Supporting Paper 2.4

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Annual Complaints Report

2013/2014

1.0 Introduction

This report presents a summary of the feedback and trends identified by the Complaints Team during the year 2013/2014. The aim of this report is to provide an overview of trends identified through the complaints process. The report outlines how the Trust responded to the complaints and identifies the action the Trust has taken to improve services in response to concerns and complaints.

2.0 Background

The current complaint handling regulations were introduced in April 2009 (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Statutory Instrument), together with guidance from the Department of Health ('Listening, Responding, and improving 2009"). A direct relationship between the Ombudsman and health bodies is embedded within the complaints system's structure. The Ombudsman has stated that when the NHS listens to patients and takes action on what they say, it can make a direct and immediate difference to the care and treatment that patient's experience.

In February 2013, the Francis report was published. The Francis Report highlighted serious failures with the complaints process and the performance of the Trust Board. The report said: 'It [the Board] did not listen sufficiently to its patients or its staff or ensure the correction of deficiencies brought to the Trust's attention …' Trust boards should be looking at what is happening on their wards and where there are problems they must act or be responsible for the failings.

In response to this report, the Government established a review into how NHS hospitals deal with complaints, led by Ann Clwyd MP and Professor Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust. In October 2013 their review of the NHS hospital complaints system was published "Putting Patients Back in the Picture". The report looked at 2,500 accounts of poor care and lack of compassion. The report makes recommendations about the quality of care, addressing the causes of complaints, improving access and responsiveness of the complaints system, and recommending that hospitals adopt a new attitude to complaints. The review recommended that it must be made easier for patients and families to raise their concerns if they have any and that NHS organisations should use complaints positively to improve care.

In November 2013, the Department of Health published Hard Truths: The Journey to Putting Patients First. This was the government's response to the Mid Staffordshire Public Inquiry. The response sets out a series of measures that in the future will ensure people know what the system knows, whether hospitals are safe, how well they are led and what patients say about their experiences. Improving the way in which the NHS manages and responds to complaints is critical in shaping a culture that listens to and learns from patients. The Government wants every hospital to encourage feedback, making it clear how they can complain, how to get independent local support and informing them of their right to complain to the Ombudsman if they remain dissatisfied.

Through its complaints policy, the Trust ensures that people, and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.

The regulations no longer stipulate a specific time-scale for responding to complaints; the Trust has therefore determined three levels of response to complaints and concerns, together with set targets for response (see Table 1).

Table 1: Grading of Concerns and Complaints

Type	Description	Timescale for Response	Target for Response
Type 1	Low Risk**[MPALS]**	10 working days	> 90%
Type 2	Medium Risk	25 working days	> 90%
Type 3	High Risk	50 Working days	> 90%

3.0 Total Complaint Numbers: Monthly Trend

Table 2: Number of Complaints/ Performance, April 2011 –March 2012

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number Type 2	29	37	32	34	31	37	37	34	40	39	35	34	**419**
Performance	76%	73%	75%	85%	84%	81%	95%	82%	70%	69%	97%	82%	**80%**
Total number Type 3	3	1	1	2	1	0	3	4	2	0	0	0	**17**

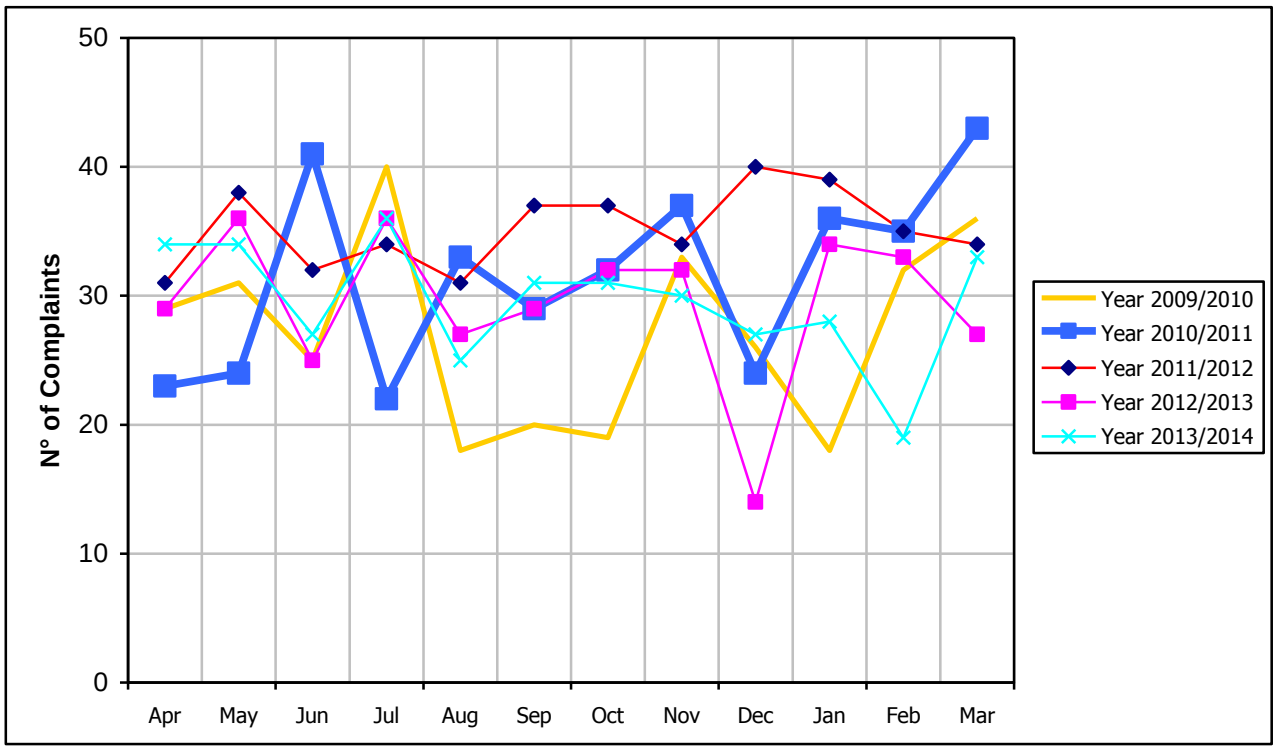
Table 3: Number of Complaints/ Performance, April 2012 –March 2013

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number Type 2	29	36	25	36	27	29	32	32	14	34	33	27	**354**
Performance	69%	83%	80%	75%	89%	86%	84%	88%	64%	80%	79%	78%	81%
Total number Type 3	2	1	0	2	1	2	0	2	2	1	7	3	**23**

Table 4: Number of Complaints/ Performance, April 2013 –March 2014

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number Type 2	34	34	26	34	24	29	31	30	25	25	19	33	**344**
Performance	88%	82%	81%	86%	75%	79%	68%	93%	72%	88%	74%	94%	82%
Total number Type 3	1	0	1	2		2	2	0	1	3	0	0	**12**

Graph 1: Type 2 Complaints Received between April 2009 and March 2014



The graph compares the number of complaints received each month during the current financial year with the four previous years. A total of 344 type 2 were received during the year 2013-2014; (82%) were responded to and resolved by the Directorates within 25 days. This falls below the Trust target to respond to 90% of Type 2 complaints within 25 days. A total of 12 type 3 complaints were received during the year 2013-2014. The response times for the type 3 complaints was extended to 50 working days to allow for the type of investigation required. All complaints identified clinical care as the primary subject. 3 complainants received a response after 50 days [range 44-116 working days].

Graph 2: Specialities Type 2 Performance 2013-2014

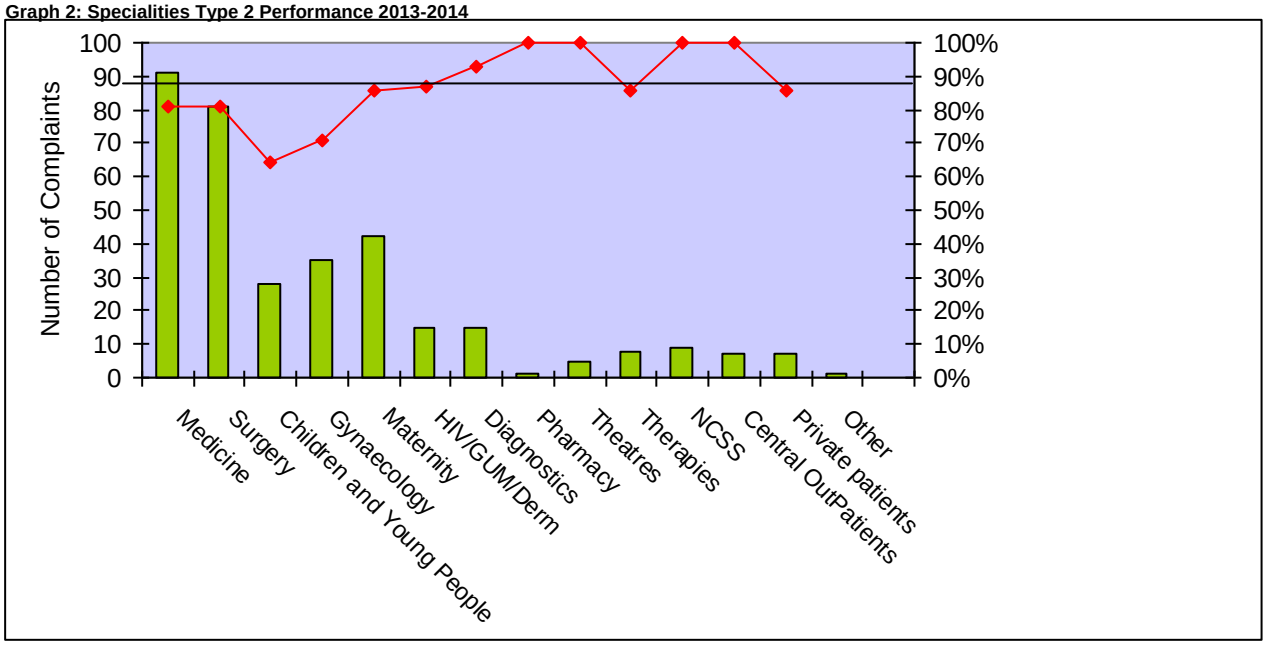


Table 5: Total Number Complaints by Directorate: April 2013-March2014

Directorates	Type2	Type3
Clinical Support Services	29	
Central Outpatients	7	
Medicine	91	5
Surgery	81	
HIV/GUM/Dermatology	15	1
Paediatrics and Neonatology	28	2
Gynaecology	35	1
Maternity	42	2
NCSS	9	1
Private patients	7	
Other	1	
Total	344	12

3.1 Complaints upheld

If any or all of a complaint is well founded then it should be recorded as "upheld locally." It is always difficult to be clear about the upheld decision particularly for those softer elements such as staff behaviours. Complaints relating to clinical care may arise due to a lack of understanding on the part of the patient. In terms of outcome categories the Trust has recorded the following.

Table 6: Outcome Categories April 2013-March2014

Apology	190	Complaints
Explanation	101	Complaints
Change in practice	54	Complaints
Reimbursement	8	Complaints
Re- training/supervision	3	Complaints

4.0 Complaints by Area

The areas with the highest number of complaints during the year of 2013-2014 are:

Table 7 2013-2014 Areas with Highest Number of Complaints April 2013-March2014

Adult Emergency Department	40	Complaints
Labour Ward	14	Complaints
AAU	13	Complaints

4.1 Emergency Department

Table 8: ED by Primary Subject and Staff April 2013-March2014

	CLINICAL CARE	ATTITUDE	INFORMATION	OTHER
Medical Staff	22	4	2	1
Nursing Staff	5	2	1	1
Admin Staff		2		

During the year, 40 complaints were received relating to the Adult Emergency Department including 8 complaints about the Urgent Care Centre. 27 concerns were raised relating to the clinical care received in the Emergency Department during the year. These are analysed in section 5.1.2.

5 complaints were received relating to the Paediatric Emergency Department and a further 5 complaints were received where the care was provided in the Emergency Department by other specialities.

4.2 Labour Ward

Table 9 Labour Ward by Primary Subject and Staff April 2013-March2014

	CLINICAL CARE	ATTITUDE	INFORMATION
Medical Staff	4		
Midwife Staff	8		2

14 complaints relating to the Labour Ward were received in the year 2013/2014. Clinical care was the most complained about aspect of service provision; 12 complainants raised this as the primary concern. 13 complaints were received relating to Obstetric Theatres. In total 43 complaints were received relating to aspects of maternity care these are looked at in more detail in section 5.1.3

4.3 AAU

Table 10: AAU by Primary Subject and Staff April 2013-March2014

	CLINICAL CARE	ATTITUDE	INFORMATION	DISCHARGE	OTHER
Medical Staff	2		2	2	
Nursing Staff	3		2	1	1

13 complaints were received relating to the AAU compared with 21 complaints last year. Of note no complaints were received relating to staff attitude or behaviour.

4.4 Outpatients

Between April 2013 and March 2014, 165 complaints were received relating to patient's experience in the outpatient areas. The themes identified include information for patients in relation to cancelled or changed appointments, information about waiting times or delays in clinic, information regarding decisions about care and treatment.

The outpatient areas with the highest number of complaints are:

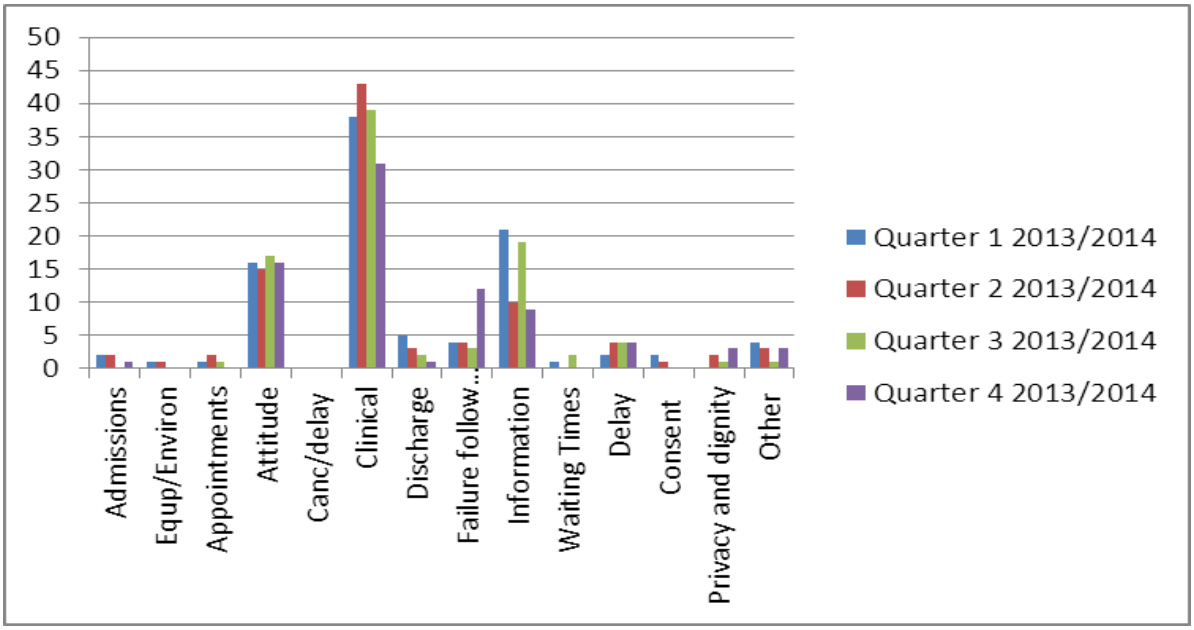
Table 11: Outpatient Areas complaints received April 2013-March2014

Outpatient 3	21	Complaints
ACU	13	Complaints
Outpatient 1	11	Complaints
Surgical Admissions Office	10	Complaints

An Outpatient Improvement Board has been set up to oversee improvement work on the following themes: - Information / Technology and Patient Communication, Customer Service and Workforce, Clinic Management, and Environment. An Outpatient Improvement Programme is currently been undertaken in the Dermatology Department, working alongside Mckinseys Hospital Institute.

5.0 Complaints by Subject 2013/2014

Graph 3: Complaints by Primary Subject April 2013-March2014



The top three subjects remain the same as in previous years, clinical care, attitude and information. A total of 356 type 2 and type 3 complaints were received during the year 2013-2014. This compares with a total of 377 received during the year 2012-2013.

Table 12: Top 3 Primary Subjects April 2013-March2014

Subject	Number of Complaints
Aspects of Clinical Care or Treatment	151 [42%]
Attitude or behaviour of staff	64 [18%]
Information/Information to patients (written and oral)	59 [17%]

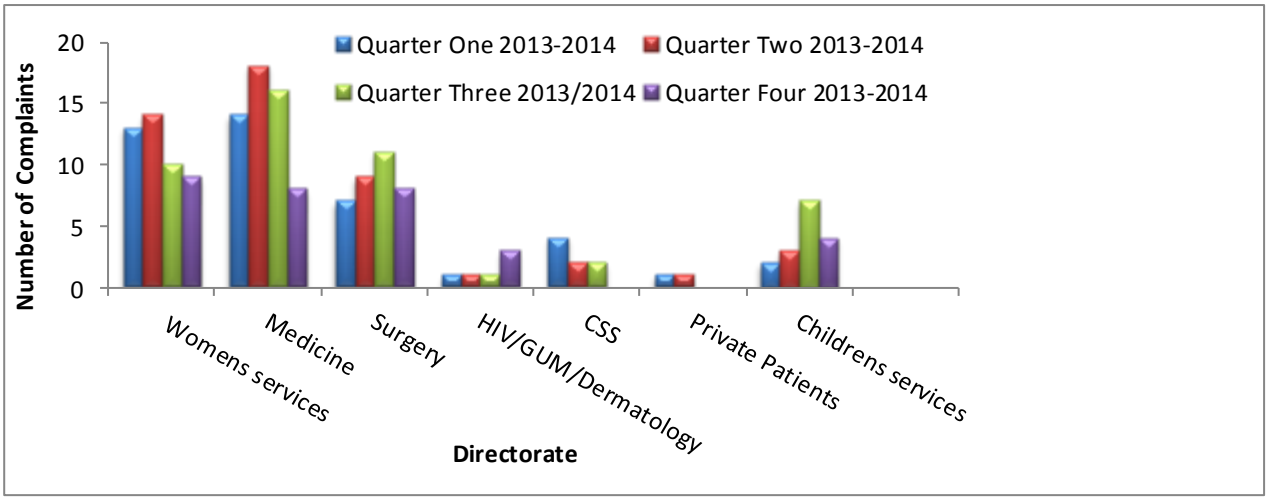
The published national data relating to complaints undertaken by the Health and Social care Information Centre for 2012-2013 showed that of the written complaints received by Hospital and Community Health Services in England last year 2012-2013, 46.2% related to clinical care, 11.1 % related to the attitude of staff and 10.5%% related to written and oral communication with patients. The Trust monitors complaints relating to attitude and communication as part of the Patient Experience Strategy.

5.1 Aspects of Clinical Care or Treatment

During 2013-2014 the Trust received 151 complaints where the primary concern relates to clinical care or treatment. A further 14 complainants identified an issue regarding their clinical care but this was not the primary subject. Complaints in this category include any allegations about standards of clinical

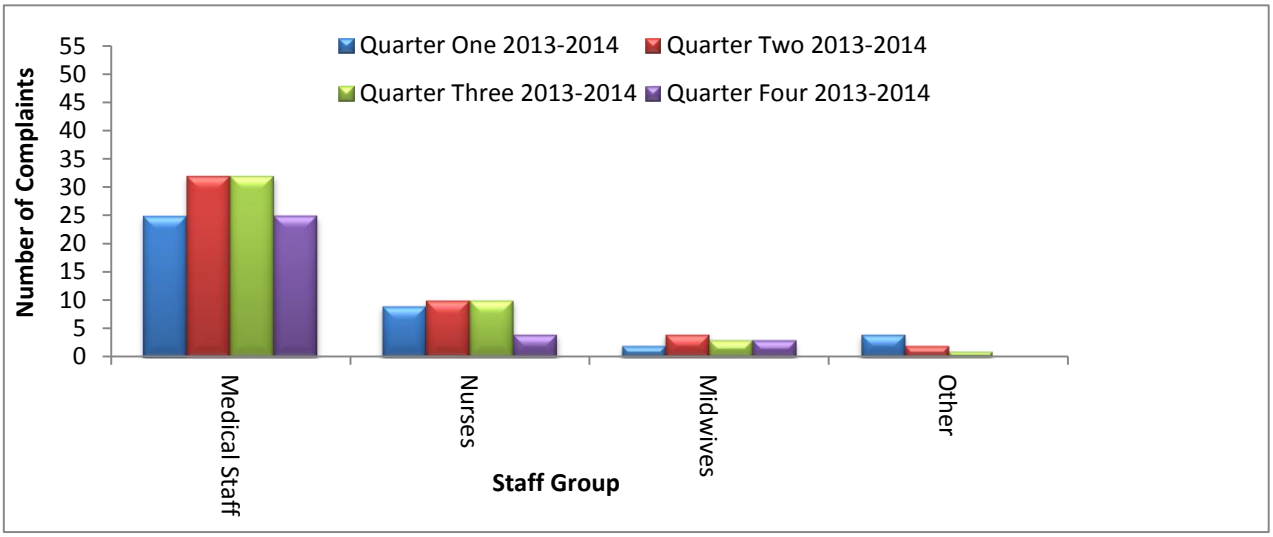
care or practice. It includes diagnosis, physical examination, disputes about the appropriateness of treatment, questioning of competence and clinical interventions.

Graph 4: Complaints about Clinical Care or Treatment by Directorate April 2013-March2014



NB: Where there is a discrepancy between the total numbers of complaints reported in an area and the total number where the complaints are analysed, this is because some complainants identify more than one member of staff where a concern is raised about clinical care.

Graph 5: Complaints about Clinical Care or Treatment by Staff April 2013-March2014



NB: Where there is a discrepancy between the total numbers of complaints reported in an area and the total number where the complaints are analysed, this is because some complainants identify more than one member of staff where a concern is raised about clinical care.

5.1.1 Aspects of Clinical Care or Treatment –Medical Staff

Table 13: Aspects of Clinical Care Medical Staff by speciality April 2013-March2014

Speciality	Medical
Anaesthetics	***2***
Burns	***2***
Colorectal	***2***

Dermatology	***1***
Elderly Care	***1***
Emergency Department	***22***
Endoscopy	***1***
Gastroenterology	***4***
General Medicine	***2***
General Surgery	***4***
Gynaecology	***12***
Hand Surgery	***2***
HIV	***2***
Maternity	***21***
Neonatology	***3***
Neurology	***3***
Oncology	***1***
Ophthalmology	***2***
Paediatrics	***9***
Pain Team	***3***
Palliative Care	***1***
Plastics	***4***
Rheumatology	***1***
Trauma and Orthopaedics	***6***
Urology	***3***

114 concerns were raised regarding the clinical treatment of patients by medical staff. The reasons for these complaints include poor communication regarding the rationale for treatment decisions and the quality of treatment given. All complaints regarding clinical treatment are raised with the clinician concerned and inform their annual appraisal. In response to concerns raised about clinical care full explanations and apologies were given in line with the "Being Open" principles. The GMC made four pledges following the Clwyd-Hart Review of the NHS Hospitals Complaints System.

- As part of the evaluation of revalidation, the GMC will look at the role of patient feedback and how it can be further developed.
- The GMC will act to support patients through fitness to practice cases, undertaking to take tailored face to face opportunities to explain the process and outcomes.

- The GMC will look at how well prepared medical graduates feel to deal with patient concerns and complaints in a positive way. They will do so as part of their review of the impact of Tomorrow's Doctors 2009, which sets out the outcomes and standards for undergraduate medical education.
- The GMC's core guidance for all doctors, Good medical practice, sets out what is expected of doctors, including in communication and partnership working with patients. The GMC is examining how these skills can be better reflected in postgraduate training and also promoted as part of continuing professional development for all doctors.

5.1.2 Aspects of Clinical Care or Treatment – Emergency Department

The Emergency Department received 27 complaints where the primary subject related to the clinical care of patients. 22 complaints raised a concern about the care received from medical staff.

Two complaints related to failure to diagnose fractures and two complaints related to a failure to ensure appropriate follow up for review.

Proactive responses have been taken in order to learn from the complaints received. For example, in response to one of the complaints received; the ED consultants have written to the lead ENT consultant at Charing Cross Hospital (to confirm whether our current practice is correct or whether we need to consider introducing a new referral pathway for viral labyrinthitis and in response to one complaint, the department intends to include a section on spider bites in their next block of junior doctor training.

In the case of one patient it was felt that she had not been appropriately streamed during initial triage as pregnant women over 12 weeks are usually seen in the 'majors' area and provided with a bed to lie on, bloods are taken soon after arrival and observations repeated at frequent intervals. This matter was escalated to the Emergency Department Matron to feed back to the triage nurses. The streaming guidelines were recently changed in order ensure all pregnant women with abdominal pain or bleeding are triaged to the majors' area.

Where the investigation has revealed a shortfall in the care given, senior consultants have met with the junior doctors involved to highlight points of learning and inform future practice. In six of the cases, the care provided was found to be appropriate and each patient/relative was given a breakdown of their care and the rationale behind the clinical decisions made.

One complaint relating to the Emergency Department was graded as orange. A patient turned and appeared to lose her balance and fell at the nursing station. A meeting has taken place with the family to feedback the findings of the review. Sincere apologies were given for the shortfalls that occurred in the patient's care. A number of recommendations were made as a result of this complaint which included arranging local training sessions about patients at risk of falls. The departmental re-build due to take place will address the issue of patients being seen in inappropriate or difficult to monitor areas of the department intended for patients with minor illnesses and complaints. During the meeting sincere apologies were given that the family felt isolated from the review process and assurances given that the team involved have learnt a lesson from this.

One complaint relating to the clinical care in the Emergency Department has been referred to the Ombudsman for review. This is reported in more detail in section 9.

5.1.3 Aspects of Clinical Care or Treatment- Maternity

33 complaints were received relating to clinical care within Maternity Services. 12 of the complaints relate to clinical care on the labour ward, 4 relate to clinical care of medical staff and 8 relate to the clinical care of midwives. 10 complaints were received which relate to the clinical care of medical staff in the obstetric theatres

The issues raised were

- The management of pain relief during labour;
- The changing rota of midwives with different opinions.
- The failure of staff to take birth plans into consideration
- Communication from staff and been left alone for long periods without information or support.
- The length of time it took for an instrumental delivery to be undertaken.
- Concerns about retained products of conception and need for further procedures
- Epidural inserted in the wrong place
- Concerns raised about delays in ensuring patient was reviewed and implementing induction.

4 complaints were received relating to complications that women experienced due to retained products following caesarean sections. Following a review of one complaint, an anonymised case study has been used in the training programmes for junior medical staff, to outline the importance of ensuring that the uterine cavity is empty and that the placenta is complete at caesarean section. This is to educate staff around the rare but serious complications of any retained products of conception.

All complainants were contacted by senior member of staff. All complaints were fully investigated and meetings were offered with senior midwife or consultant. The Birth Afterthoughts Midwife continues to be valuable in effectively resolving concerns and reassuring new mothers. All midwives or doctors involved in a complaint were met either by their midwifery manager or their consultant/divisional medical director to talk through the care they had provided and to identify points of learning. The issues raised will inform staff appraisals.

One patient expressed concerns with the care she received following the death of her baby. A meeting was held with the patient, her partner, the Head of Midwifery and a senior consultant - the rationale behind the care provided to her was discussed. Apologies were given for the way in which she was treated following the death of her baby. It is recognised that families need to be able to access flexible facilities. As a result of this money was secured from the Department of Health to create a suite with a small kitchen area with access to a fridge and simple catering.

One complaint relating to maternity services was graded as orange. The patient had a caesarean section and had to have another operation to remove retained placenta, during which she lost 3200 mls of blood. The patient was given plasma and fluids and was said to be recovering well. However she developed preeclampsia during the second operation, resulting in high pressure. She developed severe pulmonary oedema and spent the night in intensive care. A panel review took place and the couple were invited to meet with the Clinical Director and the Birth Afterthoughts Midwife to discuss the findings. It was noted that care had been appropriate and responsive. However it was recognised

that there had been a failure to ensure transparent communication about the events. The actions taken were to remind all staff to ensure that partners are kept updated throughout emergency procedure and to ensure a nominated point of contact when a patient has had an emergency procedure/admission to ITU

One complaint relating to the clinical care of received from the Maternity team has been referred to the Ombudsman for review. Concerns expressed regarding the treatment that the patient received, which culminated in the stillbirth of her baby. This is reported in more detail in section 9.

5.1.4. Aspects of Clinical Care or Treatment –Nursing Staff

Table 14: Aspects of Clinical Care Nursing Staff by area April 2013-March2014

Location	Nursing
AAU	***3***
Burns	***1***
Chelsea Wing	***1***
David Evans	***3***
Edgar Horne	***4***
ED	***5***
Gynae OP	***1***
Kobler	***1***
Lord Wigram	***2***
Nell Gwynne	***4***
Neptune	***1***
NICU	***1***
Pre Assessment	***1***
Rainsford Mowlem	***2***
Ron Johnson	***1***
St Stevens	***1***
Theatres	***1***

33 complaints were raised regarding the clinical care of nursing staff. Complaints in this category relating to the clinical care of the nursing staff include questioning of competence, drug administration and clinical interventions. Some of the issues raised were:

- A failure to initiate palliative care and to give comfort to a distressed patient with dementia.
- Concerns expressed that nurses did not appear to know how to deal with patient's pain.
- Concerns about the management and coordination of patient's care with dementia

A case manager for dementia has been appointed within the medical and surgical division team who is assisting with training and awareness of best practice in dementia care. Sixteen dementia champions are been trained throughout the trust. Edgar Horne has been made dementia friendly from a design point of view and it is hoped to do this for other adult's wards. The Trust is supporting a large programme of dementia training for all clinical and non-clinical disciplines. The case manager for dementia has provided a 1 hour slot on pain management for nursing staff and is currently reviewing the pain assessment tools that are in use.

Two complaints in this category were graded as orange and relate to patient falls on the ward areas. The final reports have been presented at the risk management committee and the findings shared with the family.

