Dear John/Ursula

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S&H
Have good w/end

INTRODUCTION

Governance is the responsibility of all staff but statutory responsibility, corporate ownership, direction and facilitation lies with the Trust Board. The purpose of governance is to ensure the continuous improvement in the quality of care and service delivery to the community we serve. The review by the Commission for Health Improvement (CHI) is an integral element in achieving this outcome. Portsmouth Hospitals Trust is currently undergoing its first CHI review. The purpose of this paper is to provide the Board with:

- An overview of CHI progress
- Specific issues identified
- Areas of notable practice
- Action already taken
- Action plan

CONTEXT

The national drivers for change have given rise to a complex local agenda with which the Trust is faced. This has adversely impacted on stability. In the light of both these matters, the Trust acknowledges that there is a need to build the confidence of all key stakeholders across the health and social care economy if we are to successfully manage and deliver the agenda in partnership. Internally, the Trust has moved on significantly since the start of the review. In part this has been as a direct result of appointments to the two posts of Clinical Governance Manager and Head of Risk Management, Complaints and Legal services. A number of new appointments have also been made at Executive level that has further strengthened the strategic capacity of the organisation. Whilst being mindful of the external agenda, recent efforts have concentrated on addressing the internal infrastructure and culture. Inevitably this process is evolutionary requiring both direction and focus. We are mindful of some deficiencies particularly around ownership of the emerging structure and the appointment of appropriate people to help in the delivery of the agenda We are confident, however, that the emerging infrastructure and change in culture will provide the means through which an effective governance agenda can be delivered.

1. An overview of CHI Progress

The CHI review process at Portsmouth Hospitals Trust (PHT) commenced on 3 September 2001 and is now in the 12th week of the 24 week programme.

Submission of Information by the Trust:

The initial part of the review was completed on 24 September 2001 and included the submission of information on the Trust's profile, strategies, business plans together with detailed information on all the components of clinical governance.

Stakeholder Meetings:

On 22 October 2001. CHI concluded public meetings in relevant localities at which members of the public were invited to talk about their experiences of PHT. In addition, CHI met with key stakeholders such as the Health Authority, Community Health Councils, Primary Care Groups/Trusts to record their experience of PHT.

Patient Diaries:

From four randomly selected consultant clinics two hundred patients were identified to complete diaries The selected patients had attended PHT, either as an in or out patient during the previous 6 months and fitted into one of the following categories

- Unplanned elderly admission (65 years or over) - Dr J Watkins and Dr T Farrell's clinic
- Unplanned admission (under 65 years of age) - Mr M Thompson's clinic
- Chronic Admission - Dr E Neville's clinic
- Patients on a waiting list - Dr H Clarke's clinic

Each patient received a diary with a request that they record their experience whilst in the care of PHT.

Summary of Evidence

A summary was prepared from an analysis of the submitted information. It will form the brief for the site visit due to commence on 10 December 2001. The summary was received in the Trust on 31 October 2001 allowing 4 working days to review and comment on the factual content.

Selection of the Clinical Teams

CHI used the information submitted by the Trust, and the stakeholder information, to select the clinical teams on which the focus of the review will be based. These teams are not intended to be representative of the whole Trust but to provide evidence of clinical governance effectiveness. The Trust was required to nominate five areas in which teams have made good progress with clinical governance. These are:

- Diabetes and Endocrine Centre
- Department of Genito-urinary Medicine
- Accident and Emergency Department
- Directorate of Child Health
- Intensive Care Unit

THIS WILL GO OUT ON MONDAY – NEEDS ALTERING One of the above teams, selected by CHI, will be included in the final selection of clinical teams. The Trust will be informed of the clinical team selection by CHI on the 9th November 2001. Thereafter, the CHI project office will immediately contact the selected clinical teams to arrange interview schedules. Unfortunately, due to the time constraints, there will be little flexibility when arranging interview appointments.

The Site Visit

The CHI review will commence on 10 December 2001 and will be conducted by a multidisciplinary team. The duration of the visit is five and a half days. From each clinical area selected, a team will be required to present an overview of how clinical governance is making a difference to the patients' experience of care and services. The review team will then visit all PHT sites to observe and conduct interviews with staff.

In addition, an interview schedule has been jointly agreed, to ensure that the review team meets with all key corporate members of the organisation.

