ensure this is sustainable / Measure or test of Effectiveness	Who is responsible for this action?	Date for completion	Update 15th January 2014
Outcome 21: Records						
Patients on Caroline Ward were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.	Med& Cardio	Identified concerns with documentation discussed widely at team and care group meetings to raise awareness. Monthly documentation audits in place. Spot checks of documentation during senior nurse quality rounds.Pathways being created for conditions often associated with thoracic procedures / illnesses that can be individualised.Staffing levels reviewed and establishment increased to enable less reliance on bank and agency.Electronic documentation being introduced Feb 2014.	Through regular audit and spot checks.Full recruitment - reduction in use of band & agency.	Alison Hughes.Divisional Director of Nursing.Medicine & Cardiovascular.	End of Feb 2014	• Monthly documentation audits completed and show continued improvement. • December results 93% on accurate completion and 94% on use and accuracy of EWS. • Care pathways created for conditions commonly associated with thoracic procedures and in use. • Recruitment into vacancies continues. Currently 1.39 of 7WTE band 6 vacant, 3 of 18WTE band 5 vacant.