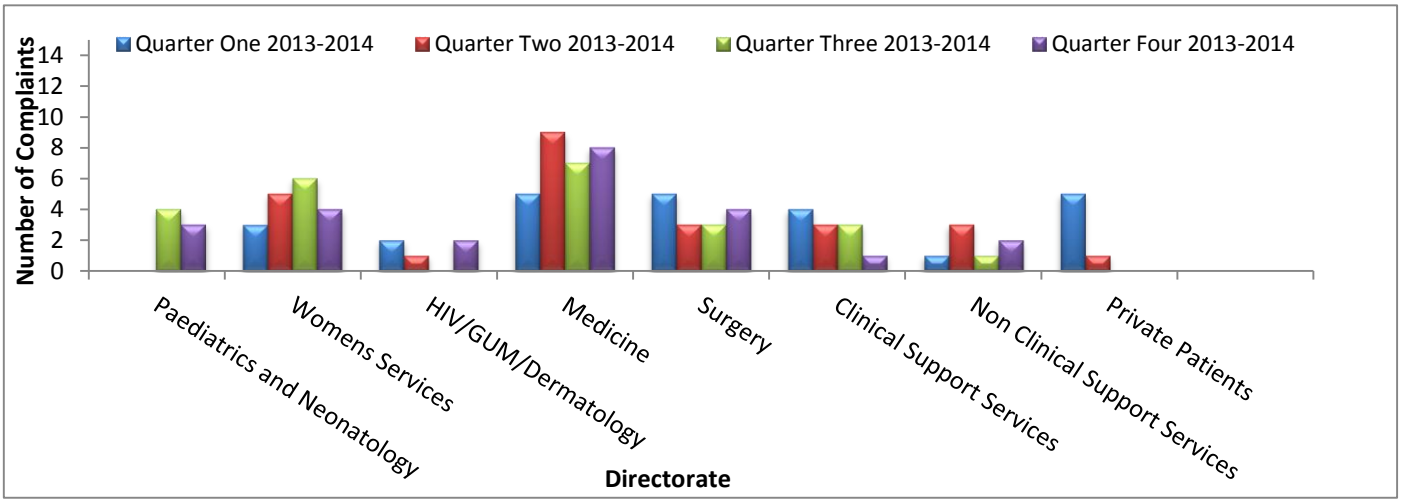
The Trust monitors the patient's experiences and quality of care provided through the clinical rounds undertaken by the senior nursing team. The visits provide a visible presence for staff within clinical areas. The visits focus on our priorities around safety, effectiveness, and patient experience and emphasise the Trust values of respectful, kind, safe, and excellent. Anything arising from these visits is taken to the Senior Nursing and Midwifery Committee and the Patient and Staff Experience Committee.

The health and social care regulator, the Care Quality Commission (CQC), undertook an unannounced visit in September 2013; the Trust was found to be fully meeting all six of the standards assessed by the clinical experts.

5.2 Attitude or Behaviour of Staff

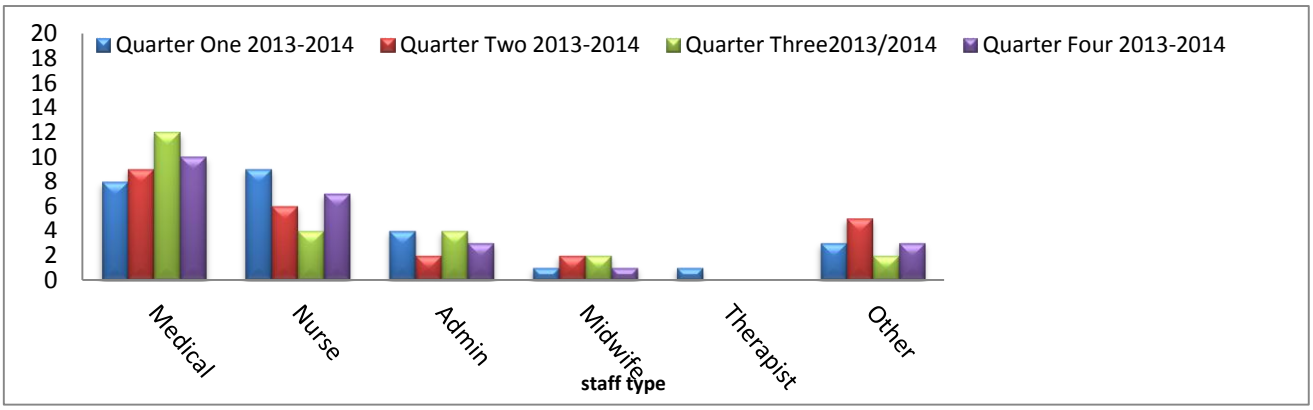
During the year 2013-2014, the Trust received 64 complaints where the primary concern related to the attitude and behaviour of staff. A further 34 complainants identified concerns regarding the attitude of staff but not as the primary concern. Complaints in the category relating to staff attitude and/or behaviour including concerns raised about rudeness, lack of sympathy, apparent disinterest and not providing a standard of personal service expected by the complainant.

Graph 6: All Complaints about Attitude and Behaviour by Directorate April 2013-March2014



NB: Where there is a discrepancy between the total number of complaints reported and the numbers where the complaints are analysed, this is because some complainants have identified more than one member of staff with regard to Attitude or Behaviour.

Graph 7: All Complaints about Attitude and Behaviour by Staff Group April 2013-March2014



NB: Where there is a discrepancy between the total number of complaints reported and the numbers where the complaints are analysed, this is because some complainants have identified more than one member of staff with regard to Attitude or Behaviour.

5.2.1 Attitude or Behaviour of Staff Medical

Table 15: Attitude or Behaviour of Medical Staff by speciality April 2013-March2014

Speciality	Medical
Anaesthetics	*1*
Chelsea	*1*
ED	*8*
Gastroenterology	*2*
General Surgery	*1*
Gynaecology	*5*
Hand Management	*1*
Maternity	*4*
Neonatology	*1*
Neurology	*1*
Ophthalmology	*1*
Pain	*2*
Paeds	*4*
Rheumatology	*1*
Urology	*6*

39 concerns were raised regarding the attitude or behaviour of medical staff during the year 2013-2014. The main themes that arose from the complaints were that staff were dismissive and unsympathetic or did not listen to the patient.

5 complainants raised a concern about the attitude of a member of the Urology team. This was managed by the Service Lead under the appropriate HR process with the support of the General Manager; the Divisional Director of Operations, the Divisional Medical Director and the Medical Director were made aware of the issues raised and the actions taken. No further complaints were received in last two quarters of the year.

5.2.2 Attitude or Behaviour of Staff Nursing

Table 16: Attitude or behaviour of nursing staff by location April 2013-March 2014

Area	Nursing
Anaesthetic room	***1***
Chelsea Wing	***5***
ED	***5***
Edgar Horne	***4***
John Hunter Clinic	***1***
Neptune Ward	***1***
Obstetric Theatre	***1***
OP3	***2***
Rainsford Mowlem	***4***
Paeds OP	***1***
Victoria Clinic	***1***

26 concerns were raised regarding the attitude or behaviour of nursing staff during the year 2013-2014. Complaints in the category relating to staff attitude and/or behaviour include concerns raised about rudeness, lack of sympathy, apparent disinterest and not providing a standard of personal service expected by the complainant.

Five complaints were received relating to staff attitude and behaviour on the Chelsea Wing; the issues identified by patients or their relatives were that a member of staff did not treat patients with respect or dignity. Staff were described as unhelpful, rude and uncaring. One of the complaints received were investigated with the support of Human Resources Team in accordance with the Trust's Disciplinary process. The Chelsea Wing team have implemented a weekly meeting reviewing standards of care, patient experience and the environment with the aim of driving forward excellence on the ward. No complaints relating to the attitude of nursing staff on the Chelsea Wing have been received in the last two quarters of this year.

5.3 Communication

During the year 2013-2014, the Trust received 59 complaints or concerns where the primary concern related to the communication and information given to patients; a further 42 complainants identified this as an area of concern. Communication is a core strand of the strategy to improve the patient experience at the hospital. The Complaints and PALS teams report on the numbers of complaints and concerns relating to communication. During the year 2013-2014, we have reported an increase in the total number of complaints and concerns received by both teams relating to communication. Having

looked at details of the formal complaints raised, 45 relate to communication and information about processes and 56 relate to the communication a patient has had with a member of staff

The issues relating to information and communication about processes are:

- Difficulties in contacting departments; patients describe phones not been answered and if they are the person is unable to help and puts them through to someone else.
- Patients are unclear who they should speak to in order to schedule operation dates and are passed between admissions and medical secretaries.
- When someone is not in due to annual leave their work is not covered and referrals wait until their return
- Operations are cancelled without a phone call or letter.
- Appointments are cancelled without a phone call or letter
- Lack of coordination between departments; patients say they have to co-ordinate their own care
- There is reluctance for anyone to take over all responsibility and help co-ordinate care.

Some of the issues identified regarding communication issues with staff members are:

- Next of kin not kept informed regarding future plans
- Failure to communicate with family following a fall
- Concern about the information provided as to what to expect following a procedure.

A key objective is to support teams across the Trust in relating the Trust values to their own work and role so that the values are owned and embedded by individuals and teams. The patient and staff experience committee meets every 6 weeks with representation from different groups of staff and patients representatives. During 2014-2015 we will continue to review the details of the complaints and concerns relating to communication to inform the development of our coaching, leadership and other training programmes.

5.4 Discharge

During the year 2013-2014, the Trust received 11 formal complaints where the primary concern related to discharge; a further six complainants identified this as an area of concern. In the year 2010-2011, the Complaints and PALS teams reported that the Trust had received 108 complaints or concerns about patient's discharge. The total number of complaints and concerns received this year relating to the discharge process is 24. Since 2011, in response to patient feedback which indicated that patients did not feel sufficiently involved in decisions about the date of their discharge. The Trust has overhauled the discharge process and this has led to a reduction in concerns and complaints in this area.

The Community in reach team has been established, this team is part of the Community Independence Service. Part of the work of the team is to ensure that patients are not readmitted post

discharge by supporting them in the community. In reach provides up to five days care and support after a hospital attendance. The Rapid Discharge Pathway has been updated and a discharge checklist for dying patients who wish to go home has been developed.

6.0 Safe Guarding

The Trust Safe Guarding Lead attends the fortnightly complaint and incident review meeting with the Chief Nurse and Divisional Directors. Complaints and Incidents that may need to be considered as Safe Guarding review are reported and discussed at these meetings. A report is shared with the Adult Safe Guarding group which includes a synopsis of complaints that identify concerns relating to the potential neglect of patients.

The complaints team and the risk team are working with the Trusts Safe Guarding Lead and Deputy Chief Nurse to provide a quarterly report to reflect complaints and Incidents where safeguarding issues have been identified.

7.0 End of Life

The Trust has prioritised End of Life Care across all services. The End of Life Committee meets monthly and a member of the complaints team attends this. A Trust End of Life Care Strategy has been agreed. An aide memoir has been developed to guide staff on the provision of End of Life Care. The Trust End of Life Care Lead is made aware of all complaints received relating to End of Life Care and has been involved in supporting staff to investigate the concerns raised identify any themes for learning and sharing and liaising with the families.

8.0. Complaints Graded as Moderate or High

Complaints are graded using the Trust matrix incorporating consequence to the patient and/or the organisation, and the likelihood of the incident recurring. Those complaints which are graded as Orange or Red i.e. Type 3 will require a longer time scale and this should be discussed and agreed with the complainant. The incident procedure should take preference in terms of an investigation, but the issues raised by the complainant will be taken into consideration when agreeing the Terms of Reference. The complaint should be acknowledged in the usual way but permission should be sought from the complainant to extend the time limit beyond 25 working days. It is important that a member of the Directorate is identified to liaise with the complainant and update them about the progress of the investigation and the timescales.

This level of detail is not available to the general public as it is considered that the synopsis of each incident at a case by case level may reveal the identity of people affected by these incidents. The Trust has therefore introduced measures to remove this level of detail from the annual and quarterly reports to ensure that information about an individual whose identity is apparent or can reasonably be ascertained from the information or synopsis is protected.

12 complaints were received during the years which were graded as moderate to high. These were considered by the various committees with overarching responsibility for risk, including the Trust Risk Management Committee and the Assurance Committee. Of the 12 complaints received in this category, three were responded to within 50 working days [range 41-99 working days].

9.0 Parliamentary Health Service Ombudsman

Around 10% of all complaints made about NHS services are brought to the Ombudsman. The Ombudsman is independent and is not part of government or the NHS. They are the final step in the NHS complaints process and their role is to investigate complaints that people have been treated unfairly or have received poor care. The Ombudsman considers the issues that each complaint raises, examine how the NHS trust responded, take clinical advice if needed, and then reach a decision. The initial decision is whether or not the PHSO will investigate the complaint. If they decide to investigate they write to the Trust with their findings and any recommendations.

From April 2013, the Ombudsman's office advised they would be investigating and sharing reports on more of the complaints. This is part of their strategy 'More Impact for More People'. They intend to investigate thousands rather than hundreds of complaints each year. The Ombudsman will continue to publish figures for the number of complaints they investigate about each organisation in their jurisdiction, but will be explicit that the change of process is a reason for the significant increase in the number of investigations undertaken during 2013- 2014.

For the year to date, the Trust has been advised that 10 complainants have referred their complaint to the PHSO for independent review.

Before the final reports are issued the Trust is invited to comment on the draft report. The Trust has received four final reports and one draft report.

Medicine 7383: Concerns expressed by the patient's daughter regarding the level of nursing care provided to her mother. The main concern raised in the complaint by the family was that they felt the patient was over-mobilised which resulted in a cardiac arrest and her subsequent death. This complaint was also dealt with as an Incident. The findings of the complaint investigation and panel review were that the patient's care management had been appropriate and her death had been unavoidable. The response to the family's specific concern regarding mobilisation was that the patient had been deemed fit to mobilise with assistance by the therapy team and there had been no clinical indication for keeping the patient on bed rest.

Referred to PHSO in October 2013. Ombudsman decision received February 2014. **Complaint upheld.**

The PHSO concurred with the Trust's findings regarding concern re mobilisation issue and felt that the response to the family was appropriate. However, they did identify two failings that they feel the Trust has not appropriately addressed with the family namely poor record keeping (particularly nursing documentation) and the failure to address the issue they raised regarding finding their mother on her own in the toilet, unable to mobilise without assistance. They have asked the Trust to address these two issues and to outline what lessons have been learnt and what measures have been put in place to ensure there are improvements. In terms of complaint handling the Ombudsman noted the delay in providing the initial response for which the Trust apologised. The PHSO considered a delay in four months of responding to second letter to be excessive and unacceptable delay.

The PHSO recommended that the Trust write to the complainant to acknowledge failings identified and describe what has been done to ensure lessons are learnt and what Trust intends to do to ensure avoidance in future. The Trust has written to the complainant apologising for the shortcomings identified in the report and has provided an update on the action taken in response to each. An action plan has been developed which includes the fo0llowing:

- The Trust has agreed a Trust wide documentation audit using the nationally agreed tool.

- The Trust will undertake an audit of nursing records/assessments within medicine and surgery to monitor the standard of record keeping and to identify and address any gaps.

- The Trust will review the current library and use of electronic care plans to ensure they are fit for purpose and utilised effectively.

- The Senior Divisional Nursing team will review the comfort rounds to identify effectiveness and any areas for improvement.

- The Trust will continue to undertake monthly nutritional audits and action plans for areas who do not meet the target.

- The Trust will implement the Great Expectations project, a coaching programme for managers and clinical leaders the use of coaching techniques to empower staff to provide compassionate, and value based care.

The Trust has ensured a copy of the action plan has been sent to the Care Quality Committee, Monitor, and NHS West London CCG. The Trust will continue to provide monthly updates to the Ombudsman's office on the progress against our action plan.

Medicine 8018: Concerns raised by sister regarding patient's management and the member of staff not responding to emails. Complainant expressed concern that the clinician felt her symptoms were a waste of his and other clinicians' time and that the content of a letter that was sent to her GP was inflammatory and incorrect. Letter sent, the consultation lasted over 30 minutes and clinician gave detailed assessment of situation. Patient's situation does not fulfil criteria to be designated as chronic fatigue syndrome. Further letter sent confirming clinician involved in initial response and that a suggestion had been made on how to manage condition.

Complaint referred to PHSO in October 2013. Ombudsman decision received February 2014. **Complaint partially upheld.**

The PHSO did not consider that the clinical conclusion of the clinician was unreasonable. However, there was a lack of evidence recorded relating to physical examination, assessment of mood and psychological wellbeing. A letter was sent to PHSO prior to final report reiterating perspective of clinician. Patient referred as tertiary referral by fellow consultant who had recently performed detailed clinical examination, clinician did not think appropriate to perform formal examination. Baseline observations had been performed and assessment of mood, appearance and responsiveness. The consultation took over half an hour and constructive recommendations were made for future management. Ombudsman considered the clinicians comments and some alterations were made to the content of the report but recommendations remained the same. The Trust was asked to ensure that that information in the report was shared with clinician to ensure lessons were learnt, that the clinician should reflect on their communication style and a letter of apology should be sent with regard to failings identified. The Divisional Director has discussed the report with clinician and a letter has been sent to the patient and shared with the PHSO.

Medicine 6788: Initially not logged as complaint as no letter of complaint received. This was managed by division as incident 47590 and it was agreed that the division would provide feedback. Family became frustrated by delays in arranging for this feedback and approached PHSO. Trust agreed to log as complaint to allow family to approach PHSO once local resolution concluded.

Family's main concerns are that patient was not stable enough to be transferred from the Royal Marsden Hospital to undergo a planned endoscopy procedure and that she received no after care on Ward. The medical staff from both the RMH and the Chelsea and Westminster felt patient was able to

tolerate the endoscopy procedure having assessed her condition. The investigation found that she tolerated the procedure well and that her observations remained within their normal limits throughout. It was acknowledged that Trust failed to provide dignified care at the end of her life. Although there was good communication between the RMH and the medical team here, once patient's condition deteriorated, there were a number of aspects of care that Trust failed to deliver effectively.

A new ward sister appointed and patient experience has since improved which is evidence by a reduced number of complaints and incidents. Following the incident a meeting was held with the senior nursing team and the policy for the 'Transfer In and Out of Patients from the Royal Marsden Hospital Undergoing Radiological Investigations Requiring General Anaesthetic' was up-dated. An End of life Committee has been established and an End of life Discharge Liaison Nurse Post created.

Complaint referred to PHSO August 2013. Draft report received February 2013. **Complaint partially upheld.**

The Ombudsman's report found that there was injustice caused to complainant by watching patient pass away in an environment with sub-standard nursing and end of life care and learning of the Trusts failure to implement the improvements recommended in transfer policy. The Trust should provide an apology for the failings identified and provide financial payment of £1000 in recognition of the distress. The Trust has been asked to provide detail regarding how improvements to end of life care have been qualified, to provide detail on how they will be audited and to audit how care has improved. The Trust has accepted the provisional report and the Lead Nurse for End of Life Care has been asked to lead on the action plan once the final report is received.

Surgery 7361: Patient expressed concerns relating to the attitude of a member of staff. Patient believes she was told she had cancer. Meeting took place, it was acknowledged that recollection of the conversation and the manner in which details regarding a possible diagnosis were conveyed is different to that of clinicians but at no stage was patient given a diagnosis of cancer. Patient does not feel Trust has resolved concerns.

Complaint referred to PHSO in November 2013. Ombudsman decision received February 2014. **Complaint not upheld.**

No failing identified with regard to staff communication. Ombudsman recognises reflection of staff on consultation and attendance at local resolution meeting. No failing identified with regard to consultation with consultant. In terms of complaint handling delays identified and it took division three months to produce notes of local resolution meeting. Delay noted in providing letter of response within agreed timeframes. Overall the response to complaint was appropriate with local resolution offered and two letters of response sent. The Trust had offered apologies for the delays.

Paediatrics 7885: Concerns raised by a solicitor on behalf of the parents of the patient regarding the rationale behind her clinical diagnosis. State that the child's condition has made little progress since meeting with the matron. The complainant also states that there were factual errors contained in the discharge summary.

Each point raised was addressed and although the clinical care was found to be appropriate it was acknowledged that the communication within the team could have been better and resulted in there being a short delay in the patient undergoing a specialist review.

Complaint referred to the PHSO in February 2014. Ombudsman decision received May 2014. **Complaint not upheld.**

No evidence to support view that complaint was not addressed by Trust. Trust acknowledged that there were some communication problems and that there were some comments in discharge summary that could be misunderstood. Appropriate apologies were given, an amendment made to discharge summary and GP spoken to clarify the treatment plan. The Trusts response was reasonable and addressed the identified service failure.

There are a further five complaints that are currently with the PHSO.

Surgery 7711: Complaint made on behalf of patient by mother. She is concerned that surgical and anaesthetic team made a decision about surgery based on their perceived quality of patient's life. An attempt was made to carry out procedure under anaesthetic which the mother believes was the wrong decision. Operation was carried out at a different hospital.

Detailed explanation of the decision making process was given. Doctors concerned are sorry if they appeared pessimistic but felt that it was important to ensure all possible options considered and possible outcomes of anaesthesia and surgery. The team were keen to ensure that the consent they obtained was informed. Referred to PHSO in September 2013. Decision outstanding

Medicine 8095: Patient's wife raised concern regarding her husband not being diagnosed with the condition that caused his death. States he had been seeing 6 different named doctors during the months leading up to his death. He had also had many different procedures. The family was given varied information about what may be causing his symptoms. States that he never received a diagnosis, but over time he got weaker and thinner and doctors gave up on him. A meeting was held to discuss the family's concerns and to go through the clinical incident report. Clinically complex case, a definitive diagnosis was not secured prior to death despite multi-speciality involvement Minutes of the meeting were sent to the family who remain unhappy with local resolution. Apologies and sincere sympathies were given to the family. Referred to PHSO in October 2013. Decision outstanding

Medicine 8673: Concerns raised by the patient's daughter regarding the management of her mother's care by the Department. Concerned that there was insufficient handover between staff at various stages, including the handover to another hospital where the patient subsequently died. Meeting took place on 25th July with Senior Manager and Lead ED clinician, followed by a response letter detailing what was discussed and answering concerns. The care was found to be appropriate although the decision making was not clear-cut due to the complexity of the patient's condition. Sincere apologies were given that the family felt isolated from the decision-making and assurances given that the team involved have learnt a lesson from this. This has also investigated as an incident, final report to be considered at Rick Management Committee. Referred to PHSO in January 2014. Decision outstanding

Maternity .8374: Concerns expressed regarding the treatment that the patient received, which culminated in the stillbirth of her baby. Throughout her pregnancy she was known to be high risk due to her existing medical conditions. She attended a routine GP visit and it was noted that the baby's heartbeat was slow and an ambulance was called to take her to hospital as an emergency case. Once she arrived at the hospital she was left waiting in the corridor for over 3 hours. During this time she was asked to provide a urine sample and her temperature was taken, but she was not put on a monitor to check the baby's heartbeat. Her husband was told that her case was not an emergency. When she found out that her baby had died she was not treated with sensitivity and understanding. Staff seemed dismissive and wanted her to leave straight away and return the next day to have her labour induced.

Sincere apologies were given for the shortfalls in her care management. Assurances given that changes are being made and these include: the re-development of the triage area, telephone triage

service which screens all calls prior to appointments being given for the maternity urgent care centre. All telephone conversations and referrals are documented; all women who are blue lighted/transferred by ambulance are now directly admitted to the labour ward. There is now an admission pathway to ensure that women are reviewed in the most appropriate area. There is a specified timeframe in which to see women (no more than an hour) and if it goes beyond this then it is escalated to the Labour Ward Co-coordinator. Allocated appointment slots have now been introduced to improve patient flow. Referred to PHSO in January 2014. Decision outstanding

CSS 8050: Concerns raised regarding the care patient received whilst in the Treatment Centre. The patient was left for 7 hours without a catheter and could not urinate following an investigation on his bladder and prostate. The patient was left in unbearable pain.

Sincere apology that situation was not escalated at the time to senior staff member. Consultant has reassured patient that no harm has been done as a result of delay. However recognised that this was extremely distressing and as a result training programme implemented for nurses to catheterise male patients. Local resolution meeting held with patient and partner. Apologies reiterated re failure to escalate concerns to senior member of staff. Referred to PHSO in February 2014. Decision outstanding

10.0 Redress

The Parliamentary and Health Service Ombudsman is clear within her Principles of Good Complaints Handling (February 2009) that "putting things right" should include, where appropriate, financial compensation for direct or indirect financial loss, loss of opportunity, inconvenience, distress or any combination of these. The level of compensation decided should take in to account:

- The nature of the complaint
- The impact on the complainant
- How long it took to resolve the complaint
- The trouble the complainant was put to in pursuing it

Details of the complaints where re-dress or reimbursement during the year of 2013-2014 as follows:

- Chelsea Wing: concerns expressed regarding the behaviour of nursing staff on the ward. The patient experienced a delay in having a pump removed. Two male members of staff spoke to the patient inappropriately when changing her sheets. Sincere apologies given; it was acknowledged that care fell below an acceptable standard. Patient assured that this was managed as part of HR process. £ 1000 offered as gesture of goodwill

- Chelsea Wing: The patient's partner expressed concern regarding the treatment that the patient received on the ward. The patient experienced delays with receiving pain relieving medication, despite many requests, when she was in a considerable amount of pain. The patient received little assistance with moving around the ward and going to the toilet. £3,600 invoice was credited in full. Acknowledgement was given that there were failures to manage the patient's pain effectively and to provide a good standard of care at all times.

- Chelsea Wing: The patient expressed concerns regarding her inpatient stay on the ward. The patient found the food provided on the ward to be unsatisfactory and experienced problems with the hot water in the taps of the sink. The patient found the ward to be noisy at night and only felt comfortable with the agency staff who were far friendlier than permanent staff. It was acknowledged that this fell short of the standards expected on a private wing. Reimbursement of 15 %(£500) was given.

- Surgical Admissions: The patient expressed concern that his surgery had been rearranged and he had not been informed. As a result he requested a reimbursement of the costs he incurred. Apologies given that he was not notified of change to list. Patient was reimbursed £88.

11.0 Reopened Complaints

Of the type 2 and type 3 complaints received between 1st April 2013 and 31st December 2013, fourteen have been reopened to date, this represents 4 % of the complaints received this year against a Trust target of 6%. Complainants who were unhappy with their responses felt that there were discrepancies between what was said in the response and their recollection of events. Some complainants felt that the investigation had been superficial and had not addressed the concerns raised. Others identified that they were unhappy with the tone of the response and that the Trust had failed to offer a sincere apology. A number of complainants wanted further information in order to help them understand the decisions made about their care. All complainants received either a further written response or met with staff and issues have been resolved.

12.0 Action Plans and resolution of complaints

The Ombudsman expects that all Trusts should work to achieve the commitment in the NHS Constitution to acknowledge mistakes, apologise, and explain what went wrong and put things right, quickly and effectively. An Action Plan is sent to the Directorates and they are required to confirm that the complainant has been given the opportunity to discuss their concerns and agreed the type of resolution and the time scales for a response. The return of action plans has been poor.

Discussions with complainants are fed-back to the complaint team by e-mail or at the weekly complaints meeting. In a number of cases this initial contact has resolved the issue for the complainant and they did not require any further action. The feedback received from patients and members of staff on this type of resolution has been very positive.

There has been a reduction in the number of complaints [type 2 and 3] where we are able to evidence that the complainant was contacted to discuss their complaint and the type of resolution they were seeking. For the year 2013-2014 81% of complainants [type 2 and 3] were contacted to discuss their complaint and the type of resolution they were seeking, this compares with 89% last year and 86% the previous year.

It is a requirement of the current regulations that complainants are given an opportunity to discuss the manner in which their complaint is to be handled and the response period in which the investigation is likely to be completed and a response sent to the complainant. Monitor

Table 17: Action Plans and contact to discuss resolution type two and three April 2013-March 2014

DIRECTORATE	NUMBER OF COMPLAINTS	EVIDENCE OF COMPLAINANT BEING CONTACTED
Medicine	**91+5**	**67**
Surgery	**81+ 1**	**61**
CSS	**36**	**34**
HIV/GUM Dermatology	**15**	**13**

Gynaecology	**35+1**	**31**
Maternity	**42+2**	**44**
Paediatrics	**28+ 2**	**26**
NCSS	**9+1**	**7**
Private Patients	**7**	**5**

Senior members of staff from all specialties have met with patients or their carers to discuss the issues they raised and successfully resolve their concerns. The feedback received from patients and members of staff on this type of resolution has been very positive. Other complainants have asked to have a written response to their concerns.

13.0 Change of Practice 2013-2014

It is important that the Trust is a "learning organisation" and ensures that complaints are used to learn lessons, and that this results in improved services. An important aspect of handling complaints is to listen to patients' views, observe what and where things are going wrong and change practice(s) to improve services. The Complaints action monitoring form is sent to the Directorates each quarter, this requires the Directorate to provide an update on actions arising from complaints. In some instances complaints have resulted in learning and reflection for individuals or in the implementation of teaching that reflects the issues raised in complaints. In a small number of cases the issues identified have been managed through the Trust's disciplinary process. The following changes have been identified as a result of concerns or complaints received during the year 2013-2014.

13.1 Surgery

- The Chelsea Wing team implemented a weekly meeting reviewing standards of care, patient experience and the environment with the aim of driving forward excellence on the ward.

- In response to concerns raised about the clinical management and communication of test results for patients who are sent to AAU for further investigation, "Hot Clinics" have been introduced to support patients to have tests done, return home and come back the following day to discuss the results.

- Teaching sessions were arranged for the nursing team on David Evans ward with the Diabetic Team. The ward sister updated the pre-operative diabetic guidelines.

- The process for arranging BSL interpreters has been reviewed; each ward has a folder outlining the process and who to contact.

- In response to difficulties identified in contacting Surgical Admissions Department, refresher customer service training was undertaken with the team. All calls are now recorded; this allows division to carry out regular spot checks whilst phone calls are taking place allowing real-time monitoring of the service being provided.