Reporting

The CHI Review Team will reconvene two weeks after the site visit to agree their key findings. These will then be fed back orally to the Trust by the CHI Review Manager on the week beginning 21 January 2002. The first draft of the report will be made available to the Trust on 4 February 2002. The Trust will have the opportunity to comment on factual inaccuracies and will be required to return the report to CHI within five days of receipt. The final report will be published in March 2002.

Specific Issues Identified

As a result of the appointments of a number of new posts identified above the Trust undertook an informal internal review of the arrangements for governance. This coincided with the formal notification of the pending CHI review. The outcome of this identified the following themes. The need for:

- More effective engagement with local partners that would allow us to jointly address particular aspects of clinical services where it is perceived that there are deficiencies.

- A cultural shift. From the evidence to date it is apparent that the culture of the organisation is key to the success or otherwise of implementing governance. This requires an understanding of the nature of the current culture at an organisational, professional and team level.

- Closing the loop. The organisational framework is insufficiently developed to allow appropriate follow-up action on identified weaknesses.

- Acknowledgement and appropriate follow up action on patient identified issues. We know from our experience of the Patient Experience Forum there is a need for an educational agenda around patient expectations, governance and service planning and delivery.

The specific issues which need addressing are:

Audit, Standards and Effectiveness
- Implementation of NSFs, NICE, HiMP, Care pathways and confidential enquiries -> actioned
- Assessment of ethnic health needs -> actioned
- Closing the audit loop -> actioned
- Closing the clinical indicator loop -> actioned
- Use of audit across the interface with external organisations -> actioned
- Increased mortality rates in non-emergency general surgery and radiotherapy -> no action plan
- Day case overstay rates high -> no action plan
- Clinical indicators v pooling -> no action plan
- High rate of D&C and grommets -> no action plan
- Discharge planning -> ? action plan
- Integrated stroke service development required -> ? action plan

Education, Training and CPD
- Review education and training strategy -> actioned
- Low uptake of statutory and mandatory training -> actioned

IM&T
- No ethnicity coding in PAS -> action plan
- Staff access to IT -> action plan
- Appropriate staff training for IT -> action plan
- Compliance with information for national, regional and local requirements -> action plan
- Communication strategy -> ? actioned
- Appropriateness of clinical coding -> ? actioned

Patient Involvement
- Patient views to inform governance activities -> actioned
- Patient information leaflets re surgical procedures etc-> actioned
- Patient information leaflet on complaints process -> actioned

R&D
- Activity linking to governance activity -> actioned

Risk, Complaints and Legal Services
- Inappropriate handling of complaints -> actioned
- Management of risk reporting -> actioned
- Management and review of serious clinical incidents -> actioned
- Linkage of incidents/complaints/claims -> actioned
- Lessons to be learned from complaints -> action plan
- Staff training in the handling of complaints -> action plan
- Hospital acquired infection/pressure sores to inform risk management system -> action plan

Staffing and Staff Development
- Appointments made to clinical posts, in line with identified gaps in service provision -> actioned
- Review HR strategy -> action plan

Strategy and Responsibilities
- Governance at divisional level -> actioned
- Revised governance strategy -> actioned
- Greater integration with RHH -> actioned
- Trust ownership of a just culture -> actioned
- Governance links with clinical practice ethics committee -> actioned
- Closing the loops within and between the pillars of governance -> actioned
- Availability of governance information on hospital intranet -> actioned
- Integration of clinical governance/business planning –> action plan
- Annual governance report -> action plan
- Insufficient recognition of inequalities – service and staffing –> action plan
- Corporate policy management and ownership -> action plan

Areas of Notable Practice

It should be noted that there are many examples of innovation and improvement in service delivery over the last few years. These include:

Corporate
- The establishment of a highly visible Health Information Centre
- Systems management of drug errors
-

Womens and Childrens
- The establishment of a 24 hr direct access emergency gynaecology ward
- Same day obstetric ultrasound scanning service
- Paediatric emergency service

Surgery
- HNU – Beacon site
- General Surgery sub specialised to allow free referral of elective/emergency patients between consultant pool ensures patient under care of appropriate specialist
- Preoperative assessment and multi-disciplinary working to achieve minimal in-patient stay following total hip replacement at RHH
- Nurse-led case management from preoperative assessment to discharge in urology/general surgery to enhance the patients' experience

Medicine
- Expansion of the rapid access chest pain clinic
- Joint development with PCT colleagues for a Consultant nurse in diabetes