- A patient's daughter expressed concerns about the management and coordination of her mother's needs in particular with regards to the staff knowledge and expertise in dealing with patients with dementia. Matron met with daughter and discussed work that is been taken

forward in the Trust; there is now a case manager for dementia within the medical and surgical division team who is assisting with training and awareness of best practice in dementia care. In relation to this specific complaint the case manager has reviewed the current training programme and will now be included a 1 hour slot on pain management and will also look into the current pain assessment tools that is been used.

13.2 Medicine

- Concerns raised that nursing staff were unaware that an elderly patient was unable to see and they did not make the appropriate adjustments to his care. Matron for the ward met with the complainant and this was followed up by a letter. It was explained that three signs have been presented to a number of committees to gauge reaction from staff and service users. A copy of the proposed sign was sent to the complainant for her approval.

- The department had previously recognised the need to redesign the X-ray report pathway moving from a paper based system to an electronic system in order to minimise the risk of a missed fracture not being recalled. It is expected that this system will be in place by Dec 2013.

- Action is being taken whereby a system has been introduced to allow calls to go to all phone lines to ensure they are answered. Also a function will soon be introduced to the department which will let a caller know where they are in the call queue.

- Patient expressed concerns relating to the difficulties she had in obtaining her test results and the attitude of a staff member. Patient was also told that she DNA her appointment when in fact she received a cancellation appointment and a new date which she did attend.

- The department intends to include a section on spider bites in their next block of junior doctor training. It was explained that all ED physicians have training in toxicology and venomous bites as part of their ED training and that doctors in the ED frequently refer to information from the National Poisons Unit who have written National Guidance regarding there management of various spider bites which we use our guidelines in the ED.

13.3 CSS

- As a result of concern raised about MSK service with regard to waiting times for an initial assessment and cancellation of appointments, the division is currently undertaking a review of the service including the use of telephone and face-to face-appointments. MSK is to change the process for rescheduling patients if the therapist is unwell. MSK to review process following telephone assessment to ensure that early referral is made to specialist if required.

- The written protocol for treatment of mallet finger injuries has been changed

- A new bed bay has been opened in Radiology which can accommodate three beds at a time and means that patients do not have to wait in the corridors.

- The MRI team have changed the letters sent to patients to include specific advice from the manufacturer about the contrast that is used during the procedure and the possible side effects.

- The EPAU will now ensure that patient details are written on the top of the referral to the treatment centre so patients do not need to discuss procedure at stressful time with reception staff.

- There are plans to change the layout of the changing rooms and waiting areas in the Treatment Centre to ensure privacy and single sex waiting areas.

13.4 HIV/GUM/Dermatology

- Further training was arranged for all staff who set 'flags' on the computer system. The division has put in place a monitoring system which shows that any letter being sent out also has to have sign-off from the patient's clinician being sent.

- In response to the difficulties a patient identified relating to difficulties in contacting the department, and a lack of co –ordination about appointments, the scheduling system has been changed to enable greater visibility of appointments along the pathway of a patient's care. Staff will be able to schedule or cancel appointments along an entire planned pathway and prevent further communication being sent out unnecessarily. A voicemail facility has now been set up this is checked regularly. In addition patients will now be able to contact the coordinator by e-mail.

- In response to the high demand for appointments at Dean Street [excess of over five thousand patients a month] a new rapid service called Dean Street Express is planned; this will help to meet the demand.

- In response to difficulties patient experienced contacting the company responsible for home delivery of medication, an out of hours telephone service has been introduced.

13.5 Central Outpatients

- An Outpatient Improvement Board has been set up to oversee improvement work on the following themes: - Information / Technology and Patient Communication, Customer Service and Workforce, Clinic Management and Environment.

- New gynaecology clinic appointments have now been put in place to reduce waiting times for new appointments. Improvements to the letter triage process; a member of the specialist team review all letters, to ensure urgent cases are accommodated in earlier appointments.

- As a result a complaint relating to gynaecology clinic, it has been agreed that Case Managers will increase their presence at reception during clinics; to offer greater supervision to the reception team and to ensure they are present to deal with requests from doctors at the time they are made. This change to the staffing of the reception should avoid patients leaving the clinic without having booked their next appointment.

13.6 Paediatrics

- A review of the administration for paediatric dental services process has been undertaken in response to difficulties families had in contacting the service. Families will be given the direct number for the paediatric dental reception. The receptionist will provide immediate response within office hours or if a voicemail is left it will be responded to within 24 hours.

13.7 Gynaecology

- As a result of a number of complaints made about the problems experienced with communication concerning funding for IVF, the ACU have introduced a system that records all funding requests made by clinicians and tracks the progress of each application by the PCT. This will ensure that clear information about the status of each funding application is readily available to all of our staff.

- There is a new process for communicating early pregnancy loss between our hospital departments to ensure patients are not contacted unless this is confirmed by our EPAU.

- It was established that the letters from the Gynaecology Department had resulted in some confusion about eating or drinking prior to procedure. It was agreed that the content of these letters will be reviewed to ensure that the instructions given are made clearer.

13.8 Maternity

- As a result of a complaint made a patient's concerning the lack of information she received from the hospital regarding her patient's miscarriage the process has been amended whereby all information such as this is now to be communicated directly with the GP and not left as a message (as was previous practice). The pregnancy loss checklist is also being updated

- The miscarriage guidelines will be updated to include information on the chance of developing Asherman's in consent process. Developing Asherman's will be presented as a specific risk for surgical management, especially in women with previous uterine surgery.

- During 2014 the Maternity Service will start to run one hour daily drop in sessions for new mothers; midwives will use the same teaching template to deliver consistent information and encourage feeding concerns to be raised and actioned as early as possible.

14.0 Hard Truths

In November 2013, the Department of Health published Hard Truths; the report made a number of recommendations with regard to how the government expects that Trusts manage patient concerns and complaints.

The government wants to see every trust make clear to every patient from their first encounter with the hospital:

- how they can complain when things go wrong
- who they can turn to for independent local support if they want it,
- that they have the right to go to the Ombudsman if they remain dissatisfied, and
- Details of how to contact their local HealthWatch.

The Department of Health wants to see patient advice and liaison services (PALS) well-sign posted, funded and staffed in every hospital. Hospitals should actively encourage and use volunteers to support patients in expressing concerns or complaints. Volunteers should be trained.

Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.

All boards and chief executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action.

15.0 NHSLA and Satisfaction Survey

In October we were assessed by the NHS Litigation Authority which is the organisation that helps the NHS manage risks. The Trust achieved level three, the highest level. Complaints were assessed against the following standards

- How staff acknowledge, apologise and explain when things go wrong
- How communication is recorded.
- How staff involved in traumatic complaints or claims are supported:
- The different levels of investigation appropriate to the severity of the event
- How action plans are followed up.

The complaints team recently undertook an audit of the complaint files for the inspection. The audit showed that there was evidence to demonstrate that complaints are investigated proportionately and to show cohesive communication and escalation to the Risk Management team.

There is evidence that early contact with complainants is happening in most cases but not in all cases. The audit of the complaint files showed a poor return of action plans to the complaints team. The action plans provide the evidence that contact has been made in line with legislative requirements and also that the Divisions have considered whether the concerns raised also need to be referred as an incident review or as a safe guarding issue.

In September 2013, the complaints team undertook a Satisfaction Survey of people who had made a formal complaint during the year 2012-2013 . The purpose of the survey was to understand what patients think about the service provided by the Trust. Positive feedback was received about the experience of accessing the complaints service in particular when complainants had been contacted by a senior member of the directorate at an early stage of the complaints process and given an opportunity to discuss their experience. Complainants identified that what mattered was an acknowledgement of the problem and someone who was able to address the issues for them personally and offer reassurance about the level of service in the future.

However a number of respondents identified that no one had contacted them to discuss their complaint. A further issue expressed was that there did not seem to be one person that could be identified as responsible for dealing with the complaint and that the staff failed to provide a sympathetic response to the concerns raised.

16.0 Summary

This report has provided a summary and analysis of complaints and concerns raised through the Complaints Service during the year 2013- 2014. There is a clear focus on complaints and concerns by the Executive Team. It is expected that each complaint response should be reviewed by the Divisional Director. The Chief Executive, the Chief Operating Officer and the Chief Nurse then provide a final review to ensure the quality of the response and investigation. All new complaints and any overdue

complaints are reported weekly at the Trust Executive meeting. The learning and changes identified are monitored and any outstanding actions escalated to the Trust Executive Team.

The findings of the survey underpin the importance of early contact and regular updates with complainant to ensure a successful resolution and experience of the complaints process. People who complain want a proportionate response. In some cases and as far as possible the hospital should try and resolve issues and concerns without the need to trigger a formal complaint. Patients want to know their complaint has made a difference.

The results of the survey show that whilst some people have had a good experience of the complaints process, this was not the case for everybody who made a complaint. The findings of the recent survey and NHSLA audits will be discussed by the Trust Executive, in order to consider the action needed to improve the experience of all persons who raise a concern about our services.

Supporting paper 2.5

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

RISK MANAGEMENT ANNUAL REPORT
2013/14

Authors	Malin Zettergren, Risk Manager Vivia Richards, Head of Clinical Governance
Contributions by	Anderley Newnham, Risk Manager Jan Gordon, Blood Transfusion Practitioner Sheena Patel, Specialist Anticoagulation Pharmacist Anna Bischler, Clinical Governance Pharmacist Olga Sleigh, Head of Decontamination Services Sarah Masterson, Tissue Viability Nurse Nick Hale, Nurse Consultant – Vulnerable People
Version	6
Date	June 2014
Reporting Committee (s)	Trust Executive Quality Committee Assurance Committee Trust Board
Distribution	• Via Risk Management Committee members • Via Trust Executive Quality Committee members

TABLE OF CONTENTS

RISK MANAGEMENT ANNUAL REPORT
2013/14 **Page**

1. INTRODUCTION

This report provides an overview of risk management activity which has continued in the Trust in 2013/14, in order to evidence that the management of risk is firmly established throughout the organisation. A culture which embraces the identification of incidents and risks, and learning will support the provision of quality, safety and continued improvement of the clinical services provided to patients. An in-depth analysis of maternity safety is covered in a separate annual report but the reported incidents, and themes for maternity are included in this report.

The Trust Board requires assurance that systems, processes, policies and people are operating in a way that is effective, focussed on key risks and are driving the delivery of objectives. This summary report is intended to be part of that process and assist in providing assurance that key risks are being identified, measured and managed.

Throughout the report, where possible comparisons are made with previous years so that trends are highlighted and where possible to identify improvements made in the Trust.

1.1 Key Achievements and Messages during 2013/14

These include:

- The Trust successfully achieved NHSLA Level 3 in October of 2013. The NHS Litigation Authority (NHSLA) concluded their assessment process for the Trust's application to meet the standards for NHSLA Level 3 accreditation on 4th October 2013 and confirmed that the Trust achieved Level 3 accreditation having passed 48 out of 50 of the criteria. This is a tremendous achievement
- A total of 7,063 incidents were reported during the 12-month period 1st April 2013 to 31st March 2014. This compares with a total of 6,314 incidents in the previous year (2012/13), representing a 12% increase.
- 81% of the total number of incidents reported during 2013/14 was closed within 45 working days. This is an improvement on 2012/13 when 71% of incidents were closed within this timescale. The best performing out of the three divisions in terms of meeting this target was CSS who closed 92% of their incidents within the required timescale, followed by Medicine & Surgery with 84%. Women, Children, Neonatal & Young Peoples' Services closed 75% of their incidents within 45 working days. Further work will be undertaken during 2014/15 with the aim of achieving 100% closure within the given timescales.
- With respect to the timely reporting and investigation of serious incidents, during 2013/14 we reviewed and revised our serious incident escalation, reporting and investigation processes. This has meant that incidents which require reporting on the Strategic Executive Information System (STEIS) are communicated and investigated in a more timely fashion.
- The standing panels are well established in all Divisions with the exception of CSS, where panel dates are arranged at an early stage following escalation of a serious incident. This has contributed to the timely review and closure of serious incidents.
- To strengthen the process for completion of the review of pressure ulcer Root Cause Analysis (RCA) a timetable for the panel to convene has been agreed. The completed reports are presented at the Preventing Harm Group, with executive sign off prior to this if required in order to meet the timescales for provision of reports to the commissioners
- Development of a training tool which brings together relevant sections of risk management policies and procedures for use in senior manager induction and lead investigator training
- The Acute Mental Health Group has strengthened communication and working relationships between Central and North West London NHS Foundation Trust.
- There was a minor reduction in the number of falls leading to significant harm when compared to the previous financial year, however, overall, there was no reduction in the total number of falls reported. Detailed analysis of the timing and location of falls was undertaken and presented at the Preventing Harm Group in order to agree recommendations to further reduce the number of falls.
- A trust VTE project aimed at driving novel initiatives in preventing VTE's was awarded second place at the Thrombus Innovation Awards.

1.2 Training

Throughout the year, the Trust has continued to develop systems, roll out training, undertake both internal and external reviews and ensure that all members of staff are encouraged to take the opportunity to learn from adverse events when they occur. In taking this ethos forward within the year we have:

Provided training in risk assessment and incident management via:

- Staff induction events such as the Corporate Induction where Risk Management forms part of the mandatory training agenda
- Department and individual specific training events, including use of the Clinical Governance Half Day meetings for feedback on learning and recommendations from incident investigation
- Mandatory training, infection control updates and CEWS, and later NEWS, related training sessions
- Individual 1:1 training for nominated Lead Investigators at the outset of an incident investigation
- 'ad hoc' training at the request of staff
- Staff annual updates

100% of the senior managers who joined to organisation in 2013/14 received Risk Awareness Training for Senior Managers provided by the Head of Clinical Governance

1.3 Risk Management Strategy and Policy

The Trust vision is to deliver safe care of the highest quality to our patients, provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state of the art technology and high class academic research.

The Trust is committed to a strategy and policy which minimises the risks of harm to people, services and the Trust and which aims to influence behaviour and develop an organisational culture within which risks are seen as everyone's responsibility and where they are promptly recognised and addressed. The Trust also strongly supports the principles of openness, transparency and candour and requires honesty openness and truthfulness in all dealings with the patients and the public.

The purpose of the Risk Management Strategy document is to outline the strategic direction for the management of risks within the Trust and to provide a framework for the continued development of the risk management processes throughout the Trust. Approval of the Trust's strategy and policy for risk management is a matter reserved to the Board.

The Risk Management Strategy is reviewed on an annual basis with the next review due in Q1 2014/15.

1.4 Objectives from the Risk Management Strategy 2013/14

- To develop a prevention strategy to include considering foresight training, continued focus on assurance on actions implemented, continued monitoring of controls and assurances for never events, the continued use of risk assessments locally and strategically and actions linked to them and focusing audit on ensuring 'right first time' for key procedures
    - Progress: A never event assurance document should be prepared for all never events. The document is presented at the Quality Committee in accordance with a predefined schedule. Further work is required to ensure that all never event reports are considered, and where necessary, strengthened during 2014/15.

- To achieve level 3 NHSLA general risk management standards in October 2013
    - Progress: This was achieved in October 2013.

- To identify and then monitor appropriate timescales for investigating incidents, including panel meetings and completion of reports in order to meet commissioner targets. A baseline will be established and targets set for the year by September 2013. Achievement of the targets may require fundamental changes to the current process
    - Progress: There has been a notable improvement in the timely investigation and closure of all incidents, including serious incidents. This objective will be taken forward in 2014/15 to incorporate the KPI of 45 working days for serious incidents.

- To implement on line incident and risk reporting and a supporting risk management system (to include incidents, claims, risks, COSHH assessments and complaints/M-PALS) by March 2014
    - Progress: Whilst the implementation of the system has not yet taken place, procurement is due to be finalised during Q1 2014/15. The anticipated timescales are six months from the date of procurements but will be implemented fully within the next financial year.

- To continue to ensure appropriate integration of all aspects of risk into day to day operations of the Trust and in particular Health and Safety by December 2013
    - Progress: This objective will be considered for inclusion in the 2014/15 objectives.

- To ensure appropriate application of the Quality Governance Framework to risk structures and processes by March 2014
    - Progress: This objective will be considered for inclusion in the 2014/15 objectives.

2. CLINICAL NEGLIGENCE SCHEME FOR TRUST RISK MANAGEMENT STANDARDS

The Clinical Negligence Scheme has made a significant contribution to putting risk management high on the organisation's agenda. It improves the safety of patient care, as well as engaging clinicians and managers in improving quality. The Trust is currently accredited at Level 2 for both Maternity services and Trust-wide general services.

The Levels are set out as follows:

- Level 1 - Policy (approved policies in place)
- Level 2 - Practice (demonstrated implementation of the approved policies)
- Level 3 - Monitoring (systems to monitor policy implementation and where deficiencies are identified, evidence that recommendations have been developed and changes implemented).

The CNST Standards consolidate best practice from a number of sources and translate this into practical guidelines which cover:

1. Governance
2. Learning From Experience
3. Competent & Capable Workforce
4. Safe Environment
5. Acute Providers

The NHS Litigation Authority (NHSLA) concluded their assessment process for the Trust's application to meet the standards for NHSLA Level 3 accreditation on 4th October 2013 and confirmed that the Trust achieved Level 3 accreditation having passed 48 out of 50 of the criteria. This is an extremely positive outcome for the Trust.

During this two day assessment the NHSLA assessors have examined evidence of how the Trust complies with their risk management standards. This process included evidence of policies and procedures and also how these are put into practice by the assessors visiting wards and looking at records.

3. RISK REGISTER

3.1 Risks Contained On the Risk Register in 2013/14

Risk assessments provide a way of avoiding incidents that cause harm by anticipating and dealing with what might go wrong. They highlight weaknesses in procedures, policies and practice. They are an important way of protecting staff and patients as well as complying with the law, which expects organisations to protect people as well as is 'reasonably practicable'. Risk assessments support better decision making through an understanding of the risks and their likely impact. They should identify the significant risks arising out of the activities undertaken within the organisation and assess the impact on the Trust.

At the end of March 2014, there were a total of **207 open** risks on the Trust wide register, representing a 5% decrease on 2012/13. **55** out of the total 207 risks relate to corporate objectives identified in the development of the **Assurance Framework** over the years and through papers provided to the Board. Assurance Framework risks relating to the current years' corporate objectives are reported directly to the Trust Board.

Of the open risks on the register, **35** out of the remaining 152 non Assurance Framework risks were graded **orange**, and **none** were graded **red**.

Risks are categorised by 'risk type', indicating the type of consequence that an identified risk may have. The open risks on the register at the end of March 2014 were categorised by type as follows:

Chart 3.1: Open risks on the register by risk type and source

	Clinical	Financial	H&S	IT	Performance	Total
Assurance framework	10	19	4	0	22	**55**
Comprehensive risk review	2	0	0	0	0	**2**
Incident	6	1	4	0	2	**13**
Risk Assessment	57	5	65	6	4	**133**
Totals:	**75**	**25**	**73**	**6**	**28**	**207**

Risks are routinely categorised by the source of the risk, i.e. comprehensive risk review, incident or assurance framework for example. 64% of all risks on the register were identified through risk assessments being carried out while only 1% arose from completion of the annual comprehensive risk review. 6% of risks were linked to an incident investigation.

In 2013/14 a total of **43** new risks were opened on the register (compared to 91 the previous year) with **8** being closed during the same time period. **3** of the new risks related to the Assurance Framework.

18 (42%) out of the **43** new risks were graded orange and **3** were initially graded red but were subsequently downgraded to orange.

Chart 3.2: New Risks 2013/14

Directorate	VLOW	LOW	MOD	HIGH	TOTAL
Anaesthetics and Imaging Directorate	**1**	**0**	**0**	**0**	**1**
Clinical Support Services	**11**	**2**	**0**	**0**	**13**
Imperial College Healthcare Trust	**0**	**0**	**1**	**0**	**1**
HIV GUM Directorate	**0**	**4**	**1**	**0**	**5**
Whole Hospital	**0**	**0**	**4**	**0**	**4**
Medical Directorate	**1**	**1**	**0**	**0**	**2**
Non Clinical Support Services	**0**	**0**	**1**	**0**	**1**
Nursing Directorate	**0**	**0**	**1**	**0**	**1**
Surgical Directorate	**0**	**0**	**2**	**0**	**2**
Women and Children Directorate	**2**	**3**	**3**	**0**	**8**
TOTAL	**15**	**10**	**13**	**0**	**38***

*5 of the new risks in 2013/14 were not assigned to a specific directorate, the majority of these were Assurance Framework risks.

Chart 3.3: Closed Risks 2013/14

Directorate	VLOW	LOW	MOD	HIGH	TOTAL
Anaesthetics and Imaging Directorate	0	1	1	0	2
Clinical Support Services	1	1	0	0	2
HIV GUM Directorate	1	1	1	0	3
Whole Hospital	2	1	1	0	4
Medical Directorate	1	1	0	0	2
Non Clinical Support Services	0	1	0	0	1
Surgical Directorate	0	2	1	0	3
Women and Children Directorate	4	3	1	0	8
TOTAL	9	11	5	0	25*

*2 of the closed risks in 2013/14 were not assigned to a specific directorate.

Chart 3.4: Risks remaining on the register for more than 1 year as at 31st March 2014

Directorate	VLOW	LOW	MOD	HIGH	TOTAL
Anaesthetics and Imaging Directorate	10	3	0	0	13
Clinical Support Services	15	5	0	0	20
Governance and Corporate Affairs	0	1	0	0	1
Imperial College Healthcare Trust	0	1	0	0	1
HIV GUM Directorate	6	8	1	0	15
Whole Hospital	4	36	13	0	53
Medical Directorate	1	4	8	0	13
Non Clinical Support Services	0	5	2	0	7
Surgical Directorate	0	4	2	0	6
Women and Children Directorate	7	16	3	0	26
TOTAL	43	83	29	0	155

*17 of these risks were not assigned to a specific directorate.

3.2 Actions Taken to Mitigate Risks on the Register

During 2013/14 a total of 46 risk assessments were downgraded. A number of action plans relating to risk assessments have been completed in 2013/14, including:

- **Provision of NIV in the ED:** An NIV machine has been purchased for the Emergency Department via capital funding with stock of disposables such as tubing and face masks stored locally. Education of medical and nursing staff on the machine functionality and its indications has been provided via (initially) daily open teaching sessions in the department, targeted Registrar teaching sessions, a study day dedicated to NIV and Team study days in conjunction with the Critical Care Outreach Team.

- **Paediatric Emergency Department Staffing:** This risk was successfully mitigated with the appointment of 6 new Paediatric consultants.

- **Paediatric PCA Pumps:** New pumps were put in use by the Pain Team and the risk was downgraded to green for a period of 3 months but as no further incidents were identified the risk was closed.

- **NICU – Access to Piped Oxygen in Radiology:** This issue was addressed in the latter part of Q3 2013/14. There is now access to piped air in one of the interventional radiology suites and as the risk has been completely mitigated it was taken off the register.

- **Current blood satellite fridge is near end of working life (Labour Ward):** The status of the fridge was frequently discussed at the Risk Management Committee and the standing panel. The fridge was in use but shut down following being unplugged in error. Trust contractors attempted to mend the fridge which led to it being out of warranty. A placebo was used to check for temperature/ cold chain compliance before reinstating its use and since there were no issues in relation to functionality the risk was closed. Further education in relation to the 'cold chain' has been provided to the relevant members of staff.

- **Risk of Cross Infection in the Burns Unit**: This risk has been mitigated through the opening of the new rebuilt unit in Q4 2013/14.

- **Labour Ward Blood Fridge:** A new fridge was installed at the start of 2014. As there had been no issues in relation to functionality but further education was deemed to be required in relation to the 'cold chain' the risk remained open on the register while this was put in place but has since been closed.

4. INCIDENT REPORTING

In the course of providing healthcare, unintended or undesirable incidents will occur, some of which may have serious consequences for patients, staff and the public. The Trust Board seeks to ensure that when they do they are promptly reported and investigated to establish "how" and why" the incident happened. The emphasis will be on discovering the root causes of an incident and not on apportioning individual blame. This approach requires each individual member of staff to understand their personal accountability and responsibility for ensuring patient safety.

The Trust recognises that many incidents occur because of systems failure rather than failings of individuals and as such the response should not be one of blame, but of learning and a drive to reduce risk for future patients, visitors and staff.

The Trust Board expects that whenever an incident is reported, it is investigated; learning will take place and services improved. Through this process of identifying, investigating and learning, services will be continually improved.

This commitment to safety will be delivered by everyone within the organisation understanding:

- the importance of timely incident reporting
- the significance of effective incident management
- the need to cooperate in the investigation of incidents, within the agreed timescales; analysing incidents and taking the appropriate preventative action
- the value of incident reviews to establish root causes, contributory factors and facilitate wider organisational learning
- the importance of involving patients and carers

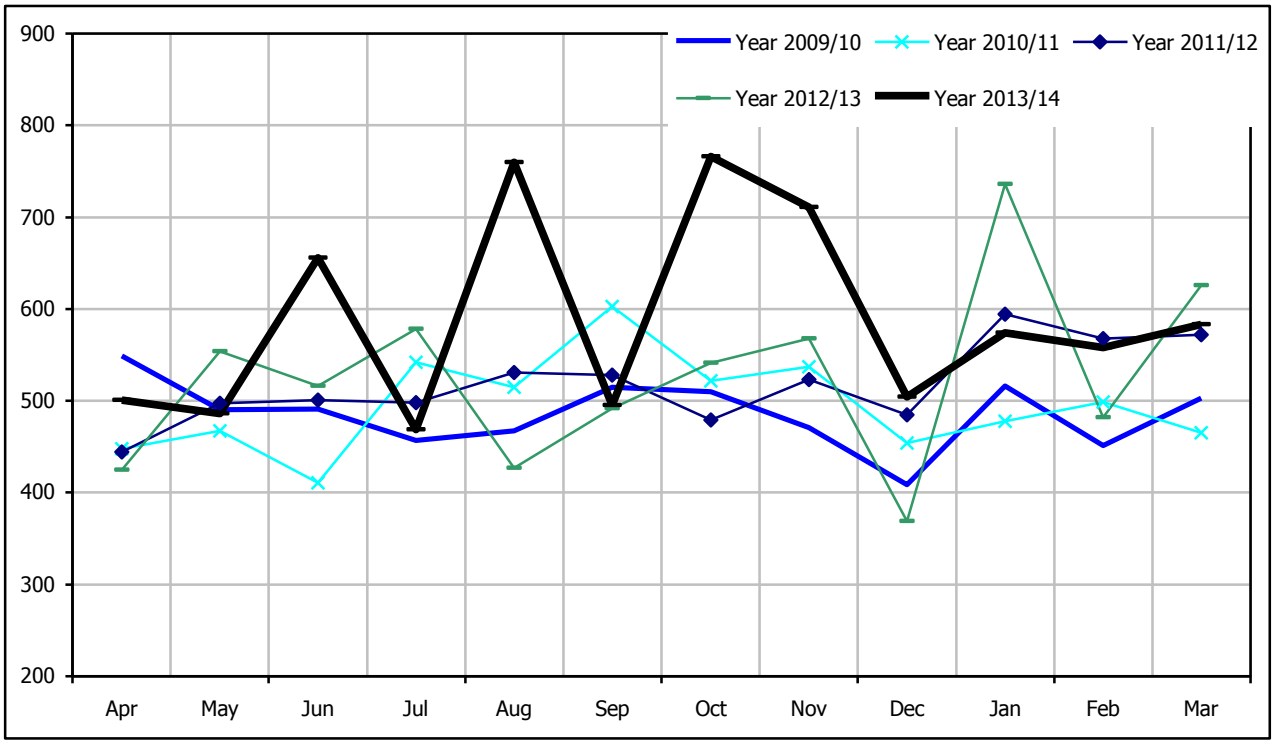
The organisation's response to incident reporting and investigation will be open and inclusive, will value learning from staff, patients, carers, external stakeholders and will react to problems positively, encourage questioning and will learn from mistakes.

Accidents, near misses and incidents must be formally reported through the Trust's Incident Reporting System. Incidents are reviewed and graded by the relevant Risk Lead or department manager, Service Director, Clinical Director or relevant Divisional Director. The Chief Executive is notified of any serious (orange or red) incident. Where indicated, for example when orange or red incidents occur, an investigation is held in order to determine the facts and details surrounding the incident and to identify actions to improve care.

4.1 Total Number of Incidents Reported 2013/14

A total of **7,063** incidents were reported during the 12-month period 1st April 2013 to 31st March 2014. This compares with a total of **6,314** incidents in the previous year (2012/13), representing a **12% increase**.

Chart 4.1: Reported incidents: Monthly breakdown incidents Apr 2009 - Mar 2014



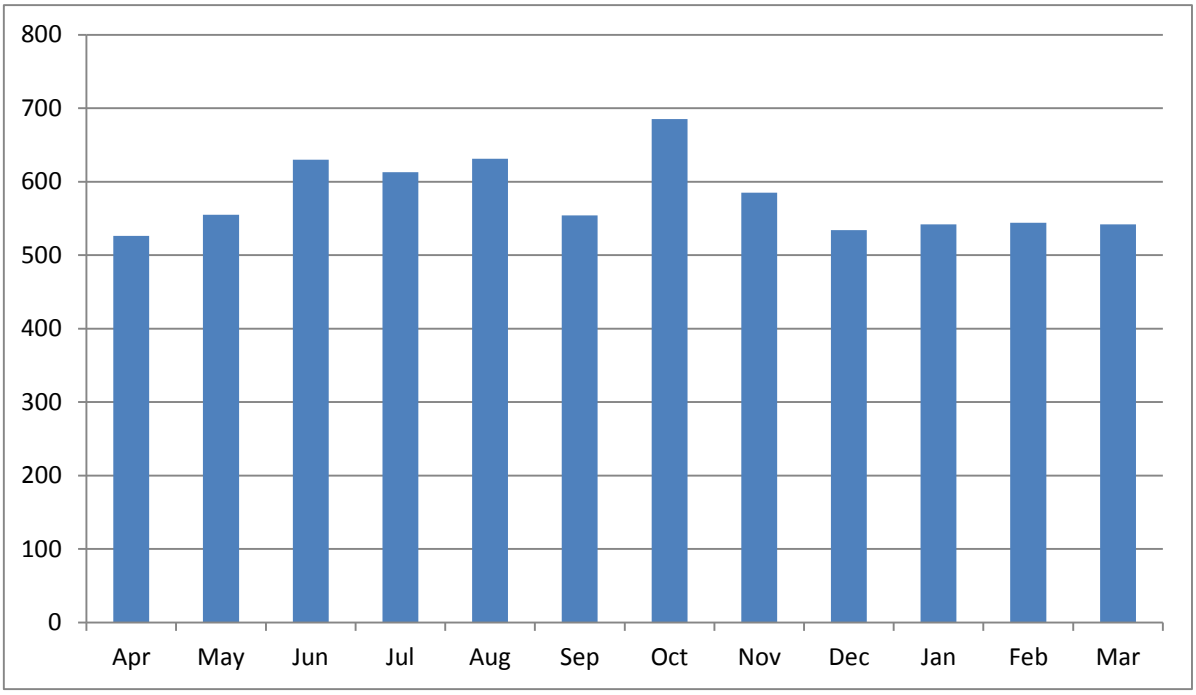
The above graph shows the total number of incidents received by the Risk Management Department by month and illustrates occasions where there has been a noticeable delay in incident forms being submitted, such as in July and September 2013. Please see section 4.3 on page 10 for more information relating to batching.

Chart 4.2: Reported Incidents: Number of incidents per month, Apr 2009 – Mar 2014

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2009/10	549	490	491	457	467	515	510	471	409	516	451	503	5829
2010/11	448	467	411	542	515	603	522	537	454	478	499	465	5941
2011/12	444	497	501	498	531	528	479	523	485	594	568	572	6220
2012/13	460	521	531	560	505	426	530	597	569	555	504	556	6314
2013/14	501	486	656	469	760	495	766	711	504	574	558	583	7063

The graph and table above compare the total number of incidents reported each month during 2013/14 with the 4 previous financial years.

Chart 4.3: Incidents in 2013/14 by actual incident date

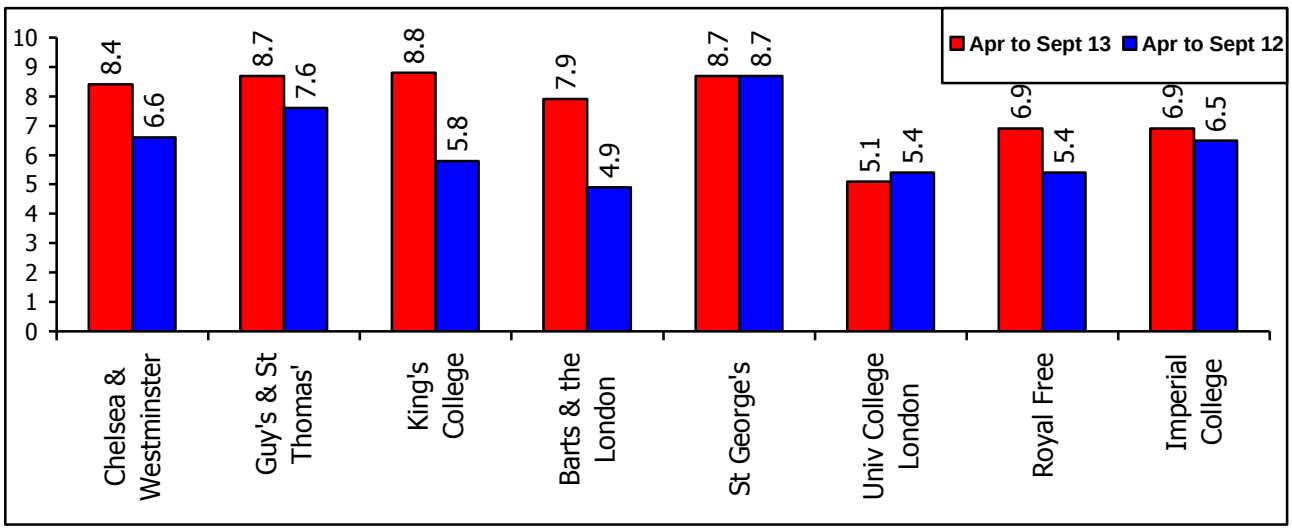


The above graph shows the number of incidents in 2013/14 by the month they actually occurred. This supports graph 4.1 in evidencing the delay in submitting forms as the number of incidents occurring has remained fairly stable throughout the year. The data in the annual report is displayed by opened date as this is the most accurate way to ensure all incidents are included in the report as batching may delay receipt of the forms.

4.2 Comparison with our Peers – Patient Safety Incidents

A high reporting rate indicates a strong reporting and learning culture. Experience from other industries shows that as an organisation's reporting culture matures, staff become more likely to report incidents. The graph below shows the reporting rate per 100 admissions, comparing the Chelsea and Westminster Hospital with other Acute Teaching Trusts in the London Strategic Health Authority, based on incidents occurring between April - September 2012, and also April - September 2013. The reporting rate per 100 admissions at the Chelsea and Westminster Hospital was 8.4 in the 6 month period April – September 2013, up from 6.6 during the same period in 2012. The reporting rate of 8.4 compares with an average reporting rate of 7.7 at similar Trusts. The data used for this comparison was extrapolated from the NPSA website.

Chart 4.4: Reporting rate per 100 admissions: Comparing Acute Teaching Trusts in NHS London



It is most often the case that those organisations which report more have a stronger learning culture where patient safety is a high priority – so resulting in better and more established reporting amongst all staff. The substantial increase in reporting seen at St George's is largely due to the recent introduction of an online reporting system.

Nationally – in 2012/13 - **67%** of incidents were reported as no harm, and 1% as severe harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way, which contributes to variations in the harm profile of each organisation. Therefore, deaths are often reported as incidents, even though it may relate to a natural course of events/the patient's illness or underlying condition.

Organisations are advised to record the actual harm to patients rather than potential degree of harm. **81%** of all incidents reported by the Trust were **no harm** incidents, well above the national average.

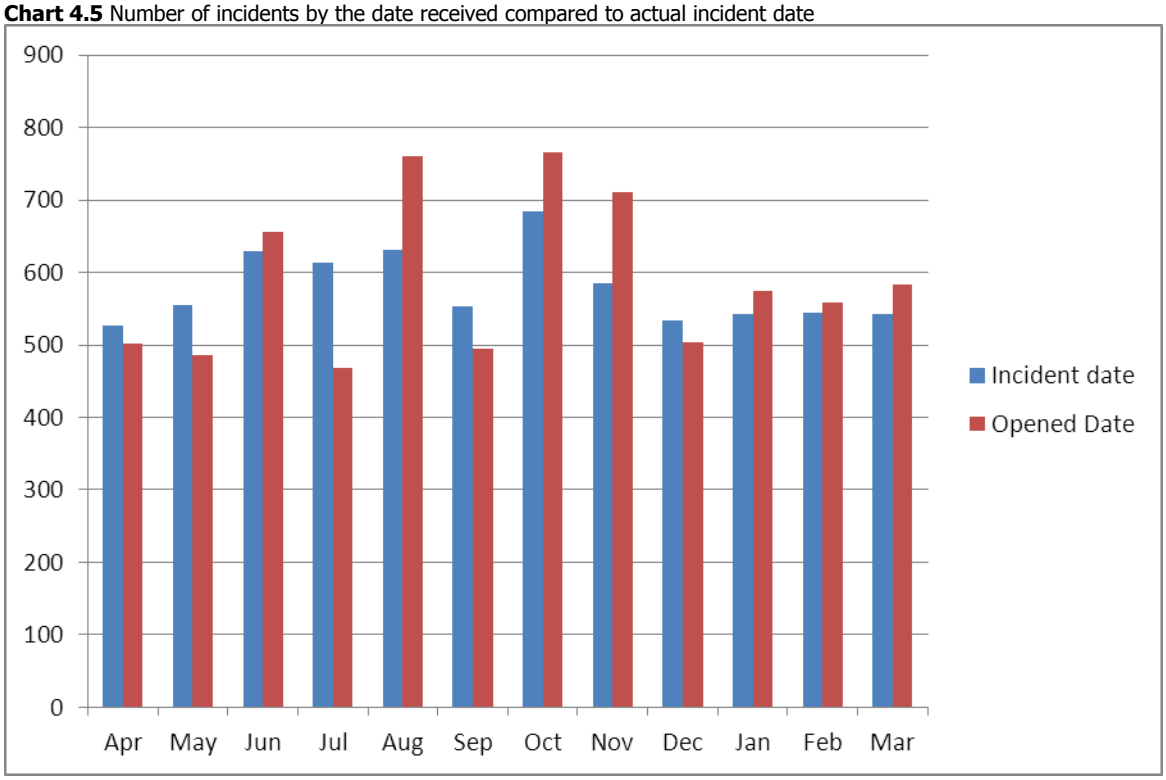
The information within the remainder of this incident reporting section will focus predominantly on the comparisons between 2012/13 and 2013/14.

4.3 Batching Incident Forms 2013/14

In order to reliably compare month on month statistics, incidents are reported according to the date that they are received and entered onto the datix system. This takes into account the frequent bottlenecks within reporting areas, and ensures that statistics reported to the range of committees, and also weekly, monthly and quarterly report data is not subject to frequent conflicting information as a result of late batches of submitted forms.

The graph below compares incidents according to the month entered onto the system and the month the incident occurred over the previous twelve months. The graph below shows a comparison between the date that the incident actually occurs and the date that incidents were added to Datix by the Risk Management Department during 2013/14.

Chart 4.5 Number of incidents by the date received compared to actual incident date



The graph above illustrates the difference between the dates the incidents occurred and when they were received and stamped by the risk management department, showing that there have been minor delays in August, October and November in submitting forms as well as an issue with residual batching in the last

quarter as the number of forms received was much greater in this month than the number of incidents occurring during the same period. It is worth noting that at the time the information for this report was collated incident forms were still being received and processed for events that occurred in December 2013, closing this gap but still indicating that forms are not consistently being submitted immediately after the incident.

In order to reliably compare month on month statistics, incidents are reported according to the date that they are reported and received by the Risk Management office, rather than the date that the incident occurs. This takes into account the frequent bottlenecks within reporting areas, and ensures that statistics reported to the range of committees, and also weekly, monthly and quarterly report data is not subject to frequent conflicting information as a result of late batches of submitted forms.

Delays in forwarding incident forms account for the discrepancies shown above. This issue has in the past been brought to the attention of the relevant departments such as Pharmacy, Maternity and Pathology, and is escalated to the relevant department managers or risk leads as required.

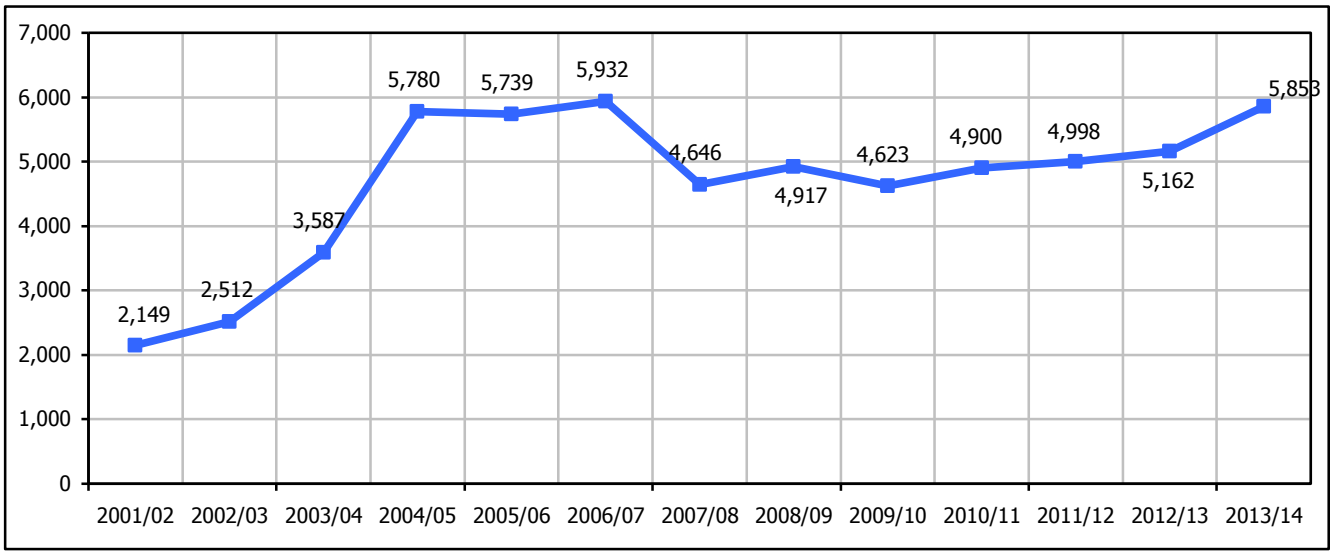
Actions taken to address the issue of batching include:
1. Introduction of an incident form amnesty across different clinical areas.
2. Allocation of risk responsibilities to area leads, who can monitor batching in their clinical areas.
3. Introduction of the Clinical Incident review form in Maternity, to provide a more comprehensive investigation into low level incidents.
4. Introduction of the incident feedback form to evidence that staff feedback from incidences has occurred.

Prompt reporting of incidents is important for:
- Ensuring appropriate management to reduce identified risks
- Documenting the incident and the circumstances, in case of later complaint or claim
- Providing accurate monitoring, so that collective data analysis can inform measures to improve patient and staff safety, and reduce the risk of further exposures.

4.4 Incident Types Reported 2013/14

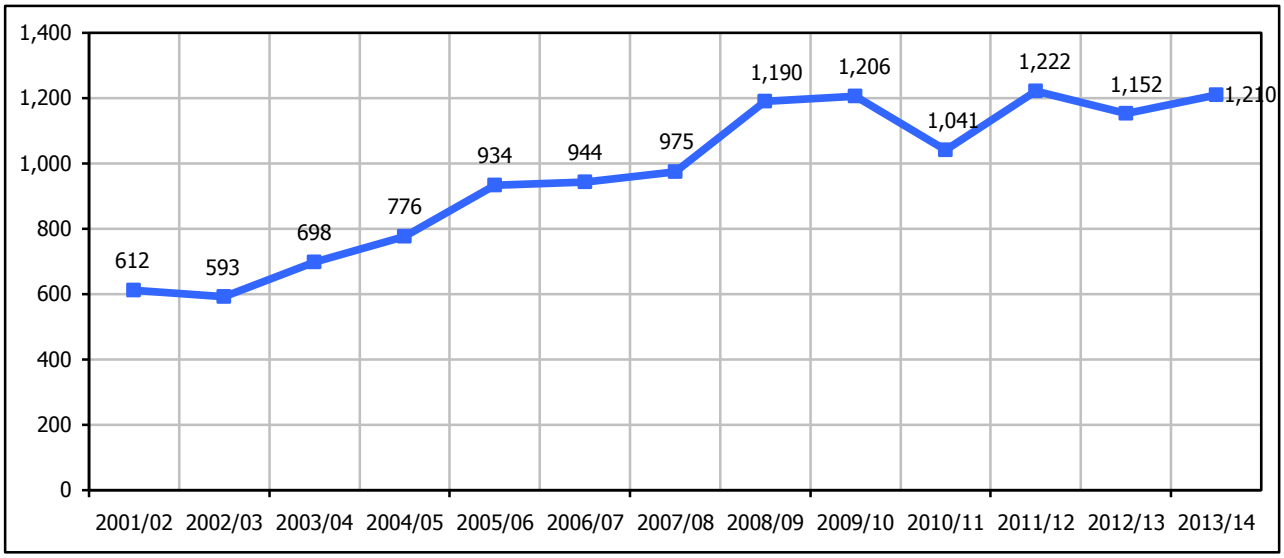
Of the 7,063 incidents reported in 2013/14, 5,853 (83%) related to patient safety incidents (clinical incidents), and 1,210 (17%) related to non-clinical (Health & Safety) incidents. The number of reported patient safety incidents is outlined in chart 4.6 and the number of reported non-patient/staff related incidents is outlined in chart 4.7.

Chart 4.6: Number of reported patient safety incidents reported over 13 years: Apr 2001 - Mar 2014



The above graph shows that 2013/14 saw the biggest increase (13%) in patient safety related incidents since 2004/05 which had seen a 61% increase from 2003/04.

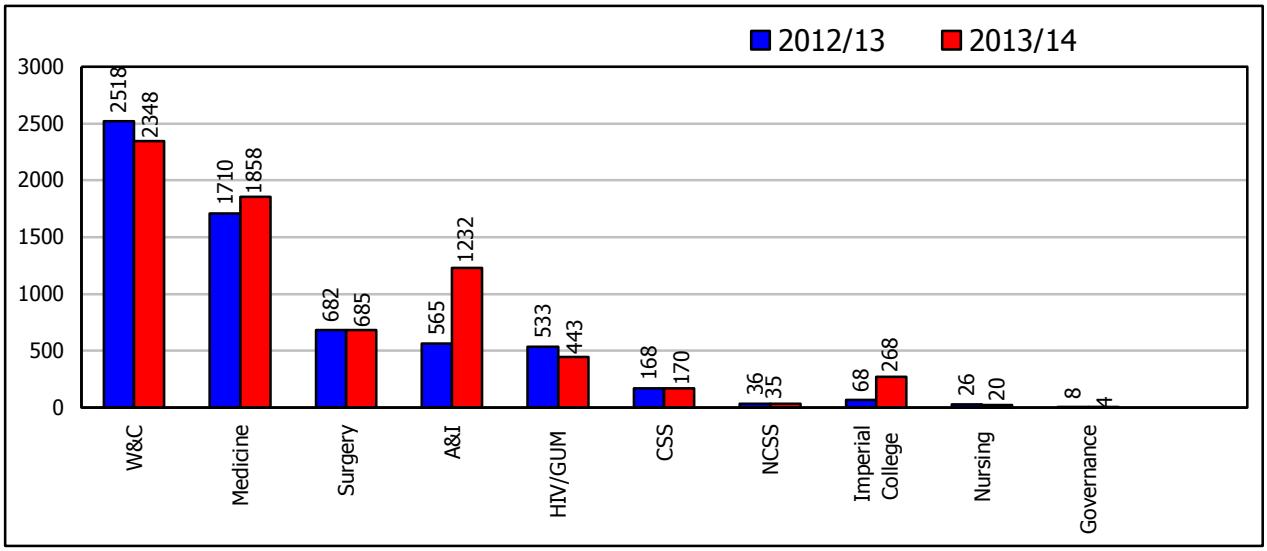
Chart 4.7 Number of reported staff-related non-clinical incidents reported over 13 years: Apr 2000 - Mar 2013



2013/14 saw an increase of 5% in the number of reported non clinical incidents, following a 6% decrease seen in the previous financial year. **This represents an increase of 12% in the total number of incidents reported (both clinical and non-clinical).**

The number of incidents received for each directorate is shown in Graph 4.8.

Chart 4.8: Incidents Reported by Directorate, 2012/13 vs. 2013/14 (Clinical and non-clinical)



The biggest increase (294%) in reporting was seen in incidents submitted to the Trust by Imperial College that relate to the pathology services. These incidents are entered onto our database, and sent out to the specific areas for follow up to enable closure. Anaesthetics & Imaging reported 118% more incidents in 2013/14 compared to 2012/13. Increases were also seen in Medicine, Surgery and Clinical Support Services. HIV/GUM saw an 18% decrease in reporting while W&C reported 7% fewer incidents compared to the previous year. A change in how blood related incidents are recorded and allocated for follow-up which led to a significant redistribution of these incidents in terms of division/directorate is thought to be responsible for the decrease in Maternity as they were previously the highest reporting specialty of these incidents.

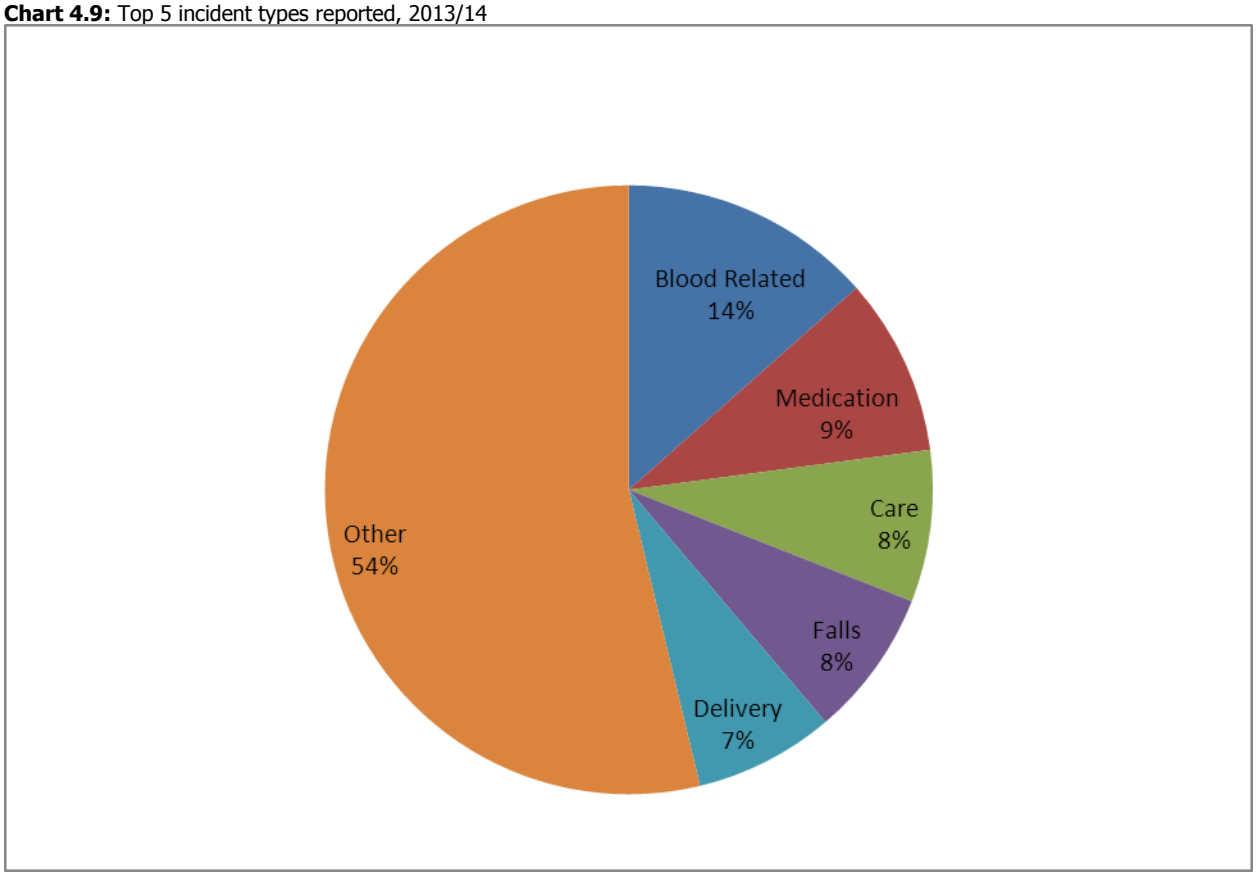
There are occasions where incidents reported by one division/directorate/department may require action by another; the risk managers employ judgement about which directorate reports and takes action on the incident. Actions taken by other divisions/directorates/departments are fed back to the reporting division or directorate.

4.5 Top 5 Incident Types Reported

The trends in incident types reported remained relatively unchanged in 2013/14, and are similar to trends reported in previous year, the only difference being that falls were previously the third highest reported category and care related incidents the fourth. Birth/delivery incidents saw the highest increase, 22%, compared to 2012/13.

During 2013/14, the top five incident types were as follows:

Chart 4.9: Top 5 incident types reported, 2013/14



The top 5 are as illustrated above:

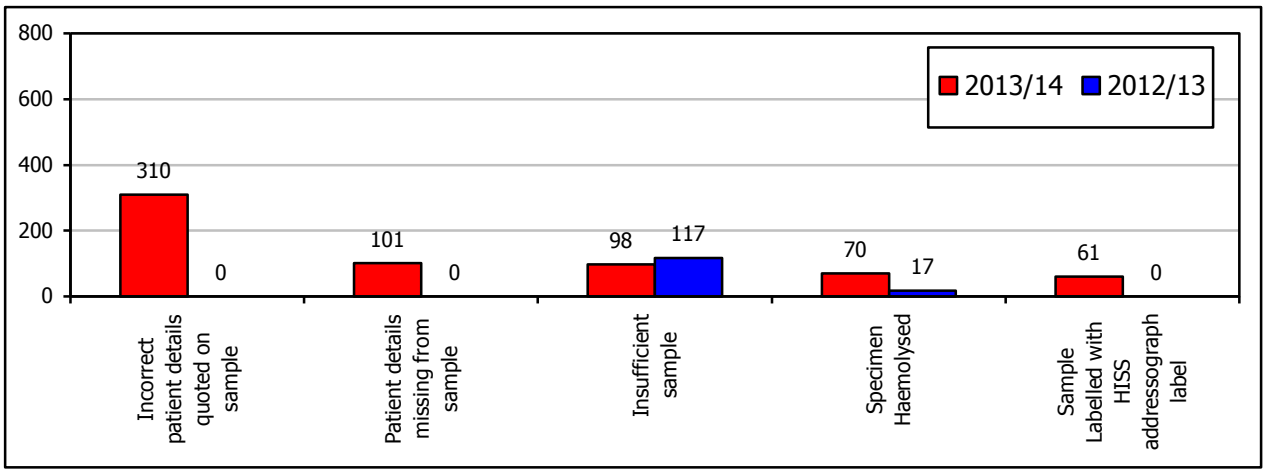
1 **Blood/blood related incidents** – 951, an **increase** of 22% from 782 in 2012/13.
2 **Medication** – 666, a **decrease** of 13% from 766 in the previous year.
3 **Care –** 570, an **increase** of 9% from 522 in 2012/13.
4 **Falls** – 554, an **increase** of 2% from 533 in 2012/13.
5 **Delivery** – 525, an **increase** of 22% from 429 in 2012/13.

Included in the 'other' incidents are all those incident reporting categories not already featured in the top 5, such as 399 staff related incidents, 395 pressure ulcers (both community and hospital acquired), 374 pathology incidents, 309 documentation related events, 264 treatment incidents, 183 equipment related incidents, 149 related to communication (written and verbal) and 136 incidents related to patient transfer matters.

1. Blood Incidents

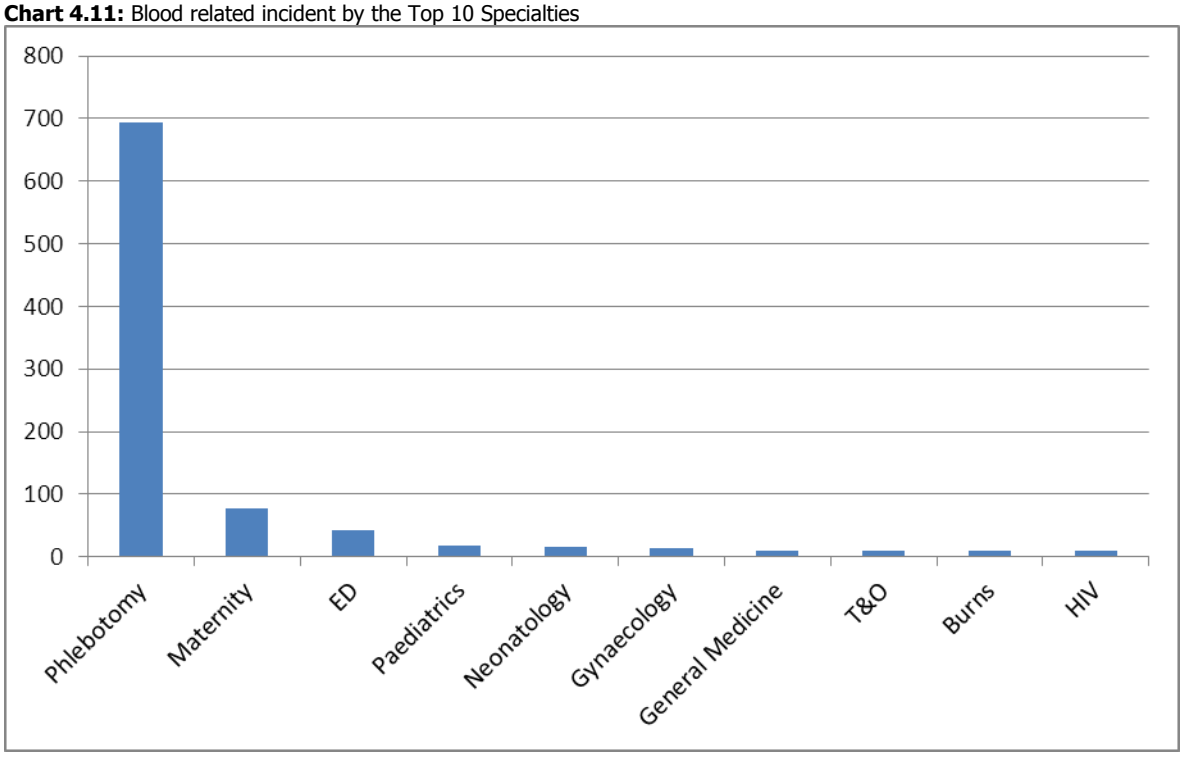
There were 951 blood related incidents reported during 2013/14, an increase of 22% compared to the number reported in 2012/13 (n=782).

Chart 4.10: Blood related incident categories, 2013/14 compared with sub-categories in previous year



The graph above illustrates that most incidents relate to sampling errors, bottles and tubes being incorrectly labelled which led to sample rejection and in some cases mean that patients have to be re-bled.

Chart 4.11: Blood related incident by the Top 10 Specialties



The majority of incident forms were generated when errors in the collection or requesting of blood were identified which led to the sample being rejected by the laboratory. In some instances this may lead to a re-bleed.

At the beginning of 2013/14 there was a change in the way in which rejection incidents were recorded and classified – the incidents were considered the responsibility of the phlebotomy team (logged under CSS). This change resulted in a significant re-distribution of the blood related incidents when compared to previous quarters.

Following communication with the laboratory it was clarified that data was available to confirm where the bloods were taken. Subsequently, during Q4 the classification changed back to that of the specialties. This

can account for an apparent reduced level of reporting in some areas, including maternity who had previously been noted to have a high rejection rate.