- Nurse Specialist in Rheumatology to improve quality of care through rapid patient access and increased throughput.
- One stop clinic for a range of cancer patients
- Nasal support ventilation on HDU preventing patient transfer to ITU
- Development of a nurse led outreach service, including clinics

Portsmouth Hospitals NHS Trust
Clinical Governance Action Plan: PRIORITIES

Objective	Action to be Taken	Expected Outcome	Named Lead	Target Completion Date
Management				
Unification of clinical policies between RHH and PHT			John Bevan	
Integration of Clinical Governance into the business planning process	To ensure clinical governance is on the appropriate agendas for business planning	Clinical governance informs business planning	Code A	December 2001
	To ensure business planning is on the clinical governance committee agenda	Clinical governance informs business planning		
Mechanism to ensure all components of governance are interlinked			John Bevan	
Trust Board receiving information on National Patient Surveys	6 monthly updates to Trust Board by PALS Manager. Last one November 2001	Board members will be properly briefed	Code A	Ongoing in November and April each year (noted in list of Standing Board Agenda Items)

Controls Assurance: Decontamination	See attached : Decontamination Review Controls Assurance standard		**Code A** (Deputy Director of Planning)	
Objective	**Action to be Taken**	**Expected Outcome**	**Named Lead**	**Target Completion Date**
Organisation of Clinical Governance				
The Trust is able to demonstrate improvement in care at clinical service level			John Bevan	

Consultation and **Patient Involvement**				
Implementation of the recommendations from patient surveys	See attached: • Action on Recommendations of Patient Experience Survey • Action on Food Audit		**Code A**	

Clinical Risk Management				
Regular, systematic feedback on adverse events: • Adverse Clinical Incidents • Complaints • Claims	• Regular monthly feedback within the Risk Department to link incidents, complaints and claims and identify trends / common themes • Regular feedback on specific issues via Link • Introduction of root cause of analysis of major / catastrophic events. Information fed back to specialty / division (staff involved, senior nurse, clinical director) who then draw up action plans with a named lead for action and implementation and review date. Copy also held in Risk Dept for tracking and trending • Specific project on adverse medication incidents / errors + associated education and training • Dedicated leads identified within Risk Department for specific risk issues (e.g. missed results) and specialities (e.g. ITU) within the Trust • Head of Risk has started to attend a variety of meetings: renal unit, surgical directorate; maternity department; medicine division • Feedback given at clinical governance committee and through divisional strategies • Introduction of new database (Datix) to commence 15th November 2001. To facilitate ease of data entry, production of appropriate, specific reports and enable correlation to be made between incidents,		Sheena King	

Clinical Risk Management cont'd				
The Trust Board follows up on changes of practice as a result of complaints	Trust Board to receive regular reports which reflect any trends in complaints and any changes made, or which need to be made, as a result of those trends	Increase in Trust Board awareness of trends in complaints and any action or resources necessary to ensure relevant changes are implemented	Sheena King (Head of Risk Management, Complaints and Legal Services)	Introduce by February 2002 but will be ongoing process
Mechanism are in place to centrally collect information on verbal complaints	All verbal complaints are recorded centrally : brief details and number received per month. Reported to Trust Board every six months.		Sheena King	COMPLETED

Clinical Risk Management cont'd				

The Trust deals with complaints in a timely manner	• Vast percentage of complaints acknowledged in a timely manner
	• Changes to processes by which complaints are handled, to ensure they are dealt with in a timely manner
	• Dedicated staff members identified to cope with current backlog of complaints, for which necessary information has been received but still awaiting final response
	• New complaints (on receipt) to be divided into clinical / non clinical. Clinical complaints to be further divided into medical and nursing
	• Dedicated, experienced staff members identified to deal with each category
	• Non-clinical complaints to be resolved within 7 working days
	• Clinical complaints to be graded – 1,2,3 : 1 can be resolved with no additional information required
	: 2 can be resolved with addition of limited information e.g. via a telephone call
	: 3 can only be resolved following input from doctor / nurse. Staff members will then:
	  • Send clinician relevant Pt records + letter, which will identify issues to be answered
	  • Visit clinician and formulate response
	  • Compile final response letter and forward to CE for signature
	  • Head of Risk Management to receive weekly status reports in order to monitor progress
			Sheena King	To be introduced by 20th November 2001