Other incident types that are reported are predetermined by the National Blood Transfusion Committee. These incident types are commonly known as Serious Hazards of Transfusion (SHOT) or Serious Adverse Blood Reactions & Events (SABRE) categories. These incidents relate to tests required for safe blood or blood component transfusions, not routine blood tests (e.g. biochemistry).

Other incident types that are reported are predetermined by the National Blood Transfusion Committee. These incident types are commonly known as Serious Hazards of Transfusion (SHOT) or Serious Adverse Blood Reactions & Events (SABRE) categories. These incidents relate to tests required for safe blood or blood component transfusions, not routine blood tests (e.g. biochemistry).

2. Medication

There were 666 medication incidents reported during 2013/14, a decrease of 13% compared to the number reported in 2012/13 (n=766). Locally,

Chart 4.12: Top 5 medication-related incident types during 2012/13, including % change since 2011/12

	N° OF INCIDENTS 2013/14	N° OF INCIDENTS 2012/13	% CHANGE
Wrong dose given to patient	93	54	+72%
Administration of medication delayed	63	46	+37%
Medication /premedication not given	60	64	-6%
Drugs not prescribed properly	54	44	-27%
Over administration	47	24	+/-0%

All medication incidents are reviewed monthly by the Lead Directorate Pharmacists (LDPs) in order that they can provide timely support to ward staff and help to change systems and processes where this would reduce the risk of recurrence. The LDPs are responsible for following up relevant incidents within their directorate and liaise with their ward nurses and or doctors as appropriate. Every quarter a Pharmacist Summary of Medication Incidents is produced to ensure that there is a centralised analysis of trends and actions taken as a result of medications incidents are followed up until point of completion. The report is used to inform agenda items referred for addressing via the Senior Nurse & Midwifery Committee (SNMC). Medication Safety initiatives are a standing item on the SNMC agenda and discussed monthly. Any actions specific to clinicians are discussed directly with the appropriate lead clinician. The Pharmacist Summary of Medication Incidents report and subsequent discussions and/or actions taken as a result of medication incidents are reflected within the Trust Quarterly/Annual Risk Management Reports for shared learning Trustwide.

An IV Task Force was established in early 2013/14 in response to an NPSA alert outlining the need for Trust's to review their injectable practices. Having undertaken audits of this, there are clear gaps in the process of IV administration in conjunction with the Trust policy.

A summary of the key themes relevant for this task force:

- Fluids- In particular, incorrect fluids being selected and given to patients and fluids being administered at an incorrect rate.
- Incorrect set-up of infusion pumps, resulting in drug administration at an incorrect rate and Paediatric PN being infused at incorrect rate.
- Incorrect drug selection and administration of wrong doses.
- Several incidents relating to heparin, in particular, rates being faster than intended according to guidelines and APTTs (1 incident resulting in moderate harm in 2012/13).
- IV antibiotics containing penicillin given to patients with penicillin allergy.
- Wrong antibiotics being given- tazocin given instead of co-amoxiclav.
- Incorrect type of insulin administered, incorrect sliding scale rate.
- Adrenaline given IV instead of IM.

Trends related to omitted and delayed medicines were presented to the SNMAC for discussion in Q4 2013/14 and senior nurses were requested to feedback the following to frontline staff:

- the importance of administration of anticoagulants and other high risk medications (e.g. antibiotics) unless a valid contra-indication is present or omitted clinically on the advice of the medical team
- the importance of administration of anticoagulant agents – unavailability is not a valid reason for a dose to be omitted – should always be followed up particularly for high risk medications
- the need to communicate to ward pharmacists if dose(s) are omitted
- The method of producing missed dose reports from LastWord was shared at the meeting and also electronically for dissemination to frontline staff.

During a meeting with the Chief Nurse a series of additional actions were agreed:

- To start quantitative dashboard analysis to be monitored through the Preventing Harm Group
- To draft written information for front line staff.

3. Care Incidents

There were 570 care-related incidents reported between 1st April 2013 and 31st March 2014, compared to 522 during April 2012 – March 2013.

Chart 4.13: Top 5 Care-related incident types during 2013/14, including % change since previous year

INCIDENT SUB CATEGORY	N° OF INCIDENTS 2013/14	N° OF INCIDENTS 2012/13	% CHANGE
Policy/procedure guidelines not followed	202	169	+20%
Failure to carry out adequate observations	179	176	+2%
Extravasation injury	65	38	+71%
Management plan/clinical advice not followed	49	57	-14%
Readmission or unplanned re-attendance	24	22	+9%

2013/14 saw a 20% increase in incidents reported relating to policy/procedure/guidelines not followed. However, it is worth noting that 90 (51%) of these incidents related to safeguarding concerns raised over care provided in the community which are reported under this category, mainly by staff in the ED.

A 71% increase in extravasation injuries was noted compared to the previous year. The 25 of these incidents occurred in paediatrics (38%) and 23 in neonatology (35%). 4 incidents were reported by Imaging (6%) and 3 (5%) by General Medicine.

No extravasation related incidents were escalated as orange in 2013/14 compared to 3 in the previous year. Work is still in progress in paediatrics and neonatology to agree a means of developing a grading matrix specific to extravasation injuries. A total 15 orange incident were labelled as care incidents (compared to 11 in 2012/13) with the majority relating to failure to carry out adequate observations (6 incidents), policy/procedure/guidelines not followed (4 incidents) or Failure to act on abnormal result (2 incidents).

Other care related incidents of note are detailed below:

- Heparin infusion noted to be down when Co-amoxiclav was being hung. Staff unable to ascertain who disconnected the infusion. Staff member on previous shift insists it was infusing on handover.
  Action taken: Staff in charge have been asked to check all Heparin and Insulin infusions at commencement of shift.

- Patient attended emergency department eight days following discharge for post-caesarean wound infection with lower abdominal pain. Patient was sent to AAU as per protocol but was not reviewed by obstetric team as she declined admission.
  Action taken: The affected staff members were briefed on the incident.

- During handover staff member noticed that the patient had a central line inserted. The line was half hanging down as only two stitches remained on the left side. There was no dressing to witness.
  Action taken: Appropriate teams informed of incident and requested to review patient. Medical staff later checked the line as part of their CVC round. Patient later transferred to another ward.

- Patient was on food plan of 'thick fluids and trials of teaspoons yoghourts/custards only'. Patient had treatment at another Trust and was given a bowl of thin carrot soup with bits for dinner in error.

Action taken: The patient aspirated and multiple medical teams were called but the patient's medical notes were unavailable.

- Patient's procedure was cancelled by specialist member of staff as no pre-assessment had been completed. Patient's clinic letters and investigation reports were also not available. No bed available for patient in ITU after procedure.
  Action taken: Appropriate staff member informed, the patient was re-booked to have their procedure at a later date and was given an appointment to attend pre-assessment.

4. Falls

Falls was the fourth highest Trust-wide reported incident type during 2013/14. 554 falls were reported during this period, of which 508 were patient safety related (compared to 489 in 2012/13) and 46 were non-clinical (staff/members of public), compared to 44 the previous year.

Although the vast majority of falls incidents result in minor injuries or no harm even these can reduce patients' confidence, lead to delays in discharge and the loss of independent living. Nationally, it is estimated that over 500 people suffer hip fractures each year following a fall in hospital, with potentially devastating consequences for their long-term health.

The reasons why patients fall are complex and influenced by contributing factors such as physical illness, mental health, medication and age, as well as environmental factors.

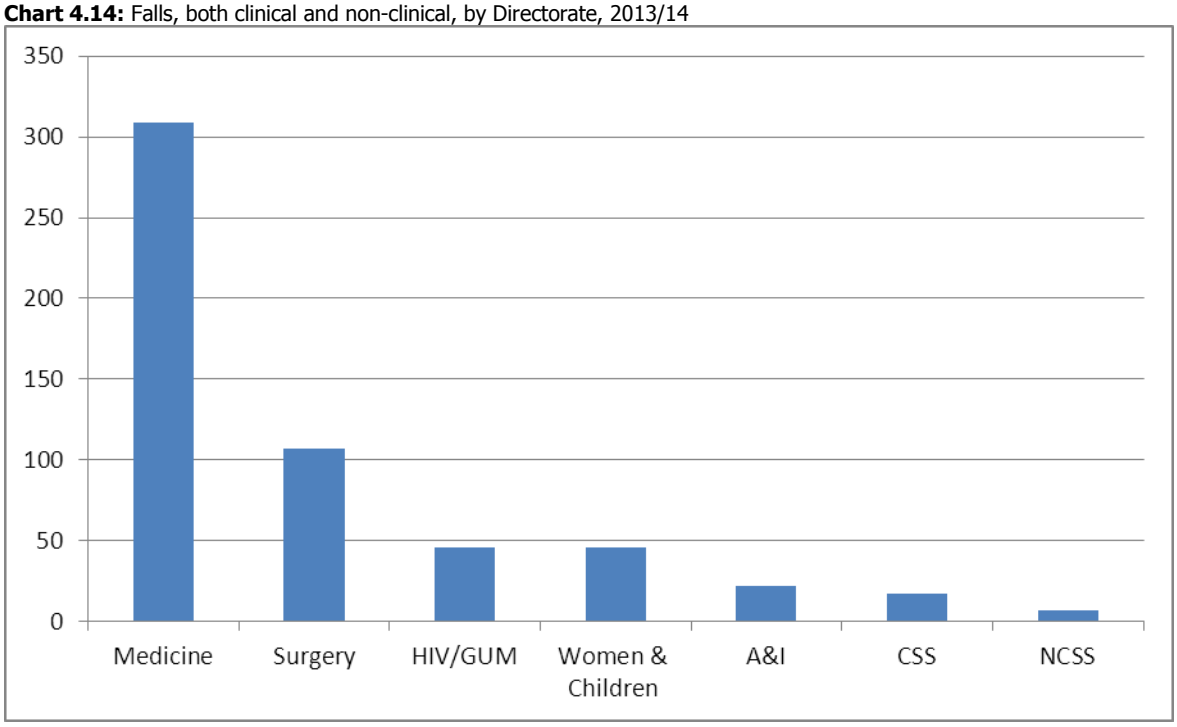
A fall can be the result of a single factor, such as tripping or fainting, affecting an otherwise fit and healthy person. However, most falls, particularly in older people, are the result of several interacting factors. The factors that appear to be most significant in hospital patients are:

- Walking unsteadily
- Being confused
- Being incontinent or needing to use the toilet frequently
- Having fallen before
- Taking sedatives

Preventing patients from falling is a particular challenge in hospital settings. Patients' safety has to be balanced against their right to make their own decisions about the risks they are prepared to take, their dignity and their privacy.

A ward where no patient ever falls is likely to be a ward where patients are unable to regain their independence and return home. Efforts to reduce falls and injuries involve a wide range of staff and, in particular, those working in nursing, medical, therapy, pharmacy, management and facilities services.

Chart 4.14: Falls, both clinical and non-clinical, by Directorate, 2013/14



Overall there was a 2% increase in the number of falls reported in 2013/14 compared to 2012/13. In 2012/13 7 clinical falls were graded orange, around 1.3% of the total number of falls reported. The same figure for 2013/14 was 6, 1.1% of the total number of falls reported. This represents a small reduction in the number of falls causing moderate or severe injuries. All falls causing moderate/severe injuries such as fractures are escalated as orange incidents with a full panel review taking place.

The Trust saw an increase in the overall proportion of falls causing injury in 2013/14. In 2012/13 75% of all falls resulted in no harm and in 2013/14 this figure drop down to 68%.

Chart 4.15: Clinical falls by degree of harm, 2013/14

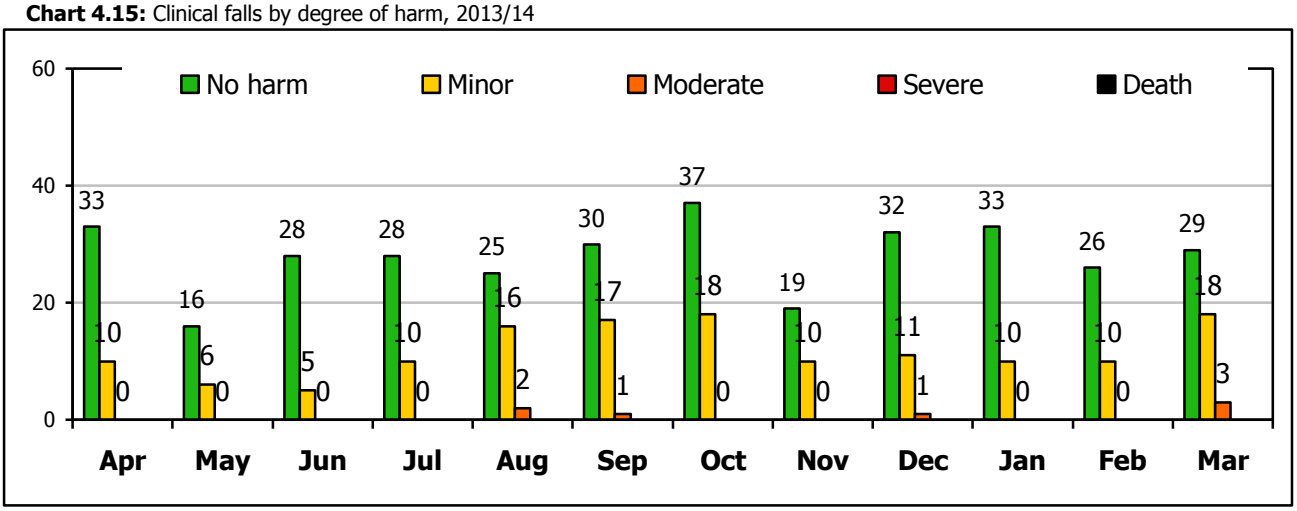
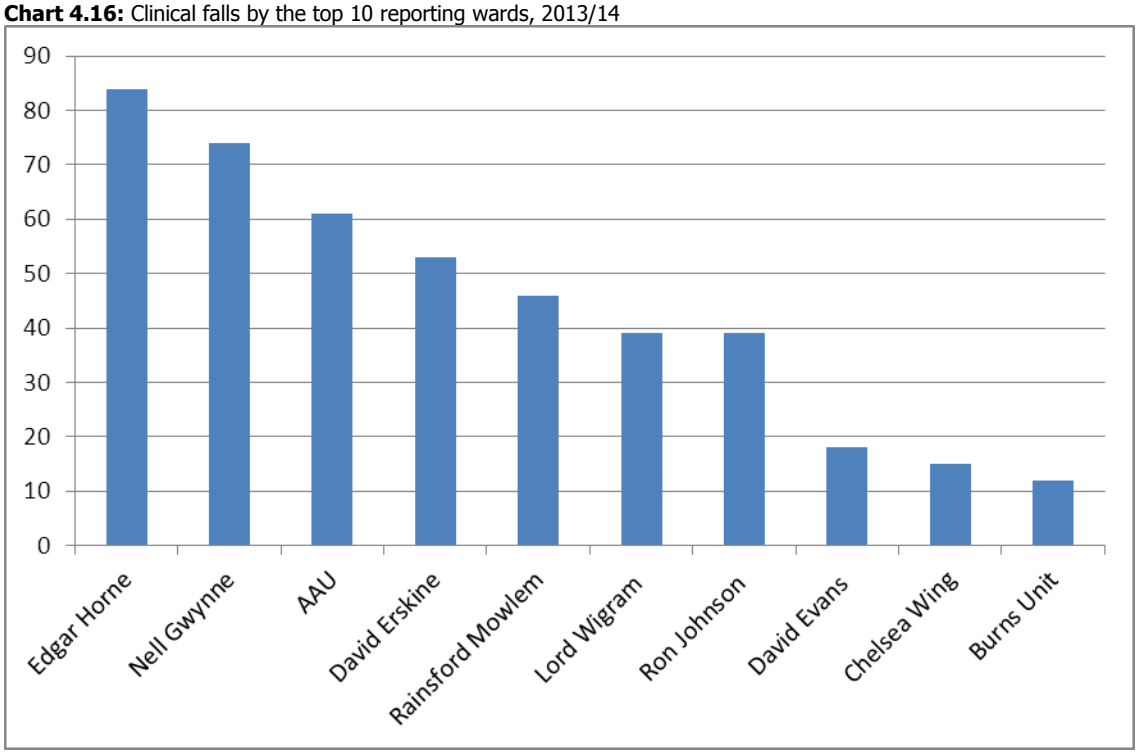
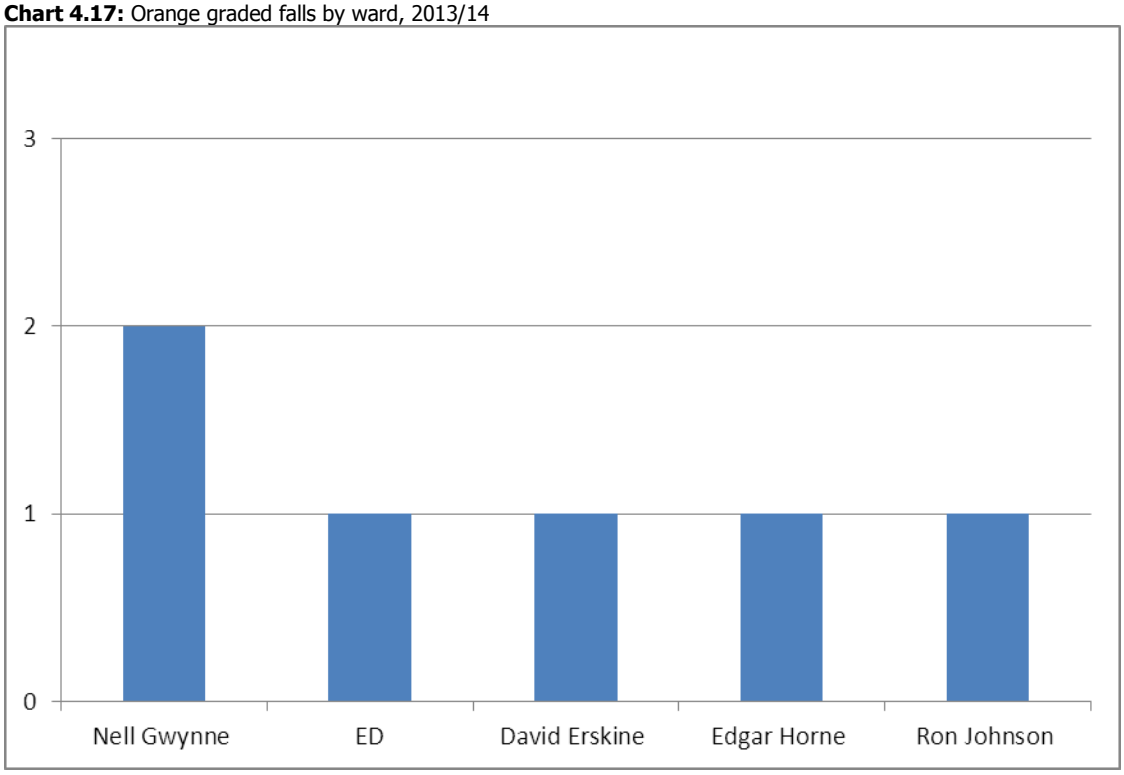


Chart 4.16: Clinical falls by the top 10 reporting wards, 2013/14



Nell Gwynne and Edgar Horne reported the highest number of clinical falls which can partly be attributed to the case mix of patients admitted to these 2 wards. Edgar Horne has seen a rise in the number of falls since a change to their patient cohort took place towards the end of 2013. These patients are often cognitively impaired as a result of a stroke or neurologically impaired and are as a result at increased risk of falls.

Chart 4.17: Orange graded falls by ward, 2013/14



A paper based falls care plan was piloted on David Erskine Ward to replace the current '7 steps to falls prevention' document. It was fed back to the Preventing Harm Group that staff on the ward felt positive about the care plan, however, completion had been ad-hoc, leading to a discussion about whether this should be rolled out if the Trust's future vision is for electronic patient record management at odds with the introduction of a paper care plan. It was agreed to put together a short life working group to review at what worked well with the paper version and how this can be used to inform a LastWord based care plan or tool.

The group continued the work started in 2012/13 around reviewing the circumstances surrounding patients who have fallen multiple times during their admission.

5. Delivery Incidents

There was a further increase of 18% in the number of delivery related incidents reported during this financial year when compared to 2012/13 when 426 were reported. This is also reflected in the top 10 categories of reported delivery incidents.

Table 4.18: Top 10 delivery incidents previous three years

Delivery Incident Sub-Categories	2011/12	2012/13	2013/14
PPH >1000 mls	113	160	180
Unanticipated admission to NICU	56	55	108
Shoulder dystocia	48	41	45
3rd/4th degree tear	54	45	37
Stillbirth/Neonatal Death	25	25	31
Born Before Arrival	9	24	24
Documentation	4	0	18
Undiagnosed breech	10	12	15
Soft tissue damage to bladder	1	14	11
Birth Injury	8	2	11

The main subcategories have remained constant throughout the past three years; the majority of incidents relating to postpartum haemorrhage. However, there has been a significant increase in the number of incidents relating to unexpected admission to the neonatal unit. The other areas with of note are documentation (n=18), an increase when compared to 2012/13 when no incidents were reported, and birth injury (n=11).

Actions taken:
The number of incidents of postpartum haemorrhage greater than 2000mls is monitored through the maternity dashboard and is also subject to a review using a standardised tool. The data is analysed on a six monthly basis. Any incident where there are care or delivery issues identified, or when an ITU admission is required unexpectedly, is escalated as an orange incident. Areas for learning identified during review will be considered for inclusion in the MOH skills-drills training. Incident investigation has identified a number of recommendations which will be included in the update of the guidance for management of post-partum haemorrhage. These include:

- Availability of fibrin and collagen products in theatre – to include flowseal
- Agreement of the use of FFP in pregnant women
- Identified individual to co-ordinate communication with haematology

There was a significant increase in the number of infants admitted to the neonatal unit from 55 in 2012/13 to 108 in this financial year. A review of the admissions indicated that 25% of these cases were from women whose infants were born by elective caesarean at term. Transient tachypnoea of the new born is a recognised complication of elective caesarean section.

There were 11 birth injuries reported during the 2013/14. The emerging themes were injuries such as bruising and laceration sustained during instrumental delivery. This is a rare, but recognised complication and indicates increased awareness of reporting requirements. Specific incidents include:

- Infant was delivered by forceps following failed kiwi. Infant sustained bruising to right eye and broken skin above eye and head during delivery. Infant required basic resuscitation
- Patient reviewed four days after delivery complaining of faecal incontinence. Delivery had been complicated by forceps and second degree tear
- Delivery complicated by shoulder dystocia. Infant sustained right eye lid laceration secondary to traumatic forceps delivery. Abrasion also noted to cheek
- Patient sustained burn on their right thigh from diathermy forceps during procedure
- Perineal trauma sustained during management of postpartum haemorrhage when bimanual compression was required. Perineal proforma not completed (this one should be re-categorised)
- Infant sustained laceration to face during forceps delivery
- Staff member noted small laceration on the side of infant's right eye with extensive bruising of the head following forceps delivery
- During emergency caesarean section infants ear got slightly cut by surgical knife

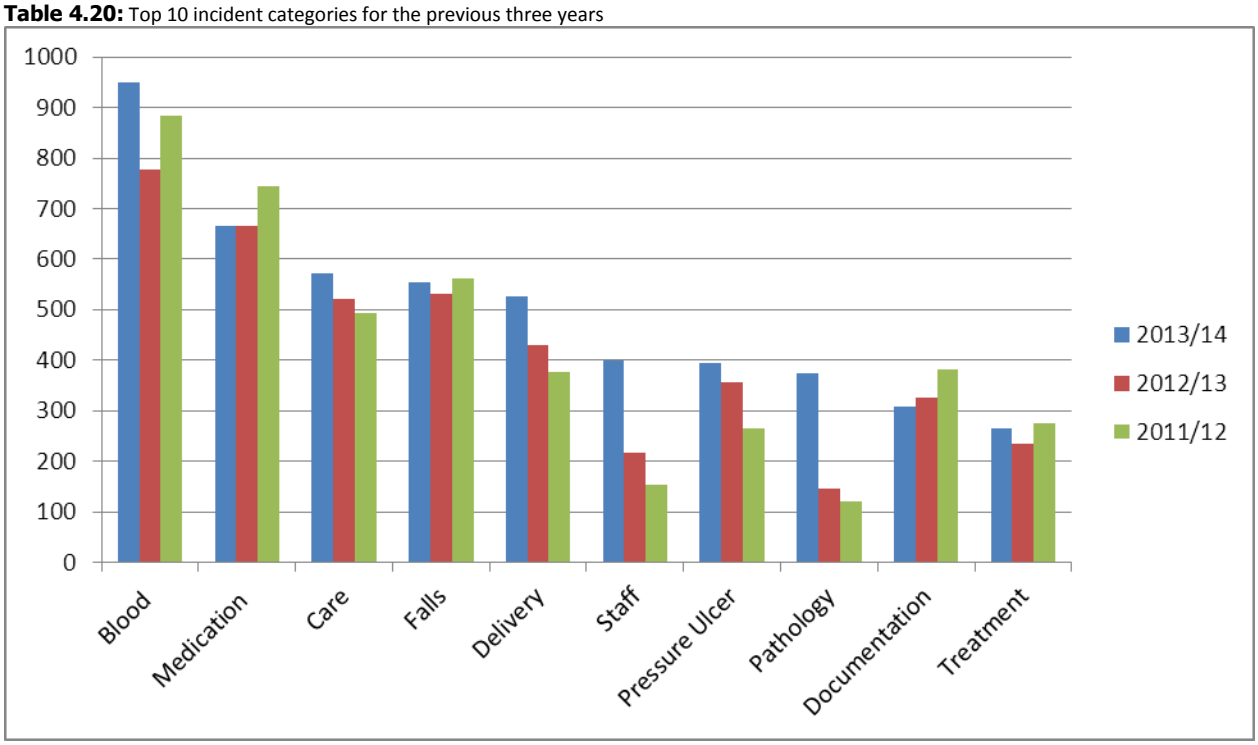
- Infant sustained a scratch on the left buttock from scalpel during caesarean section procedure.

Further information relating to Delivery Incidents can be found in the Annual Maternity Risk Management Report 2013/14.

Table 4.19: Top 10 incident categories for the previous three years

Top 10 2011/12		Top 10 2012/13		Top 10 2013/14	
1	Blood (n=884)	1	Blood (n=778)	1	Blood (n=950)
2	Medication (n=743)	2	Medication (n=666)	2	Medication (n=666)
3	Falls (n=562)	3	Falls (n=532)	3	Care (n=571)
4	Care (n=493)	4	Care (n=522)	4	Falls (n=554)
5	Documentation (n=382)	5	Delivery (n=429)	5	Delivery (n=525)
6	Delivery (n=377)	6	Pressure Ulcer (n=356)	6	Staff (n=399)
7	Treatment (n=274)	7	Documentation (n=326)	7	Pressure Ulcer (n=395)
8	Equipment (n=269)	8	Treatment (n=235)	8	Pathology (n=373)
9	Pressure Ulcer (n=264)	9	Equipment (n=218)	9	Documentation (n=308)
10	Staff (n=154)	10	Staff (n=218)	10	Treatment (n=266)

Table 4.20: Top 10 incident categories for the previous three years



Incidents categorised as 'Other' – 54%

Chart 4.19: 'Other' incidents by category

Staff Incident	399
Pressure Ulcer	395
Pathology Incident	374
Documentation Incident	309
Treatment Incident	264
Equipment Incident	183
Communication Incident	149
Patient Transfer Incident	136
Behavioural Issues	129
Physical Assault	110
Operation Incident	109
Contact with Needle or Other Sharps	106
Accidental Injury	102
Capacity Incident	92
Verbal Abuse	91
Environmental Incident	80
Discharge Incident	69
Patient Absconded	60
Theatre Instrument Incident	59
IT incident	48
Infection Control Incident	41
Dissatisfaction	39
Admission Incident	36
Appointment Incident	35
Transport Incident	34
Bleep Response Incident	33
Confidentiality Incident	31
Diagnosis Incident	30
Referral Incident	30
Splash Incident	30
Theft	28
Lost Property Incident	26
Nutrition Incident	24
Imaging Incident	19
Security Incident	16
Consent Incident	14
Staff Injury	11
Porter Incident	9
Food Safety/Hygiene Incident	8
Moving and Handling Incident	7
Anaesthetic Incident	6
Unexpected death	6
Accidental Fire	5
Other Incident	4
Self Harm	3
Accidental Property Damage	2
Exposure to Harmful Substances	2
Phlebotomy Incident	2
Financial Incident	1
Harassment	1

4.6 Incidents Reported by Time of Day

Times of reported incidents are influenced by variations in patients' abilities and activities, including variations in alertness, or by staff workload, breaks and shift patterns, basic routines such as mealtimes, and clinical routines such as medication rounds and surgery schedules. The pattern of incidents by time of day remains consistent between weekends and weekdays, and across weekdays.

Incident rates begin to rise around 7am and peak in the period between 8 and 10am. This is the period when patients are most likely to be active. Staffing levels are usually highest during this period, but workload is also high. Many nursing activities will involve caring for one patient behind closed curtains or doors, which makes observing other patients more difficult – this will impact on incidents such as falls.

The charts below are reasonably consistent, and compare the times that serious and less serious incidents occur across the organisation.

Chart 4.20: All Incidents by Time of Day (where recorded on the incident form, n=4324) – All grades

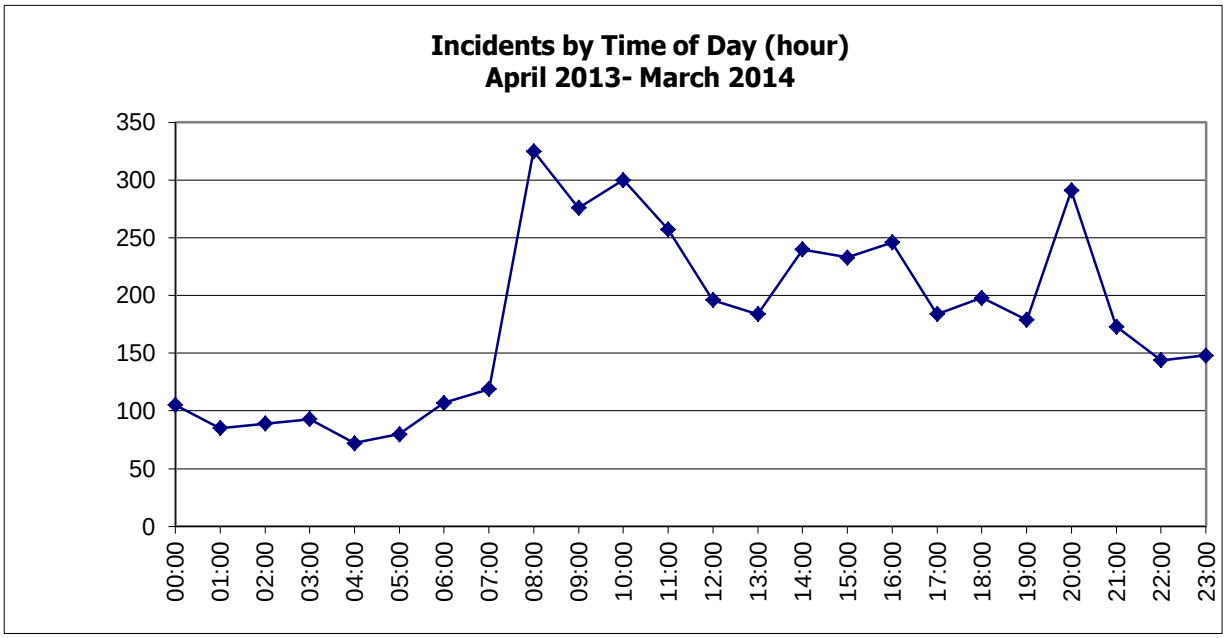
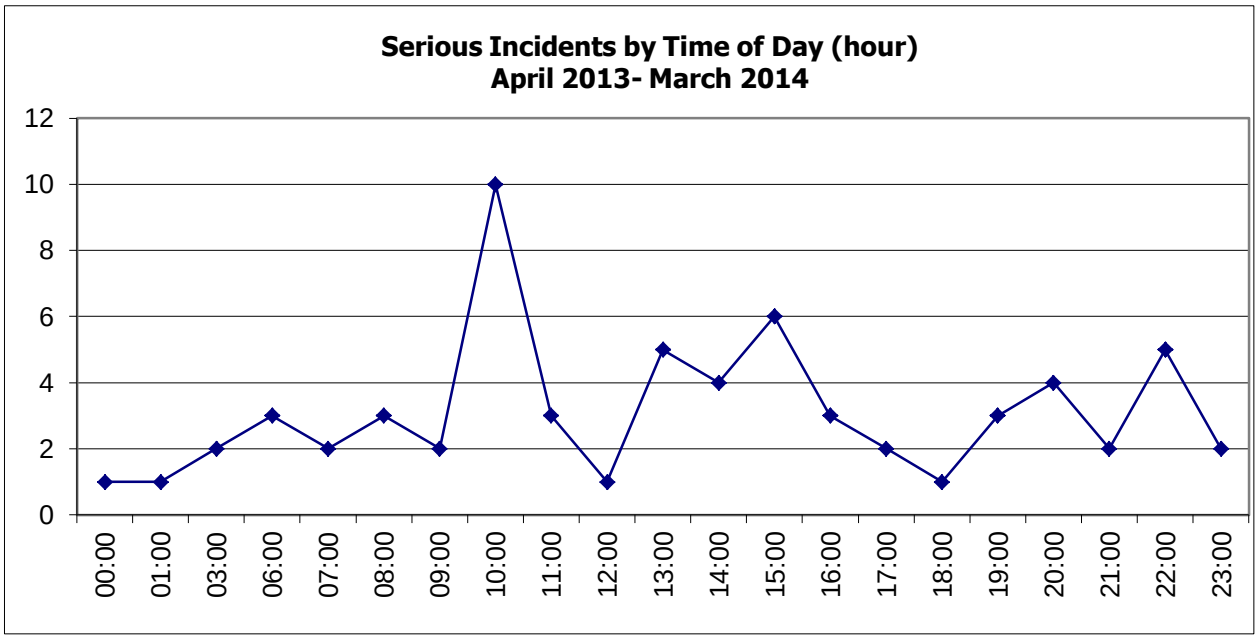


Chart 4.21: Serious Incidents by Time of Day (where recorded on the incident form, n=4004) – Orange/Reds



An analysis was carried out of the 10 orange incidents that occurred between 10:00 and 11:00 but no common themes were found. A small number of these incidents (3) related to pressure ulcers and may be

explained by the fact that personal care is often carried out around these times which is why the ulcers would have been identified at this time of day.

5. INCIDENTS AND LEARNING DURING 2013/14

5.1 Incidents Graded Orange or Red

Chart 5.1: Number of Incidents Reported in 2013/14 – by Grade

	VLOW	LOW	MOD	HIGH	TOTAL
Patient Safety Incidents (Clinical)	3,180	2,539	134	0	5,853
Staff Related Incidents (Non-Clinical)	703	502	4	1	1,210
TOTAL	3,883	3,041	138	1	7,063

Chart 5.2: Number of Incidents Occurring in 2013/14 – by Grade

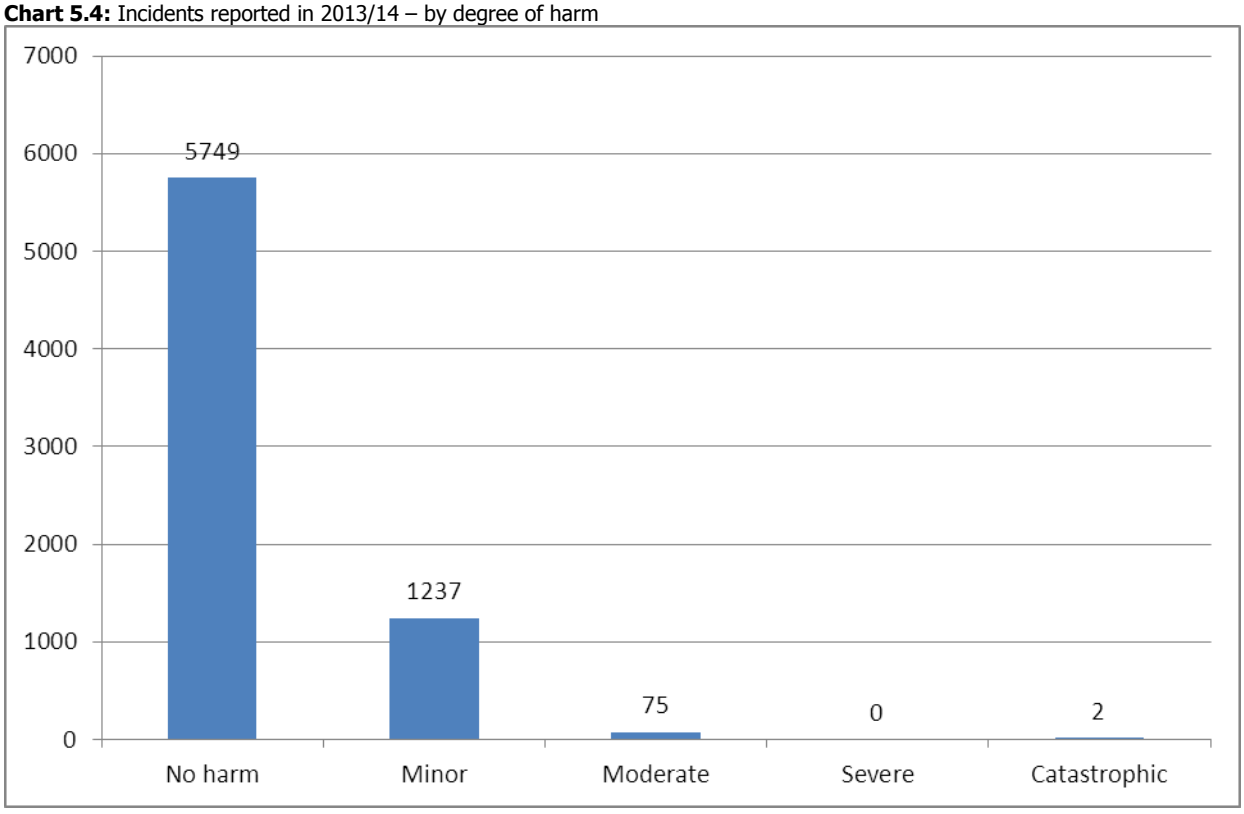
	VLOW	LOW	MOD	HIGH	TOTAL
Patient Safety Incidents (Clinical)	3,105	2,509	133	0	5,747
Staff Related Incidents (Non-Clinical)	692	496	4	1	1,193
TOTAL	3,797	3,005	137	1	6,940

Table 5.3: Incidents of all grades 2013/14 closed within working 45 days

Closed incidents	Currently open	Closed within 45 days	Closed after 45 days	% Achieved 45 Day Target
6200	863	5739	461	81%

The best performing out of the three divisions in terms of meeting this target was CSS who closed 92% of their incidents within the required timescale, followed by Medicine & Surgery with 84%. Women, Children, Neonatal & Young Peoples' Services closed 75% of their incidents within 45 working days.

Chart 5.4: Incidents reported in 2013/14 – by degree of harm



The two incidents leading with a catastrophic outcome were as follows:

- Transport took patient back to his nursing home after an outpatient appointment. An ambulance was later called by staff as they were concerned that the patient stated that he had fallen out of his wheelchair whilst on a transport vehicle that day and now had left leg pain. The patient was brought back to the hospital where his left leg was noted to be shortened and rotated which is a clinical indication of a fractured neck of femur. The patient underwent surgery but sadly died shortly after the procedure. This incident was graded red.

- The patient was having a coil bronchoscopy as part of a clinical trial. Complications during the procedure and a sudden deterioration in clinical condition. When bleeding was identified high flow oxygen was administered via rebreathing bag, adrenaline given as well as cold normal saline. Crash call instigated and input from resuscitation team but the patient could not be resuscitated. This incident was later downgraded to yellow following investigation.

The Trust's risk assessment scoring matrix provides a tool for assessing the seriousness of an incident. The grade is categorised as red, orange, yellow, or green. This rating helps to identify the level at which the incident will be investigated and managed in the organisation. This scoring system can be applied to outcomes for patients, staff and relatives, and also for implications for the Trust.

The level of investigation to be undertaken will be determined by:
- The level of severity of harm to the patient/carer/relative or staff member, and/or
- Results of risk assessment; and/or
- The potential for learning (which could include investigating those incidents, complaints or claims which are high frequency, but are of low severity)

Red and orange incidents are subject to a review and root cause analysis, after which a summary of the investigation, outlining key learning points, is presented at the Risk Management Committee to support Trust-wide learning and dissemination of recommendations. Copies of Trust investigation reports are also occasionally requested by, and provided to, the Coroner.

Safeguarding Alerts (SGAs) raised against the Trust are graded orange and investigated as such. Generally, the trust internal investigation will inform the SGA conference or the other way around in some circumstances. There were 22 such incidents reported in 2013/14 with 10 of them relating to hospital acquired pressure ulcers of grade 3 or 4 or of an unstageable nature.

5.1.1 Incidents Graded 'Red' (n=1) and 'Orange' (n=138) during 2013/14

138 orange incidents and 1 red were reported during 2013/14, compared with no red and 135 orange in 2012/13, reflecting a 2% increase in orange incidents while 2012/13 saw a 42% increase in orange incidents compared to the previous year. The contributing factors of serious incidents are being monitored in order that themes and trends can be addressed. For more information on contributory factors please see section 5.3 on page 32.

Red and orange incidents are subject to a review, after which a summary of the investigation and any recommendations are presented at the Risk Management Committee to support Trust-wide learning. Incident summary reports are published on the intranet and recommendations placed on the incident review register to track progress towards completion. The register is updated as recommended actions are achieved and a report including details of all open orange risks with Trust wide implications is presented to the Risk Management Committee on a quarterly basis and divisional-specific outstanding actions reported Quarterly within the divisional Quality Reports for local management and divisional oversight of progress toward completion of actions. Copies of Trust investigation reports are also occasionally requested by, and provided to, the Coroner or patients and their families.

Incidents graded orange during 2012/13 occurred in the following directorates/services:

Chart 5.5: Red and orange incidents by directorate

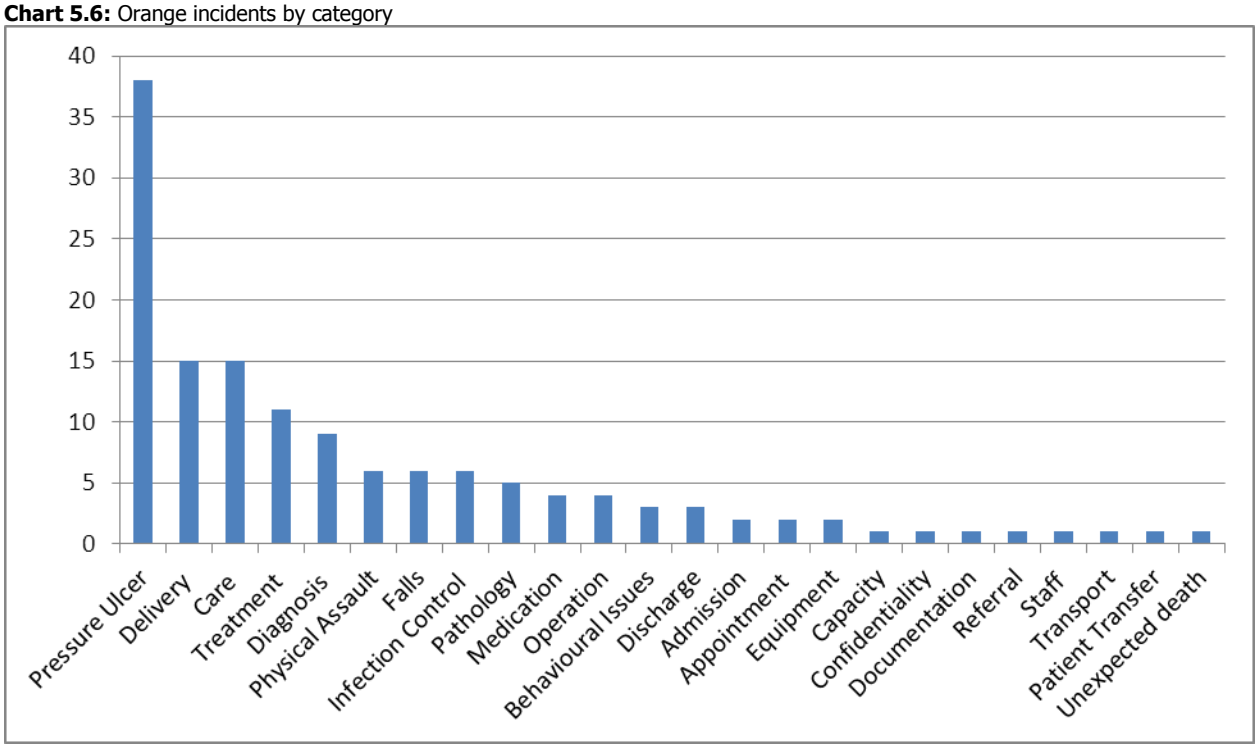
	2013/14	2012/13	**2011/12**	**2010/11**	**2009/10**
Anaesthetics & Imaging Directorate	12	6	3	6	9
HIV & GUM Directorate	12	8	9	3	2
Medical Directorate	48	53	37	23	21
Pathology	0	1	0	3	0
Clinical Support Services	3	0	2	1	0
Surgical Directorate	30	27	17	12	7
Women and Children's Directorate	33	40	27	22	30
Whole Hospital	0	0	0	4	7
Non-Clinical Support Services	1	1	0	0	0
Total	138	135	96	74	76

Incidents giving rise to risks are noted on the Trust Risk Register. A system of control is in place, whereby the risk management team reviews the grading and detail within the risk assessment documentation prior to their transfer to the Risk Register.

A précis of incidents and the recommendations are placed on the incident review register, which tracks progress towards completion. This register is updated as recommendations are achieved and actions reviewed every quarter to ensure progress and identify any significant delays. The Incident Review Register is also uploaded on the Intranet and is kept up to date by the Clinical Governance Support Team.

The incident categories for orange incidents can be found in the table below:

Chart 5.6: Orange incidents by category



- **11** orange incidents were also linked to a formal complaint with joint investigations undertaken.
- **3** incidents were linked to a legal claim.
- **4** were **near misses** that resulted in no harm.
- A further **32** orange or red incidents were recorded as no harm incidents while **24** resulted in minor harm.
- **73** incidents resulted in moderate harm such as increased length of stay and/or admission to high dependency/ITU, grade 3 and 4 pressure ulcers, 4th degree tears during delivery, fractures sustained through a fall and major obstetric haemorrhages.
- **9** incidents were linked to, without being the primary cause of, a **patient death**:

Information relating to the 138 orange incidents and 1 red reported during 2013/14 was considered by the various committees with overarching responsibility for risk, including the Trust Risk Management Committee and the Assurance Committee. In addition, the Preventing Harm Group is responsible for reviewing and disseminating the learning from serious incidents relating to falls and pressure ulcers.

This level of detail is not available to the general public as it is considered that the synopsis of each incident at a case by case level may reveal the identity of people affected by these incidents. The Trust has therefore introduced measures to remove this level of detail from the annual report, to ensure that information about an individual whose identity is apparent or can reasonably be ascertained from the information or synopsis.

Closure of orange incidents within 45 days in 2013/14 and 2012/13:

Table 5.7: Orange and Red Incidents 2013/14 closed within 45 days

Closed incidents	Currently open	Closed within 45 days	Closed after 45 days	% Achieved 45 Day Target
111	28	22	89	16%

Table 5.8: Orange and Red Incidents 2012/13 closed within 45 days

Closed incidents	Currently open	Closed within 45 days	Closed after 45 days	% Achieved 45 Day Target
127	2	15	112	12%

There was a small improvement in the number of orange and red incidents that were closed within the 45 working day target in 2013/14 when compared to 2012/13.

With the increasing number of externally reportable incidents, further emphasis needs to be placed on the timely conclusion of incident investigation and panel review within 45 working days of the event. As outlined above the Trust's compliance is poor (despite a 4% improvement on the previous year) with only 16% of investigations being concluded within the target timeframe. This compares with 81% of incidents of all grades as outlined in table 5.3 on page 24.

Further analysis will be undertaken in 2014/15 to address the shortfalls but anecdotal evidence suggests that reasons for delays in concluding investigations into serious incidents include:

- Access to medical records,
- Issues surrounding obtaining statements from staff,
- Lead Investigator's capacity and workload,
- Wait for the monthly standing panel depending on when in the standing panels' rolling schedules the incident occurred,
- Delays in updating the final report due to the high number of incidents considered at panel and obtaining agreement from the panel members.
- Sign off at the Risk Management Committee, depending on when in the month the incident was reviewed by the panel.

5.1.2 External Reporting on the Strategic Executive Information System- STEIS

From December 1st 2010 all trusts, including Foundation Trusts, are required to use the Strategic Health Authority's incident reporting system 'STEIS' within 2 working days of discovering the incident. Reporting on STEIS has further highlighted the need for prompt recognition and escalation of serious incidents. Audits were carried out in April and May 2013 in order to identify if any incidents had not yet been reported externally that should have. These reviews resulted in a further 6 incidents being uploaded on STEIS.

In 2013/14 the Trust reported 37 incidents on STEIS which is 16 more than in the previous year and an increase of 76%. The 37 reported incidents included 3 Never Events. The reporting categories include, but are not limited to, unexpected outcome of surgery, serious injury in a child, disruption to maternity services, transfusion errors, medication errors, breaches of the LAS handover time target and grade 3, 4 and unstageable hospital acquired pressure ulcers.

5.1.3 Hospital Associated VTE Events

VTE Risk Assessments:
All adult patients should have a VTE risk assessment completed on hospital admission, with a national and Trust target of greater than or equal to 95%, to identify any risk factors that may be present. This target has been achieved with weekly and monthly monitoring of completed VTE risk assessments.

Hospital Associated VTE Events:
The Trust has established a root cause analysis process for hospital associated VTE events. A root cause analysis (RCA) is performed on all confirmed cases of deep vein thrombosis (DVT) and pulmonary embolism (PE) associated by patients whilst in hospital (including those cases arising during a current hospital stay and those cases where there is a history of hospital admission within the last three months, but not including patients admitted to hospital with a confirmed VTE with no history of an admission to hospital within the last three months).

It is important to perform a root cause analysis for VTE events which will provide a systematic method of what factors or events lead to a patient suffering a VTE. The results of the RCA will help gain a better understanding of the contributory factors and causes associated with VTE events and take action to reduce the risk of them occurring in the future.

The Trust's target for 2013/14 was to have a 25% reduction of hospital associated preventable VTEs than the previous year i.e. to have no more than 10 hospital associated preventable VTEs and this was achieved. Between April 2013 and March 2014, 5 hospital associated preventable VTEs were identified (a significant reduction from 13 hospital associated preventable VTEs in 2012/13). In 2014-15, the continued focus will be to address the contributory factors for preventable VTEs.

In 2013/14:

- 154 new VTE diagnosis were identified.
- 43 hospital associated VTE events (HATs) occurred.
- 27 HATs occurred in Medicine.
- 14 HATs occurred in Surgery.
- 1 HAT occurred in HIV.
- 1 HAT occurred in Gynaecology.
- 43/43 root cause analyses were performed for hospital associated VTEs, meeting the CQUIN target for root cause analysis completion.
- VTEs were preventable and 38 VTEs were non-preventable.

Identified contributory factors for preventable VTEs included:

- Inaccurate completion of VTE risk assessments - thrombosis and bleeding risk factors not identified to prompt prescribing of thromboprophylaxis.
- VTE risk assessment not repeated when clinical situation changed to indicate risk factors for VTE and prompt the prescribing of thromboprophylaxis.
- Inaccurate VTE risk assessment completion delaying thromboprophylaxis prescribing on day of admission and 5 days into admission.
- Delayed surgery and thromboprophylaxis not prescribed in the interim until planned surgery date.
- Thromboprophylaxis not prescribed post-surgery when documented in the operation record for evening dose.
- Thromboprophylaxis indicated on discharge for a high risk patient of VTE (multiple VTE risk factors present), however not prescribed by medical team.
- Doses of thromboprophylaxis prescribed but not administered (not given to patient by agency staff) before VTE diagnosis during admission (patient with more than 4 risk factors and at high risk of VTE).
- Thromboprophylaxis doses prescribed but not given by nursing staff, unknown reason for omission but not clinically omitted.
- Team considered anaemia a reason not to prescribe thromboprophylaxis but is not a contraindication, and a patient could have received thromboprophylaxis before clinical deterioration. Delayed diagnosis and failure to escalate for medical/haematology review/advise. Thromboprophylaxis could have been considered when patient deteriorated/desaturation and signs of shortness of breath, which resulted in a fatal PE.
- Thromboprophylaxis not prescribed 2 days before surgery. Enoxaparin prophylactic dose not increased once renal function improved (sub-therapeutic dose). One omitted dose of prescribed rivaroxaban (unknown reason for omission).

In 2014/15, the Trust target is to have no more than 7 preventable hospital acquired VTEs and work will continue with root cause analysis for hospital associated VTE events with a focus on addressing the contributory factors for preventable VTEs by:

- Continuing to provide monthly feedback on completed VTE risk assessments by ward and department, and following up on the areas which do not meet the 95% target.
- Encouraging the use of the missing doses report on Lastword for ward nursing staff to use at handover meetings and follow up on any doses not given.
- Monitoring omitted and delayed medications doses via the Preventing Harm group, as agreed by the Director of Nursing and Quality.
- The Electronic Prescribing team to grant LastWord access rights to certain agency nursing staff to allow for medication doses to be given ('signed') within working hours.
- Continuing to highlight the importance of VTE prevention and treatment at multidisciplinary educational meetings.
- Continuing VTE ward rounds on medical, surgical and maternity wards with education to ward staff and dissemination of findings to department.

Pharmacological and Mechanical Thromboprophylaxis:
Patients at risk of VTE should be offered appropriate pharmacological and mechanical thromboprophylaxis, if indicated and no contraindications are present. The Trust set a target of 90% of adult patients should receive appropriate pharmacological and mechanical thromboprophylaxis. Monthly audits were performed on adult wards to establish whether patients received appropriate thromboprophylaxis. Results of the audits are fedback to the ward, medical and pharmacy staff, and the Thrombosis & Thromboprophylaxis Committee.

During 2013/14, an average 95% of adult patients received appropriate pharmacological thromboprophylaxis, and approximately 87% of adult patients received appropriate anti-embolism stockings. In specific clinical areas, we introduced the prescribing of anti-embolism stockings by nursing staff to help improve performance.

VTE Patient Information:
The VTE patient information leaflet 'Are you at risk of blood clots?' should be offered to all patients admitted to the hospital, all pregnant women and all patients attending A&E who require a lower leg plaster cast. It is important to provide patients with information about the risks of VTE, its signs and symptoms, and when to seek urgent medical attention. The importance of providing VTE information to patients has been included in the VTE newsletter circulated to all staff and educational meetings.

Audits were performed throughout the year showing:
- 67% of patients were given information on VTE, which has been an improvement since the last year. The hospital discharge checklist has a reminder to provide the VTE patient information leaflet to patients.
- 85% of patients with leg plaster casts were given the VTE patient information leaflet in Urgent Care Centre/A&E.
- 100% of patients undergoing day case procedures in the Treatment Centre were offered the VTE leaflet.
- VTE patient information leaflets were available and visible on all adult wards by monthly audits.

5.1.4 Pressure Ulcers

The 2013/ 14 Quality Targets for the Trust aim to support a reduction of Hospital Acquired pressure ulcers. The aim is for a 50% reduction in Grade 2 Hospital Acquired pressure ulcers and a 50% reduction in grade 3 or unstageable pressure ulcers. There is an internal target of zero tolerance for Hospital acquired Grade 4 pressure ulcers.

Panel reviews are undertaken for all hospital acquired grade 3, 4 and unstageable pressure ulcers. One of the aims of the panel is to determine whether or the pressure ulcer was avoidable or unavoidable in accordance with the below definitions.

Avoidable Pressure Ulcer: "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the person's needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."

Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence".

In 2013/14 a total of 395 incident forms were completed in relation to pressure ulcers, 264 (67%) were community acquired (present on admission) and 131 (33%) were hospital acquired (developed during admission). All community acquired incidents are graded green as the patient did not sustain any harm whilst under the care of the Trust.

Specific actions being taken to eliminate hospital acquired pressure ulcers:

- Root cause analysis is undertaken for all hospital acquired grade 3, 4 and unstageable pressure ulcers and the learning shared at the Preventing Harm Group meetings for onwards dissemination to local areas.
- Development of a patient information leaflet: One of the contributory factors to hospital acquired pressure ulcers has been cited as the lack of information given to patients and their carers to enable them to make informed decisions when preventing skin damage resulting from pressure. Patient leaflets have been developed and will be distributed in Q4.
- Update of the Pressure Area Care Bundle: The care bundle has been updated to reflect patient's capacity in relation to their ability to make decisions about skin care and also to include the new Skin Assessment document developed as part of the POP project. These are currently on order and once delivered, will be rolled out to all adult inpatient areas.
- Product related pressure ulcers: New Face masks have been trialled in ITU and AAU with positive results so far. The Procurement Team are providing support.
- POP: In July 2013, the Trust joined other national trusts working with McKinsey on a campaign to eliminate pressure ulcers. The Trust chose to focus on the Acute Assessment Unit (AAU) as the majority of adult patients are first admitted to this unit and therefore, it was felt the biggest impact could be made there. POP (Push off the Pressure) was launched with the engagement of a multidisciplinary team of staff and support from McKinsey with education, tools to support change and fantastic networking opportunities with other trusts to share and develop good practice. The main principle supported by McKinsey to support pressure ulcer elimination is to make things simple and easy for staff. By using the PDSA (Plan, Do, Study, Act) approach, the team have developed a new skin assessment documentation tool that is simple and easy to use for all staff. This has significantly increased the reporting and documentation of patient's skin condition on admission, ensuring that patients have prompt and appropriate management and prevention measures put in place right at the beginning of their stay. On transfer to other wards staff are to check the patient's skin with the receiving nurse to ensure any pressure ulceration is clearly identified and communicated so that the care is seamless for the patient.

5.2 Never Events in 2013/14

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. An updated list of the never events list for 2012/13 was published on 18 January 2012. There are 25 national categories of "never events" on the expanded list. This includes the original eight events from previous years, some of which have been modified, and builds on the draft list published in October 2010.

In 2013/14 the Trust reported 3 incidents linked to never events (the same number as in 2012/13), 2 related to paediatric surgery and 1 to Maternity.

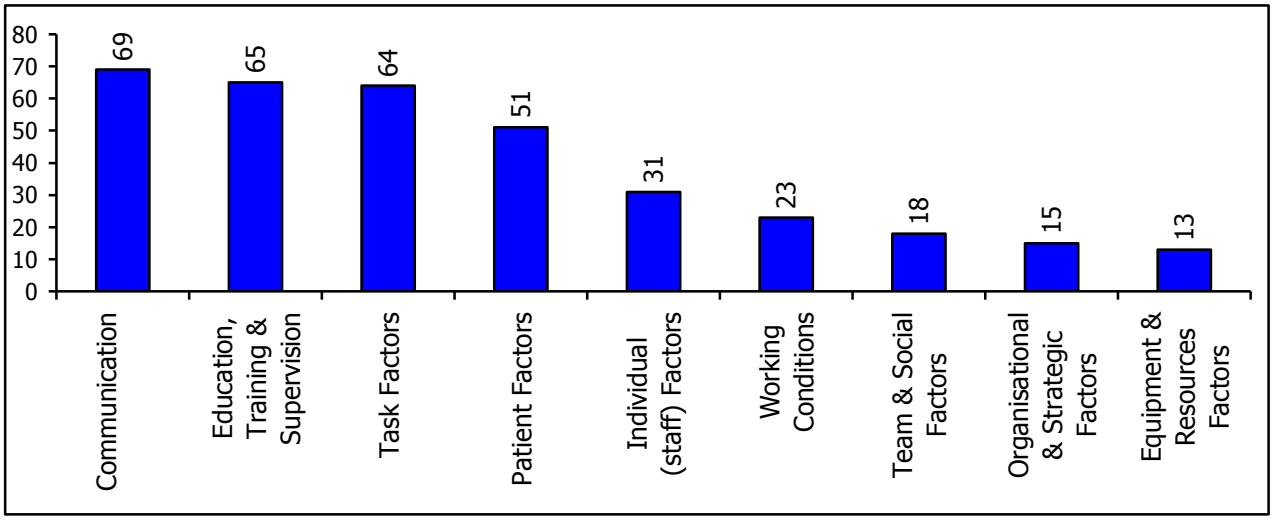
Full reports relating to Never Events have been provided to the board and is published on the internet within the Trust's Quality Account, however further information is available upon request from the Head of Clinical Governance.