Clinical Risk Management Cont'd				
	• Vacant full time Complaints Officer post to be filled		Sheena King	
Information is published to inform patients of the right to and process to follow when making a complaint	Leaflets available across the Trust		Sheena King	COMPLETE
The adverse incident reporting process is used appropriately	• Appropriate policies in place • Use of adverse incident reporting system identified / monitored – good uptake • Recognition that a small percentage of adverse incident reports are being used inappropriately		Sheena King	

Clinical Risk Management cont'd				
The number of pressure sore incidents are reduced			Code A	
Controls Assurance requirements for Health and Safety Management are met			Code A	

Clinical Risk Management cont'd				
Resuscitation Training is undertaken by all staff annually	Trust takes full ownership for sta development ensuring service staffing levels are adequate and allow for staff training and development Ward Managers ensure resuscitation training is included in personal development plans (PDP) PDP's are followed up to ensure they are implemented Adequate resourcing of resuscitation department to ensure it can meet demand		**Code A**	
Clinical Audit:				

There is a system in place to assess changes in practice as a result of audit – monitoring implementation of audit recommendations	• Re-audits • Audit Manager to write to audit leads asking for written progress report for our audit annual report • CASE Committee to chase progress reports	Discussed at our September CASE Committee meeting agreed to: • Develop and maintain a database for all audit projects undertaken in the Trust • Develop a system to send a letter to each audit lead after six months of finish date asking for progress report on implementation of agreed action plan	**Code A**	COMPLETED September 2001 November 2001
Monitoring of the implementation of audit recommendations takes place	• Database to update standards, achievements and agreed action plans and progress reports • Regular review of specialty audit	• Review of existing information systems and develop new database to capture all activity • Regular reports to divisional CASE	**Code A**	November 2001 COMPLETED April 2001

Research & Effectiveness				
There is an established central mechanism to monitor evidence based guidelines – NICE / ICP's/ NSF's			John Bevan	

Research & Effectiveness cont'd				
Confidence is restored in clinical information – clinical coding			John Bevan	
Information / Data and use of Information				
All staff have access to the Internet / Intranet			**Code A**	

Information / Data and use of Information cont'd				
A systematic, co-ordinated approach to the collection of clinical information is established			John Bevan	
Management of Medical Records is improved			Code A	
Appropriate foreign language leaflets are available	Effective progress in place to identify leaflets and departmental information requiring translation.	All departments to have leaflets available in foreign languages	Code A	February 2002
	Ensuring that all departments are aware of the procedure for the translation of documents and have access to agencies.	Information translated to be available in all areas		

Information / Data and use of Information cont'd				March 2002
Communication materials to be made available for those with visual and hearing impairments	To provide information on tapes and videos for those with visual and hearing impairment.	Tapes and videos accessible to those with hearing and visual impairment. Provision of above in foreign languages.	Code A	
	Ensure resources are available to fund the provision of tapes and videos.			November 2001
	Extent of funding required to be established.			November 2001
	Identity source of funding			December 2001
Ethnic coding of PAS information is undertaken	Prior to March 2001 the PAS system contained the 'original' national codes for ethnic coding. These codes are included in the Data sets for 99/00 and 00/01 supplied to CHI (see attached sheets) In March 2001 the PAS system was upgraded to include the 'new' (DSCN 21/2000) codes. These are currently in use and can be seen in the 2001 / 2002 data sets supplied to CHI (see attached sheets)		Code A	

Information / Data and use of Information				
The Trust complies with the information requirements of the NHS ie HES, common information core			Code A	
Staffing and Staff Management:				

Human Resources Strategy			**Code A**	

Staffing & Staff Management cont'd Compliance with 'New Deal'			Code A	

Medical staff compliance with 'Working Time Directive is recorded - monthly attendance records			**Code A**	

Staffing and Staff Management cont'd A mechanism / body is established that ensures the Trust complies with it's duties under the Race Relations Act			**Code A**	
Education, Training and Continuing Personal and Professional Development:				

An Education and Training Strategy is developed			**Code A**	

Education, Training and Continuing Personal and Professional Development cont'd				
Multidisciplinary training takes place			**Code A**	

An induction programme for locum staff is established			Code A	
Education, Training and Continuing Personal and Professional Development cont'd				
A reporting mechanism to feed back on performance to staff agencies is established			Code A	

A training needs assessment is undertaken			**Code A**	