5.3 Contributory Factors

Root cause analysis (RCA) involves identifying those issues which may have had an influence or may have directly caused an incident. During incident investigations, the use of RCA tools such as the fishbone technique with its contributory factors framework supports identification of relevant contributory factors. This exercise is useful in informing appropriate recommendations and ensures that further action can be taken where gaps have been highlighted for example in relation to training and education provided to staff.

An analysis of contributory factors relating to incidents reported in 2013/14 highlighted the contributory factors noted in the graph below:

Chart 5.6: Identified Contributory Factors for orange and red incidents in 2013/14



The most commonly occurring contributory factor identified during 2013/14 was issues around communication, bot written and oral, including inappropriate communication of diagnosis/treatment and failure of communication at handover or ward round. Written documentation in the medical notes is often poor and sometimes even affects the investigation into an incident as no evidence can be found to verify if a task was completed or not. Education and training issues also feature frequently, especially in relation to the incidents related to hospital acquired pressure ulcers and patient falls.
Task factors are common in the maternity service but are also common in relation to incidents in other specialties involving failures to escalate deteriorating patients where guidelines are not followed. Individual patient factors features much more frequently than in the last few years, most often in relation to hospital acquired pressure ulcers and non-compliance with care and advice given to patients who have mental capacity to make informed decisions.

5.4 Lessons Learned During 2013/14 and Changes to Practice

Reporting incidents is essential, but even more important is how we respond to, and learn from them, and that includes looking for any emerging themes or trends, so that we can nip potentially more persistent or serious issues in the bud. Investigation of serious incidents can support identification of trends and provides an opportunity to discover what the service can learn from these events. A number of specific areas for further scrutiny were identified during investigation.

The outcomes from incident reviews are also presented at a variety of meetings, and in particular at the Risk Management Committee. This allows staff to share their experiences and learn from each other. Examples of actions taken and lessons learned in 2013/14:

- The patient locator on AAU has been re-launched by the Lead Consultant to ensure it is being used by junior medical staff to highlight any delays in clerking patients and initiate treatment.

- Psychiatric Liaison staff employed by CNWL now have access to LastWord and there is a process in place for new starters getting access. This has led to improved communication between Trust and Mental Health staff.

- Additional security measures were put in place with the introduction of infant tagging within the maternity service. There have been some issues with availability of the tags and additional supplies have been purchased. Additional teaching on application and removal have been initiated and a risk assessment is in place to ensure controls are in place to manage the emerging risks.

- On AAU patients' pressure ulcer risk scores are now handed over with their CEWS score and is also documented on the handover sheet. Stickers of green, amber and red to notify staff of the level of risk are placed on the medical notes so that the whole MDT are aware of the risks and likelihood of that particular patient developing pressure ulcers.

- The Infection Control Team and Nell Gwynne ward staff developed a C.Diff algorithm for insertion in the bedside observations folder to help guide staff on when and when not to, take stool samples in patients with diarrhoea. Further education was also provided to ensure efficient use of the stool charts and screening tools.

- Visual aids are now used in all cancer related MDTs in order to ensure that the site of any malignancy can be determined and is clear to all those attending the meeting. The diagram is then inserted in the patient's notes for future reference. Scopeguides are also routinely used during all colonoscopy procedures to reduce the risk of malignancies being missed.

- In maternity a suturing proforma which requires two signatures was introduced as a response to a retained swab never event.

- A 'quick prompt guide' was developed by a consultant in the ED and circulated to all staff in the department to help, in particular junior members of the team out of hours when the ED is struggling with capacity. By including helpful hints and tips on actions to take, and when, the aim of the guide is to prevent handover and waiting time related target breaches. The ED Escalation Policy was also updated to include clearer roles and responsibilities to aid communication.

- In Dermatology a policy was developed to help staff manage patients who receive overexposure of phototherapy as a response to an incident where medical advice was not sought before the patient was discharged from the department. The phototherapy machine in questions has also been replaced as the timer was found to be faulty.

- Although not considered surgical procedures the WHO checklist was introduced for all pain management related procedures, such as nerve blocks, carried out in the Treatment Centre.

- Following receipt of a formal complaint it was highlighted that the patient's pain score had not been recorded in triage or at a later stage of their attendance therefore a pain audit was carried out in the

ED. In response to the results the documentation used was re-designed with the aim of emphasising the importance of recording and re-evaluating a patient's pain score.

- The alcohol withdrawal policy has been reviewed by an expert group to simplify the content after an incident revealed that the policy had not been followed on this occasion as it was unclear. Accessing the policy was also highlighted as an issue therefore staff are working on ensuring that the policy is easily found on the Trust intranet. The current alcohol withdrawal education provided to junior doctors is being reviewed and a withdrawal algorithm is being developed.

- Following 3 incidents relating to NJ tubes becoming detached from the main tube specific training was completed in association with the company supplying the tubes. Further work is also ongoing to get the company to develop stickers which can be placed in the notes to identify batch numbers.

- LastWord has been updated to provide triggers for neonatal staff when requesting blood products to ensure the requirements are made clear to laboratory staff. The lab standard operating procedure has also been updated as a response to an incident which occurred in Q4 where an infant received non-irradiated blood contrary to their requirements.

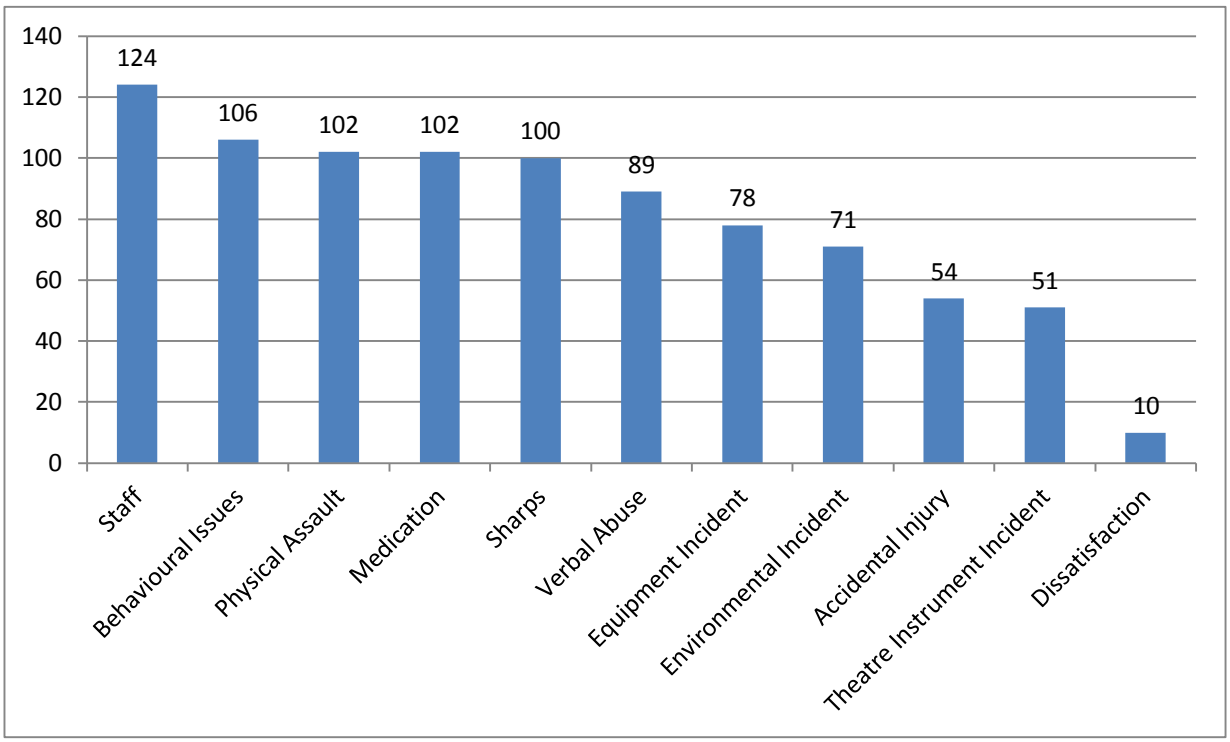
- An MDT has been introduced in paediatrics where complex cases are discussed and further management agreed.

Opportunities for Trust-Wide Learning from Orange and Red Incidents:

- The decision to transfer a critically unwell level one patient should consider care requirements prior to transfer, during transfer and for a defined time frame within the receiving area.
- The importance of clear documentation of individuals involved in care on relevant charts (in this particular case the anaesthetic consultant's name did not appear on the anaesthetic chart although was documented on the Massive Obstetric Haemorrhage proforma and operation chart).
- The National Audit Office published more evidence that poor record keeping in the NHS has been a significant contributory factor in more than 40% of medical negligence claims
- Importance of escalating a concern and addressing the issue, rather than introducing a 'work around' process.
- Use of the 'SBAR' (Situation, Background, Assessment, Recommendation) framework to ensure prompt and appropriate communication; this has been proven to result in a more appropriate clinical response to concerns raised.
- There should be no change to process, however small, which has not been thoroughly considered and agreed by all relevant staff prior to implementation.
- Local Standard Operating Procedures (SOPs) should be published on the intranet to ensure effective document version management and archiving when no longer relevant.
- It is a national requirement for key medical staff to live at a reasonable distance/time from their main place of work for emergency on-call needs. Teams should ensure that other key on-call staff are available, and consider the following questions:
  - How long does it take your on-call staff to attend for emergencies?
  - How far away do they live?
  - Can your escalation plans cope with these?
  - Does it cover all key staff, not only medical (for instance, scrub and anaesthetic practitioner as well as surgeon)?
  - Have you had any serious near-misses with delay to emergency surgery or diagnostic procedure out of hours?
- NHS clinical governance arrangements to be applied to all areas where private practice is undertaken, particularly learning from incidents or assurance required in relation to preventing never events.
- Teams or specialties affected by Unit closures should be consulted when the local guidance is developed.
- GP Liaison Manager to be notified of incidents which require communication of pathways to General Practice.

1. HEALTH & SAFETY/ NON-CLINICAL INCIDENTS BY CATEGORY

Graph 6.1: Top 10 non-clinical incident reporting categories in 2013/14

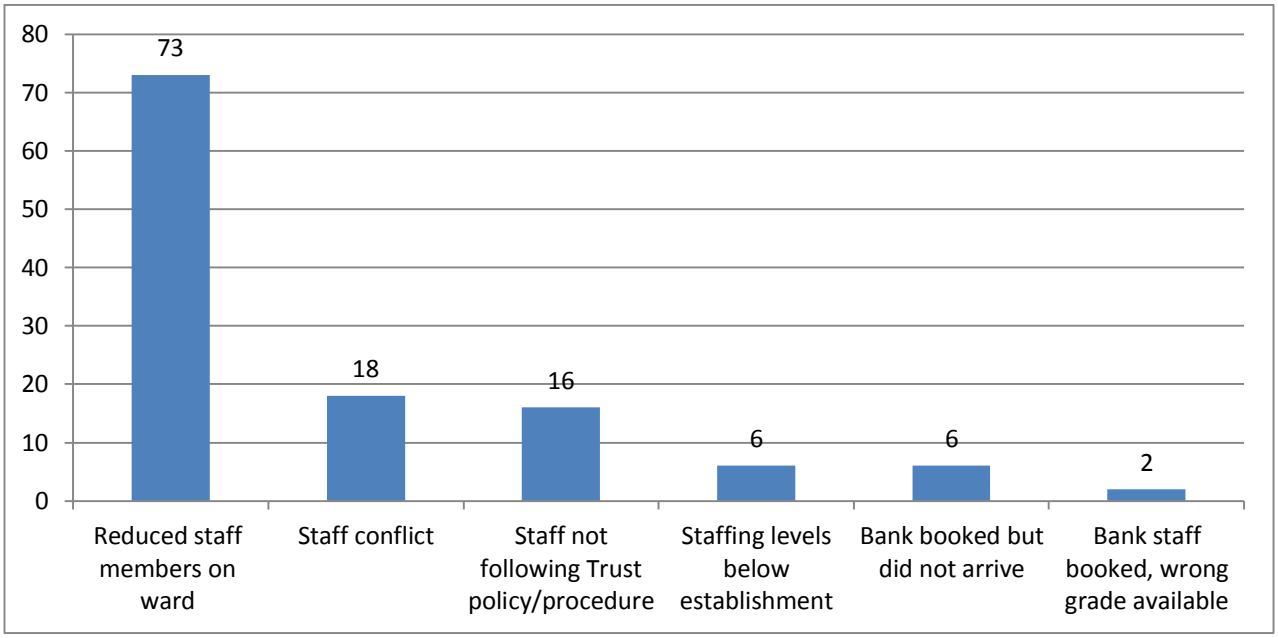


There were 1209 non-clinical incidents reported during 2013/14, compared with 1152 in 2012/13 (a 5% increase). 703 incidents were graded green (58%), 502 (41%) were graded yellow and 3 orange (1%).

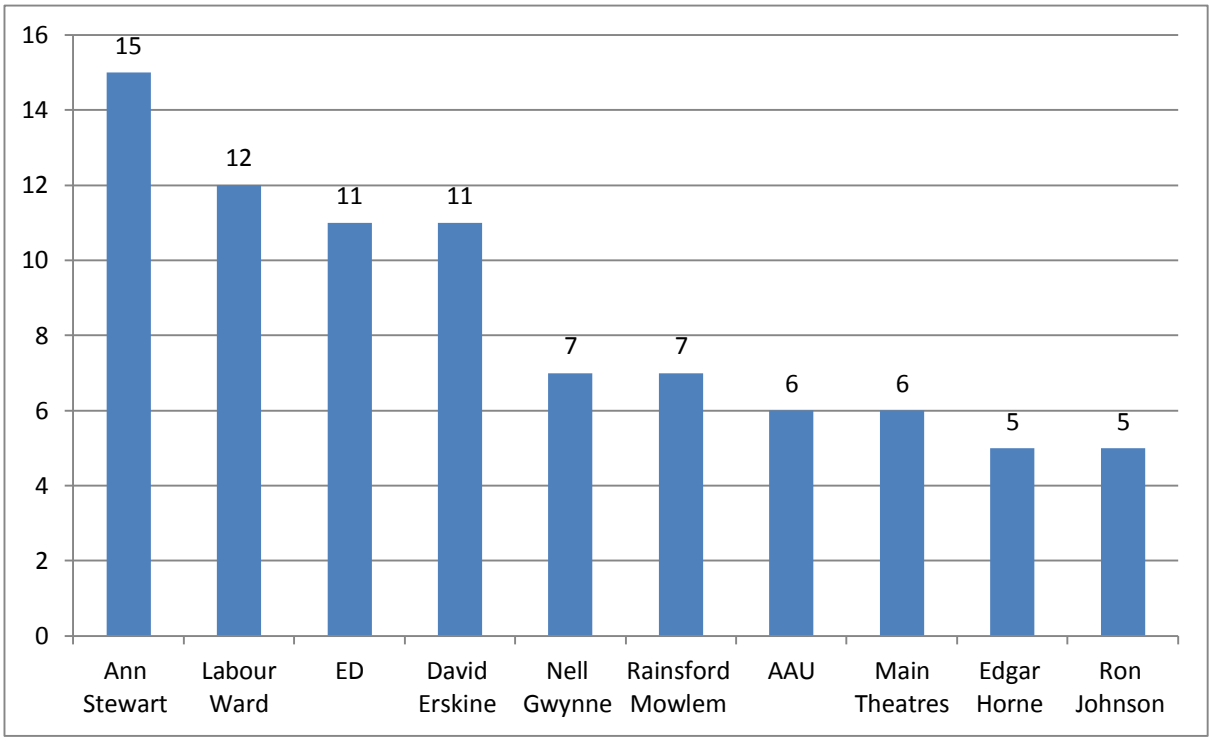
Staff

The majority of the non-clinical incidents related to staff with 67% of those incidents being reported as reduced staff members on the ward.

Graph 6.2: Staff related incidents by sub-category



Graph 6.3: Staff related incidents by ward – top 10



Actions taken to address staffing related issues:

- Continuous monitoring of staffing levels, continued substantive recruitment to reduce Bank and Agency staff (via rolling, advance planned recruitment days).
- Work undertaken in partnership with HR to design a process for expedited immediate recruitment as soon as a vacancy is identified to reduce non substantive staffing.
- Consider increasing substantive staffing to offset future Maternity leave, sickness etc. thus reducing non substantive staff peaks (e.g. nursing pool / RMN pool)
- Use appropriate tools to assess establishments and skill mix (under the Direction of the Director of Nursing).

Behavioural Issues

- A patient had brought an electrical heater with them onto the ward and was using it to dry her clothes by placing them directly on top of it.
- Patient very anxious and paranoid. Wandering around and disturbing other patients. Patient aggressive when asked to be by bedside, trying to punch department staff.
- Whilst a staff member was encouraging a patient to go back to bed the patient poured a glass of cold chocolate over the staff member.
- A relative of a patient arrived in the unit intoxicated, slurring her words and smelling of alcohol. The relative was talking loudly to the patient and when asked to keep the noise down they began being verbally abusive towards the staff.
- A staff member received 11 abusive e-mails from a patient within one hour.
- When a staff member answered the patient's call bell they noticed that the patient had disconnected his PCA cannula. The patient stated that he had disconnected it to put on his gown, using his teeth.
- Whilst specialist staff member was on a break the patient attempted to leave the ward. The patient was stopped by several staff member but then proceeded to push staff members out of their way. The patient then undressed and hit staff members with the gown they had been wearing.

Physical Assault

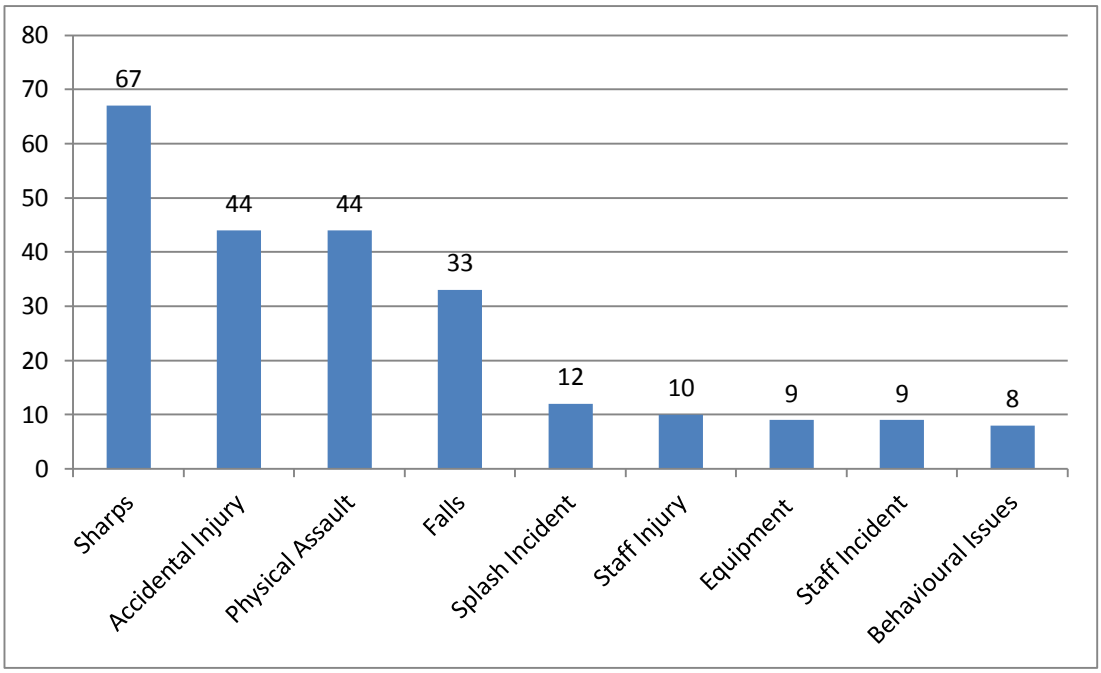
88% of physical assaults were committed by a patient and the remaining 12% by a relative or visitor.

- A patient punched a staff member in the face in an unprovoked attack. The patient was also being racially abusive to other staff members in department.

- A patient's relative assaulted a staff member; they threw a computer monitor at them and tried to break the department door with a storage cage. The staff member's left hand was left swollen and bruised.
- A staff member heard shouting and doors slamming. When they went to investigate they found that a patient from another ward had wandered into the ward and had become aggressive towards staff members, hitting one in the arm and punching the other in the eye.
- A patient with learning disabilities bit a member of staff in a presumed unprovoked episode of violence which required hospital admission and treatment under the care of the relevant surgical team.
- A patient became physically aggressive towards staff member. The Police attended to help, but the patient began to hit them and spit at them. The patient kicked a staff member and their finger got crushed under the patient's leg. The patient also scratched the staff member's left arm, breaking the skin.

A total of 256 (21%) out of the 1209 reported non-clinical incidents resulted in some form of harm. For the clinical incidents that same figure was 23%.

Graph 6.3: Top 10 incident reporting categories resulting in injury, harm or loss to staff, contactors and visitors



In addition to the H&S sections presented in the quarterly and annual Risk Management report a separate monthly report is provided to the Assurance Committee.

7. REPORTS FROM COMMITTEES

Trust Risk Management Committee

The Risk Management Committee is a cross divisional multidisciplinary committee which aims to achieve a safer service for patients through the review of incidents and risks, safety alerts and relevant external guidance to facilitate Trust wide learning and changes in practice.

The committee calendar includes Divisional and Specialty updates from nominated risk leads, presentation of investigation reports, new risks graded orange or red, progress on recommendations arising from incident investigation and review and ratification relevant clinical guidelines. The Committee also receives feedback from sub-committees including the Maternity Risk Management Committee, Medical Devices Committee and Blood Transfusion Committee, regular reviews of the incident review register, risk register and quarterly risk management and maternity risk management reports. The sharing of information and discussion at the meeting facilitates Trust wide learning.

Assurance:
Audit was undertaken on compliance to the processes outlined within several risk related policies during 2013/14. The audits identified overall compliance and where deficiencies were identified actions were introduced to strengthen controls. Progress on implementation of the agreed actions is monitored through the committee in accordance with the committee calendar.

Issues raised at the committee:
To support risk management processes a number of incident investigation related templates were updated and approved by the Committee in 2012/13. These include the template for escalating orange and red incidents, the incident investigation task list and the panel investigation report template. The purpose of this was to strengthen areas such as 'being open' and 'supporting staff' by inclusion of specific triggers on the check list and investigation report template.

A number of policies and procedures were reviewed and approved by the members, for example the Artificial Radiation Safety Policy, Tourniquet Policy, Blood Transfusion Policy and the Nasogastric Tube (Adults) Policy. These policies are particularly relevant as there have been incidents in the past where guidance has not been adhered to, which has impacted on patient care, or the policies relate to 'Never Events'. To provide assurance that controls detailed within the policies are effective, audits on compliance to the policies are presented to the committee. Where deficiencies are identified, the committee members consider actions which will support future compliance to the guidelines. A new innovation introduced during this year, was to invite clinical staff to participate in the update of relevant older guidelines and preparation of new guidelines to ensure they are achievable in the clinical environment.

For further information on Risk Management Committee issues, **contact Vivia Richards, Head of Clinical Governance & Chair of the Committee, or one of the Risk Managers – Anderley Newnham and Malin Zettergren.**

Blood Transfusion Committee
The Hospital Transfusion Committee, and the Hospital Transfusion Team, seeks to ensure a high quality of blood transfusion practice in the Trust.

Controls:
The Trust adheres to the following regulations to maintain and improve the safety of transfusion:

- The Blood Safety and Quality Regulations (BSQR (2005) Statutory Instrument)
- The National Patient Safety Agency (NPSA) Safer Practice Notices
- The British Standards in Haematology (BCSH) Guidelines
- SHOT (Serious Hazards of Transfusion)

These initiatives focus on correct patient identification, documentation and communication.

Trust Transfusion Guidelines and Policies
Following a review of all of the Trust Clinical Transfusion Guidelines and Policies, the following policies and guidelines have been updated or replaced:

- Blood Transfusion Guidelines for Neonates and Children - updated April 2013.
- Guidelines for patients refusing blood - updated July 2013.

The Trust Transfusion Policy was being updated at the time of the collation of this report to include guidance from:

- BCSH - British Committee for Standards in Haematology - Guidelines on Pre Transfusion Sampling
- SaBTO - The Advisory Committee on the Safety of Blood, Tissues and Organs - Recommendations on the provision of CMV negative blood components

Assurance:
Blood Safety and Quality Regulations 2005
The Medicines and HealthCare products Agency undertook a "For Cause" inspection of the transfusion laboratory on Friday 21 September 2012. The triggers for this inspection included the new 24 hour shift system, problems with validating the new LIMS (Laboratory Information Management System), plans to change the auto-analysers, and apparent procedural controls to prevent Electronic Issue on samples where results have been entered manually. Chelsea and Westminster Hospital had never previously been subject to an MHRA inspection.

The inspector's report identified no Critical or Major non compliances but seven other non-compliances were identified. The Quality Manager at Imperial HealthCare identified which Trust needed to deal with the seven non compliances. The blood transfusion laboratory manager in conjunction with the Chelsea & Westminster Transfusion Team then produced an action plan in order to address these issues and which was submitted to the MHRA by the end of October 2012.

Training and Competency Assessment
The Transfusion Practitioner has reviewed and updated the transfusion training packages used for induction and mandatory update so that they are in line with current guidelines. Induction training is conducted face to face and mandatory update training is delivered using a workbook. The Transfusion Practitioner has requested at the Mandatory Training Committee that the mandatory update training be conducted as face to face for a period of a year and this was agreed. In the future it is hoped to move to the national e-learning packages, Learn Blood Transfusion, to fulfil the requirements for mandatory update for all staff.
The Transfusion Competency Assessment documents were also reviewed and have been replaced with new ones that are more in line with national guidelines. To facilitate the requirement under the NPSA Safer Practice 14, Right Blood, Right Patient, to competency assess all staff involved in the process of transfusion; Transfusion Link Nurses/Midwives have been recruited from every clinical area to undertake basic training and competency assessment for all staff requiring it.

Audits
The following national audits were undertaken in the last year:

National Comparative Audit of Bedside Transfusion Practice
This audit showed that a number of porter's competencies for the collection of blood components had expired in recent months. This is being addressed and 63% have now been retrained and competency assessed since the completion of the audit. When the new blood track kiosks are implemented all porters will have to be retrained and competency assessed in blood collection.

A 'train the trainers' day for those assessing competencies in blood transfusion will be run in the near future. The March date had to be postponed due to some midwifery staff being unable to attend.

National Comparative Audit of Patient Information and Consent for Blood Transfusion
This audit is in progress and due to be completed on 4th April 2014. So far 15 patients have been surveyed, their notes audited and the Medical staff making the decision to transfuse have been asked to complete a questionnaire.

National Comparative Audit of Anti-D Usage
The data is currently being analysed and the report will be issued in the near future.

National Comparative Audit of Medical Transfusion Practice
The report is expected in Q2 2014/15.

National Comparative Audit of Sample Rejection
This audit has been completed and the report is available on the transfusion intranet site.

For further information relating to blood transfusion or blood related incidents, **contact Transfusion Leads: Francis Matthey, Consultant Haematologist or Jan Gordon, Transfusion Practitioner.**

Medication Safety Initiatives

Medication Safety is a monthly standing agenda item at Pharmacy Board meetings and the SNMC (Senior Nursing and Midwifery Committee). Joint feedback is provided to the Risk Management Committee in accordance with the schedule. The purpose is to monitor trends related to high risk medications/medication practices, learn from medication incidents and implement medication safety initiatives as appropriate.

Controls and Assurance:
The Control and assurance for Medicines Management within the Trust lies within the Trust Medicines Policy which is audited yearly. Additional Trust assurance has been sought specifically against the nine medicine related Never Events which are discussed and RAG rated at the Trust Quality Committee. A gap in assurance has been identified into the Never Event relating to the proportion of staff having evidence of Medicines Management Training, which stood at 72% at the end of year 12/13. Strategies were introduced to improve the percentage of staff with evidence of Medicines Management Training, and there has been some improvement in this area, which now stands at 81%.

During 2013/14 the pharmacy department considered areas where there is evidence that compliance to guidance had not been followed. These include:

The safe administration of IV medications
A trend in serious incidents related to the administration of IV medications and the identification of over infusion being the second most frequent type of medication incident, led to an audit being conducted which assessed adherence of administration practices against Trust policy standards in 11/12. The audit findings were presented back to the SNMC and the Trust Medicines Committee and re-audits with associated recommendations continued throughout 12/13. Actions include:

- The Trust 'IV addition sticker' was reviewed in consultation with the SNMC and a pilot of the new design undertaken in Obstetrics. The new design was approved after the pilot identified that adherence to standards improved. A trust-wide roll out of the stickers is in progress.
- In response to two moderate incidents related to the infusion rate of variable rate infusions, Trust policy was updated to include the requirements of a double check at the point of a syringe change and/or infusion rate change. The method in which to document this check was approved through the SNMC and disseminated to frontline staff.
- The SNMC continued to impress to ward managers the importance of assessing the competencies of all ward staff, including bank and agency staff prior to assigning medication administration duties. Only nurses that have evidence of competency (completion of learning package, a series of learning profiles and a series of supervised practice) have authority to administer IV medications and a MAPs implementation group has been initiated to ensure the Trust maintains a central database of authorised staff.
- The injectable standards were incorporated into the Nursing and Midwifery 'CQC walk arounds' in order to target specific clinical areas and engaging frontline staff. Using the pro-forma to spot check Injectable practices continued throughout 12/13

Reducing the risk of patients being prescribed medications that they are allergic to
A trend was identified of a number of near misses where a patient was prescribed medications for which they had a documented allergy to; fortunately none of these incidents led to serious harm. The SNMC led on dissemination of the trend analysis and encouraged frontline staff to continue to check allergy as part of the administration process, highlighting the potential risks. The annual identification audit considered appropriate use of allergy bands.

Reducing the inappropriate storage of Medications
Audit identified that there were some clinical areas where safe storage of medication could be improved. Trust Policy for safe storage was reviewed by the SNMC and agreed standards disseminated amongst frontline staff e.g. requirement for Controlled Drug keys to be separate from other medication storage keys. All Clinical areas where the fridge was identified as being unlocked made arrangements either to fit on a suitable locking device to the fridge if required and all fridges were moved into locked treatment rooms if appropriate. Work is on-going in some areas to minimise risks in relation to this area. Where compliance is challenging, risk assessments have been undertaken.

Improving the appropriate management of patients with hypoglycaemia
The SNMC led on the implementation of recommendations from a pharmacy led audit:

- Ensuring that hypo boxes are in a prominent, accessible place on the ward
- Ensuring that all HCAs measuring blood glucose on the ward know when to refer to a nurse so that treatment can be administered and/or arrange hypo training for these staff members
- Highlighting to frontline staff the importance of documentation of hypo treatment (as per the Trust algorithm) in comm. notes/ BG chart

Improving appropriate and timely administration of Analgesia
One of the most significant trends identified was the number of patients reported as not receiving adequate analgesia in the post -operative period. There were 12 such incidents reported over the course of the year and in response:

- The Trust has relaxed the regulations surrounding the prescribing, administration and recording of Morphine Sulphate 10mg/5ml Oral Solution (Oramorph®). These changes are intended to reduce unnecessary delays in administration, ensuring patients receive prompt analgesia.
- A system has been set up to ensure that the Acute Pain Team are provided with a summary of Medication Incidents reports related to analgesia quarterly and these are discussed as a standing item at the Acute Pain Team Clinical Governance Meetings.

For further information relating to medication safety related initiatives, contact **Anna Bischler, Pharmacy Risk Management Lead.**

Decontamination Committee

The committee objectives included improved patient safety initiatives and prevention of cross infection.

Controls:
The Decontamination Committee oversees the development and implementation of the National Decontamination Programme, which states that every department for the decontamination of surgical instruments and flexible endoscope must meet requirements of the Medical Devices Directive, health Act and Care Quality Commission.

The Chelsea and Westminster Hospital Decontamination Service has developed and implemented a Quality Management System (QMS) ISO 9001 and ISO 13485 in order to ensure compliance with the standards and reduction of risk for the patients associated with the hospital acquired infection.

The QMS addresses the requirements of the Medical Devices Directive 93/42/EEC (including the amendments of 2007/47/EC) The system covers all the activities undertaken by both the Sterile Services Department (SSD) and Endoscope Decontamination Unit (EDU) relevant to the quality of the products and services provided by the department.

Assurance:
The decontamination department has been accredited during the year. This is confirmation that there are established systems and procedures in place. Evidence is held within the department.

The Trust is compliant with the requirements of identifying patients with risk of CJD; patients safety-checking instruments after surgical procedures by theatres staff; loan medical devices to other organisations; single use medical devices and consequences of re-use; safe transportation of surgical instruments and flexible endoscopes; traceability.

Trust has implemented a new guidance Choice Framework for Local Policies and Procedures which requires that instruments after surgery are kept moist. Decision was made to introduce a plastic bag and place instruments after surgery into bags. It was successfully implemented in treatment centre, maternity theatres, paediatric, burns. Main theatres are still not complying with this recommendation.

Issues raised by the Committee:
Missing Instruments: Between May 2013 and December 2013, a total of 24 incidents of missing instruments were reported when instruments were returned from theatres. Clinical incident reports were raised and theatres staff was informed; a thorough investigation by theatres staff had been done to make sure instrument is not left in patient. Additional controls introduced include monitoring of checklists to ensure sets have been checked and signed following procedure.

For further information relating to decontamination safety related initiatives, contact **Olga Sleigh, Head of Decontamination Services**

Health, Safety & Fire Committee

The Health Safety and Fire Committee in co-operation with site partners where appropriate, aims to consider general policy matters relating to the health safety and related welfare of employees, contractors, visitors and members of the public and to ensure a safe working environment. The committee has nominated representatives from clinical divisions, major site partners, resident contractors and specialist advisers.

The committee calendar includes Divisional and specialist updates from nominated representatives, presentation of investigation reports, new risks graded orange or red, progress on recommendations arising from incident investigation and review and ratification relevant health and safety policies and guidelines. The Committee also receives feedback from sub-committees including the Fire Action Group, Medical Gas Committee and Radiation Protection Committee, regular reviews of the monthly reported incidents and mandatory training compliance. The sharing of information and discussion at the meeting facilitates Trust wide learning.

The Trust has developed a range of health and safety policies which have been approved by the Health, Safety & Fire Committee. Policies are reviewed at least every two years to reflect current/best practice. These policies set out the minimum standards required to safeguard patients and staff, both within Trust premises and when working in the community. Each policy establishes the need for risk assessments to identify key operational and organisational risks, as well as the monitoring and review processes anticipated.

Assurance:
Audit was undertaken on compliance to the processes outlined within several health and safety related policies during 2013/14. The audits identified overall compliance and where deficiencies were identified actions were introduced to strengthen controls. Progress on implementation of the agreed actions is monitored through the committee in accordance with the committee calendar.

The most significant assurance during the period is the external assurance provided by the NHSLA assessment – all health and safety related criteria were judged to meet level 3. The assessors said 'Throughout the assessment, the attention to detail and diligence in developing and using effective risk management processes was demonstrated and staff were clearly engaged and committed in support of both patient and staff safety'.

Issues raised by the committee:
A number of policies and procedures were reviewed and approved by the members, including: the Health & Safety Policy; Display Screen Equipment Policy; Management of Slips, Trips & Falls; Portable Electrical appliance Policy; Control of Contractors Policy; Moving & Handling Policy.

Mandatory training attendance data is reviewed on a monthly basis, with areas of concern highlighted to Divisional/Departmental leads. A series of KPIs have been developed and will be used to monitor training and key risk assessment compliance.

For further information on Health Safety & Fire Committee issues, contact **Kevin Ray, Health & Safety Consultant**.

8. CONCLUSION

The Chelsea and Westminster Hospital NHS Foundation Trust is committed to the management of risk and this is clearly demonstrated by the progress that has been made during 2013/14, however there are still areas for improvement and these will be reflected in the risk management objectives for 2014/15.

To ensure that staff feel involved in the risk management process, can appreciate the benefits, and continue to report incidents, feedback mechanisms will continue to be developed during 2014/15.

All of the above requirements are to be addressed through the Trust's risk management systems. Good incident reporting and management practices can only be achieved through effective communication at all levels within the organisation, which is the lynchpin to the effectiveness of all risk management systems.

FREQUENTLY ASKED QUESTIONS ABOUT INCIDENT INVESTIGATION

APPENDIX 1

INCIDENT INVESTIGATION Q&A
RISK MANAGEMENT/ASSESSMENT Q&A

Incident Investigation Q&A

1. **How are incidents reviewed?**
   Red, Orange and many yellow incidents are subject to a detailed investigation. A key purpose of the investigation and subsequent report is to introduce safety measures and share learning from incidents, claims and complaints.

2. **How is the quality and appropriateness of investigations checked?**
   The Director of Governance and Corporate Affairs, Head of Clinical Governance, and nominated membership of the investigation team (and other Directors, if necessary) reviews and approves a summary of the investigation and recommendations. The summary and recommendations are also presented at the Risk Management Committee and, where relevant, the Trust Executive Quality Committee, Information Governance Committee or the Health and Safety Committee.

3. **How is learning shared?**
   Incidents which have been investigated, predominantly orange or red incidents, are presentation at the Risk Management or other relevant departmental and Trust-wide Committee. The causes of the incidents are discussed, along with contributory factors. Recommendations with trustwide implications are discussed and, where appropriate, directorates are allocated actions to mitigate the possible repeat of a similar incident in their departments - even if the incident happened elsewhere. Incident summary reports and action plans are published on the Intranet and frequently presented and discussed at clinical governance half day meetings.

4. **How are the actions from incidents monitored?**
   A précis of the incident and the recommendations are placed on an incident review register, which tracks progress towards completion. The register is updated as recommendations are achieved. Actions are reviewed every quarter to ensure progress and identify any significant delays. The Incident Review Register is also uploaded on the Intranet and is available to view.

5. **Why are some incidents still outstanding after some time?**
   There may be a variety of reasons. An incident is considered open until all the actions are complete and some actions outstanding may be relatively minor. Some delays have occurred as the named individual for an action has left the trust and the action has not been reassigned yet. Directorates are being encouraged to prioritise their actions so the most significant relating to the root cause(s) are actioned first. This is, however, an area that requires some attention.

6. **Are incidents linked to complaints and claims?**
   Yes. Incidents, complaints, claims and PALS enquiries are all recorded on our Risk Management Reporting System and, where applicable, are linked.

7. **What do we do to involve and support patients, relatives or carers affected by incidents?**
   The Trust has a policy describing what we do to ensure that we are open and honest with patients who are affected by incidents. Our investigations will always address and consider the extent to which those affected have been given an accurate, open, timely and clear explanation of what has happened, regardless of, but with sensitivity to, the distressing nature of the incident. We also provide information to those affected to explain what is going to happen regarding any investigation.

   Patients, relatives or carers affected by serious incidents are advised of investigations and notified that findings will be shared with them as they wish, and advised of whom they can contact should they want information on the progress toward completing investigations, or implementation of recommendations.

Risk Management/Risk Assessments Q&A

1. **Why do we need to undertake risk assessments?**
   We need to understand what might cause harm to people or the organisation in terms of achieving our strategic objectives. We do this in order that we may assess whether we are doing enough to prevent that harm or service continuation. Once we have decided that, we need to identify and prioritise putting in place, appropriate and sensible control measures to manage or mitigate any identified risks.

2. **What should be included in a risk assessment?**
   You do not need to include insignificant risks. You do not need to include risks from everyday life unless work activities increase the risk. You should be able to show from your risk assessment that:

   - there is a clear and accurate description of the risk
   - all people or services who might be affected have been considered and consulted with
   - the controls in place are reasonable, and
   - actions are proposed to address identified risks.

3. **Is there a template staff can use?**
   Yes, the Trust's risk assessment form should help with guiding assessments and ensuring that the above information is considered, and also helps with communicating and managing the identified risks. This is not the only way to record your risk assessment. You can record the assessment in any convenient way so long as it is retrievable and covers the main points listed above.

4. **What should risk assessments cover?**
   Risk assessment should cover all groups of people or services who might be harmed or affected by the identified problem. Highlight risks at your team meetings as often teams working together will resolve identified problems quickly.

   - Is there a potential for patient harm as a result of an identified hazard?
   - Remember that the most vulnerable patients are more likely to suffer harm.
   - Are staff affected because of risks associated with the particular jobs they do, such as the environment, training or competencies, breakdown/repair and maintenance of equipment.
   - Temporary staff or contractors may not be familiar with some of our Trust processes and the controls we have in place.
   - Think about new employees – they may be inexperienced, and/ or lack maturity/ experience to recognise risks. They may not be familiar with a particular way of working within a team or department – they may not be aware of what is and what isn't acceptable.
   - Think about staff with poor literacy skills. If staff can't read, write or add up, this can affect their ability to read, understand and follow guidance and instructions.
   - Think about lone workers, and those who may be more exposed to unexpected risks (physical, biological or chemical risks).
   - Additionally, think about any other groups, such as members of the public and groups of people who are present in your area of work.

   Look for your comprehensive risk review. This is a detailed list of potential risks which apply to all departments within the Trust – it covers both clinically related and non-clinical risk e.g. moving and handling, security. The aim is to identify issues for which a fuller risk assessment may be necessary.

5. **Who is responsible for doing a risk assessment?**
   The Trust has a risk management strategy and policy in place, which sets out the key responsibilities and accountabilities for managing risk within the organisation.

   It is the responsibility of ALL staff working within the organisation to bring any previously unidentified or new risks to the attention of their relevant management team.

   Heads of departments are responsible for that appropriate and effective risk management processes are in place within their designated area(s). This includes ensuring that risk assessments are completed when new or previously unidentified risks emerge.

Supporting paper 2.6

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Risk Management Strategy and Policy 2014/15

START DATE:	July 2014	**NEXT REVIEW:**	June 2015
COMMITTEE APPROVAL:	Trust Board	**CHAIR'S SIGNATURE:**	
	DATE:		
	ENDORSED BY: Risk Management Committee	**DATE:** 17th July 2014	
DISTRIBUTION:	Trust wide		
LOCATION:	Intranet: Trust Policies and Procedures		
RELATED DOCUMENTS:	Procedure for the management and Investigation of incidents, including Serious Untoward Incidents (SUIs) Procedure for risk assessment and the risk register. Raising Concerns (Whistleblowing) Policy Training Need Analysis and Trust Training Policy Health and Safety Policy Major Incident Policy Flu Pandemic Contingency Plan Governance Structures and Processes policy Slips, Trips & Falls Policy Fire Safety Policy COSHH Policy Display Screen Equipment Policy Moving & Handling Policy Stress Policy Management of Body Fluid Exposure Policy Prevention of Body Fluid Exposure Lone Working Policy Security Policy Policy for Staff Induction		
AUTHOR / FURTHER INFORMATION:	Vivia Richards, Head of Clinical Governance		
STAKEHOLDERS INVOLVED:	Divisional Risk Leads (membership of the Risk Management Committee), Executive and Divisional Directors, Senior Nursing and Operational Managers.		

DOCUMENT REVIEW HISTORY:

Date	Version	Responsibility	Comments
May 2006	1	Director of Governance and Corporate Affairs	Revision of document May 2006

Oct 08	1.1	Director of Governance and Corporate Affairs	Update to reflect current structure and other minor amendments.
Mar 08	2	Director of Governance and Corporate Affairs	Yearly review. Incorporates changes to governance and health and safety
May 09	3	Director of Governance and Corporate Affairs	Yearly review. Changes to objectives
July 10	4	Director of Governance and Corporate Affairs	Yearly review. Changes to objectives
Dec 10	4.1	Director of Governance and Corporate Affairs	To include recently updated terms of reference of committees.
June 11	5	Director of Governance and Corporate Affairs	Yearly review. Changes to objectives. Inclusions recommended by internal audit
Oct 11	5.1	Director of Governance and Corporate Affairs	Revision to reduce duplication and provide more clarification in some areas. Terms of reference of the reporting committees have been removed.
June 12	6	Director of Governance and Corporate Affairs	Yearly review.
June 13	7	Director of Governance and Corporate Affairs	Yearly review. Changes in responsibilities
June 14	8	Head of Clinical Governance Risk Manager	Yearly Review. Updated to include changes in responsibilities, and objectives for the coming year
DATE EXPIRED:		August 2015	

CONTENTS

1. INTRODUCTION

The Trust vision is to deliver safe care of the highest quality to our patients, provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state of the art technology and high class academic research.

The Trust is committed to a strategy and policy which minimises the risks of harm to people, services and the Trust and which aims to influence behaviour and develop an organisational culture within which risks are seen as everyone's responsibility and where they are promptly recognised and addressed. The Trust also strongly supports the principles of openness, transparency and candour and requires honesty openness and truthfulness in all dealings with the patients and the public.

The purpose of this document is to outline the strategic direction for the management of risks within the Trust and to provide a framework for the continued development of the risk management processes throughout the Trust.

Approval of the Trust's strategy and policy for risk management confirmed by the Board, and is endorsed by the Risk Management Committee.

2. SCOPE OF THE STRATEGY AND POLICY

2.1 General

The risk management strategy and policy relates to risk in all areas of the Trust's activities, and covers risks to both staff and patients and the organisation's assets.

It applies to all staff employed within the Trust on a permanent, temporary, contract or volunteer basis. All staff are expected to be aware of the strategy and policy, understand their responsibilities in relation to managing risk and follow the guidance contained in the Trust risk management procedures. These are available on the Trust intranet

.

The strategy section of this document outlines the Trust's objectives for risk management with the overall objective of protecting patients, staff and assets. Key objectives for 14/15 are identified in 4.2. The policy section outlines the roles and responsibilities of staff, structure of committees overseeing risk management and risk management processes.

2.2 Health and Safety

In the context of effective corporate governance, management of health and safety risks is a key issue for the Board, who have a collective role in providing committed leadership in the continuous improvement of health and safety performance. The Board will ensure that their actions and decisions always reinforce this commitment, and that they will review the effectiveness of the health and safety management system and performance, at least annually.

The Board has a specific responsibility under the Health and Safety at Work etc Act (1974), to prepare a General Policy statement and all staff are expected to comply with this policy, as outlined in the statement. The Board has a monitoring, review and policy setting role in health and safety.

With respect to risk management and in particular, Health and Safety, the Trust is committed to delivering the following:

Strong and active leadership:

- Visible, active commitment from the Board;
- Integration of good health and safety management with business decisions;
- Establishing effective 'downward' communication systems and management structures.

Staff Involvement:

- Engaging the workforce in the promotion and achievement of safe and healthy conditions;
- Effective 'upward' communication;
- Attending training.

Assessment and review:

- Identifying and managing health and safety risks
- Accessing and following competent advice
- Monitoring, reporting and reviewing performance

This is undertaken by the Health, Safety & Fire Committee which reports into the Assurance Committee. There is a health and safety representative at the Risk Management Committee.

3. DEFINITIONS

3.1 Risk is the likelihood something will happen that will have a detrimental consequence on the achievement of our objectives or service delivery to patients, staff or visitors. This may include damage to the reputation of the Trust, which could undermine the public's confidence in us. It is measured in the terms of consequence (impact or magnitude of the effect of the risk occurring) and likelihood (frequency or probability of the risk occurring).

3.2 Hazard

Anything with the potential to cause harm (for example, disease, electricity, chemicals, sharps, an event with business or clinical implications).

3.3 Risk management

This is the term applied to the use of a logical and systematic method of identifying, analysing, evaluating, controlling, monitoring and communicating risks associated with any activity, process or function necessary to the achievement of the organisation's objectives.

3.4 Risk Management Processes

The risk management process is "the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk." Australian / New Zealand Risk Standards 4360:1999

3.5 Training Needs Analysis (TNA) Minimum Data Set 2014/15

The Training Needs Analysis minimum data incorporates key subject areas in relation to risk and incorporate aspects of training which include the following topics:

- Health record keeping training
- Hand Hygiene Training
- Risk awareness training for senior managers
- Moving and Handling Training
- Consent Training
- Health & Safety
- Slips, Trips and Falls Training (Staff and others)
- Slips, Trips and Falls (Patients)
- Fire Safety
- Inoculation Incident Training
- Harassment and Bullying Training
- Violence and Aggression Training
- Health Record Keeping Training
- Medicines Management Training
- Transfusion Process Training
- Resuscitation Training
- Venous Thromboembolism Training
- Investigations of incidents, complaints and claims training

3.6 Controls

Policies, procedures, practices, training, behaviours or organisational structures to manage risks and achieve objectives. Examples include a written system of working e.g. counting swabs; training programmes; software e.g. the system not allowing you to do something; physical barriers e.g. locked or key pad controlled access; security levels on software systems. The strength of controls can vary e.g. a policy or procedure is a weak control and in itself it does not help as it needs to be followed.

3.7 Assurance

Can be defined as confidence, based on sufficient evidence that internal controls are in place, operating effectively and objectives or actions are being achieved. Or 'Where can we gain evidence that our controls/systems, on which we are placing reliance are effective' or simply 'how do we know that an action is in place?' Examples of assurances include external validation eg external assessment, internal audit; Internal validation, data available; procedure in place; minutes of meetings demonstrating discussion; surveys; circulation lists.

Having a policy or procedure in place is a weak assurance: it demonstrates that a practice has been described but provides no assurance that it is being followed. Minutes of meetings demonstrating discussions is slight stronger as it demonstrates active input, but the real test would be observation or audit. A negative assurance is that an incident occurs, which may demonstrate that a process is not being followed.

3.8 Comprehensive Risk Review:

This is a detailed risk review of all departments within the Trust covering both clinically related and non-clinical risk e.g. moving and handling, security. The aim is to identify issues for which a full/ individual risk assessment may be necessary. For the full list and description of process refer to the document 'Comprehensive Risk review'.

3.10 Acceptable risk

The Health and Safety Executive (1988) has suggested the following definitions; -

"the risk although present, is generally regarded by those who are exposed to it as not worth worrying about."

The Trust classifies risks according to a risk classification matrix, which allocates a colour to indicate the level of risk associated with a hazard (green = very low, yellow = low, orange = medium, red = high) – refer to Appendix 2.

The Trust considers a risk to be acceptable when there are adequate control measures in place and the risk has been managed as far as is considered reasonably practicable. Risks falling in the green "very low" risk category are considered "acceptable" although the Trust will still need to take action on these risks where the assessment has identified that risks can be easily minimised.

3.11 Managed risk

'A risk that society is prepared to live with in order to have certain benefits and in the confidence that the risk is being properly controlled."

The Trust regards tolerable risks as those falling within the yellow "low" risk category. (Refer to risk classification matrix – appendix 2)

3.12 Significant risk

"a risk, that requires action in the short to mid term to reduce the likelihood of harm."
The Trust uses its risk classification matrix to categorise risk ratings and regards risk which fall into the orange "medium" category as significant. These are managed as described in the 'Procedure for Risk Assessments and the Risk Register' available on the Trust intranet.

Risks that are categorised as red are unacceptable. Therefore, the activity must be stopped immediately until the risk is substantially lower. These are managed as described in the 'Procedure for Risk Assessments and the Risk Register' available on the Trust intranet.

3.13 Residual risk

The risk remaining following treatment or mitigation.

3.14 Risk categories and risk appetite

The Board sets the overall risk tolerance. One of the ways it constrains overall exposure to risk is to set authority limits for managers within policies and processes under the governance structure.

Risk tolerance has been divided into the following areas, based on the current classification and definitions of risks. *Risks can have more than one category e.g. a risk may be organisational and financial and reporting on risks refers to the main categorisation.*

3.14.1 Clinical risk

Those risks, which have the ability to affect patient care and may cause harm to the patient. This covers anything related to the diagnosis, treatment and outcome of each patient. Psychological harm or distress is also included.

Tolerance: Zero tolerance in respect of risks associated with patient safety including non-compliance with Child Protection and Safeguarding Adults Policies.

3.14.2 Health and safety risk

Health and safety risks include risks that affect the environment of care and risks that could cause injury or ill health to any person in connection with the Trust's activities. This includes fire, security, environmental and health and safety issues.
Tolerance: Nil tolerance in respect of risks associated with patient and staff safety

3.14.3 Financial risk

Those risks which have the ability to affect the financial well-being of the Trust.
Tolerance: Low tolerance to financial risks to safeguard public funds.
Moderate tolerance to financial risks with potential significant benefit to the Trust – patient care, efficiency and reputation.

3.14.4 Reputational risks

Those risks which adversely affect the reputation of the Trust
Tolerance: Low tolerance to risks that affect our reputation and the confidence patients have in the organisation.

3.14.5 Strategic risk

Those risks, which have the ability to affect the development, implementation and control of agreed strategies.
Tolerance: Moderate tolerance to opportunities that might arise through the course of normal business and moderate tolerance in respect of taking well-considered risks that influence and promote positive change.

3.14.6 Performance /organisational risks

Those risks that threaten the achievement of the organisations principal objectives and the viability of the organisation.
Tolerance: Nil tolerance

4. STRATEGY

4.1 Risk Management aims

Risk management underpins and supports all activities aimed to deliver the corporate objectives which are:

To improve patient safety and clinical effectiveness
To improve the patient experience
To deliver excellence in teaching and research
To ensure financial and environment sustainability

The risk management aims are:

- To ensure that all systems of risk identification and management are integrated and that risk management is a key part of all the Trust's business and clinical activities.
- To ensure excellent systems are in place for identifying, managing and monitoring risks including escalation of risk within the organisation to the appropriate committee or the board

- To comply with relevant external risk management standards and all applicable Health and Safety and Environmental legislation.
- To promote and support an open and fair culture.
- To ensure that all staff are aware of their individual responsibilities, with respect to risk management and have a sound working knowledge of the Trust procedures.
- To provide risk management training in line with the Trusts Training Needs Analysis (TNA) Minimum Data Set to support effective and safe working practices.
- To provide training in other key areas associated with risk management such as risk assessments and health and safety training
- To support an ongoing programme to raise awareness of risk management throughout the organisation, in particular for senior managers and all Board members.

4.2 Key Objectives for 14/15

General:

- Roll-out and implement on line risk management system, specifically the incident reporting system by December 2014.

- Improve the process for the escalation and investigation of serious incidents to ensure that appropriate STEIS incidents to be reported within 2 working days of identification of the incident

- Continue to improve processes to ensure that serious incident investigation reports are completed with appropriate Executive-level sign-off within 45 working days.

- Receive assurance on actions implemented following serious incident investigations through the Incident Review Register, monitoring of controls and assurances for 'Never Events'

- Populate and maintain the Risk Register that profiles all of the organisation's significant clinical, strategic and operational risks and is reported on a regular basis to the Trust Board, Risk Management Committee and other identified/responsible committees in line with the Trust's reporting requirements.

- To ensure appropriate integration of all aspects of clinical and non-clinical risk, including health and safety risks into the day to day operations of the Trust through the review of CRR and actions arising

Health and Safety objectives 2014/15 will be located within the Health and Safety strategy

5. RISK MANAGEMENT POLICY

5.1 Purpose

The purpose of the risk management policy is to define the framework for managing risk and the structure of risk management related committees. The policy also outlines the roles and responsibilities of all staff and the Trust's incident reporting and risk management arrangements.

5.2 Duties

5.2.1 All staff

Risk management must be seen as everyone's responsibility and not just that of any one individual or department. It is the responsibility of all staff to practice safely and to participate in the assessment, reporting and management of risk. All staff have a responsibility to attend risk management training and ensure they understand the requirements of the Trust's risk management policies and procedures. In addition staff are responsible for fulfilling the professional requirements of their regulatory bodies.

5.2.2 The Trust Board, Directors and Sub Committees of the Board

The Trust Board is responsible for overall governance of the organisation including risk management. The Chief Executive is the accounting officer.

a) Non-Executive Director / Chair of Assurance Committee

The Assurance Committee is chaired by a non-executive director. It is the responsibility of the Chair, working with the Director of Governance and Corporate Affairs, to ensure that this committee works effectively and reports regularly to the main Trust Board.

b) Non-Executive Director / Chair of Audit Committee

The Audit Committee has responsibility for effective internal control. The Audit Committee will provide the Board with a means of independent and objective review and assurance of the adequacy of governance arrangements, financial systems and compliance with legislation.

c) Finance and Investment Committee / Chair of Finance and Investment Committee

The Finance and Investment Committee conducts an objective review of financial and investment policy issues, on behalf of the Board.

d) Directors

All Board Directors have a collective responsibility for risk management and individually for advising the Board as necessary in areas of particular expertise. All directors are responsible for ensuring that the risk management programme is effective both in their responsible areas and using their expertise, in the organisation. They are accountable to the Chief Executive for ensuring safe and healthy working conditions and will provide appropriate support to divisional managers in order that they are able to meet their responsibilities for health and safety.

e) Chief Executive

The Chief Executive is the Accountable Officer for risk management, including health and safety. The duty to implement Health and Safety Regulations has been delegated to the Director of Nursing and Quality.

f) Medical Director and Chief Nurse and Director of Quality

The Medical Director and Director of Nursing and Quality have board level responsibility for risk management relating to their professional fields.

The **Chief Nurse and Director of Quality** is also responsible for the operational aspects of Health and Safety. This post holder chairs the Health, Safety & Fire Committee; ensures that the Health & Safety policy is reviewed annually or as appropriate; promotes a healthy, safe environment by effective communication and coordination on matters of health and safety; ensures that health and safety is given a

sufficiently high profile to maintain a culture which encourages effective health and safety management; supports the Chief Executive in relation to corporate health and safety responsibilities; and ensures that staff have access to fire safety advice as part of their induction and to a range of health and safety related training as required to undertake their roles.

g) Chief Financial Officer

The Chief Financial Officer is responsible for finance overall and in particular developing income streams outside of the NHS This post delegates operational financial risk management to the finance director

h) Director of Finance

The Director of Finance is responsible for maintaining an effective system of financial control ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective audit function. The Finance Director is responsible for insurance arrangements in the Trust.

i) Chief Operating Officer

The Chief Operating Officer has operational responsibility for the running of the trust, manages the directors of Information Communication and Technology, Director of Estates and Facilities and has board level responsibility for these areas. This post is also the executive lead for Information governance

j) Director of Human Resources

The Director of Human Resources is the director with responsibility for human resource issues with the Trust. The Director of Human Resources is also responsible for Occupational Health, the moving and handling advisors, and the Training Resource Centre, including the Trust's training database, the identification of training needs, the training prospectus and monitoring attendance at mandatory training.

k) Director of Information, Communications and Technology

The Director of Information Communications and Technology is the Director with responsibility for information technology. This post holder has a key role to play in business continuity of IT systems.

l) Director of Corporate Affairs

The Director of Corporate Affairs is responsible for identifying the risks associated with strategic objectives as part of developing the Assurance Framework and identification and management of corporate risks via the Board in conjunction with the Director of Quality Assurance.

m) Executive Team

This refers to the Chief Executive, and all Directors including the Divisional Medical Directors and Divisional Operations Directors.

5.2.3 Trust-wide Responsibilities

The following committees and staff have designated Trust-wide risk management responsibilities:

a) Risk Management Committee

This is chaired by the Head of Clinical Governance and it is a cross divisional multidisciplinary committee which aims to achieve a safer service for patients through reviewing incidents and risks, safety alerts etc and through facilitating learning and changes in practice. The Terms of reference are included as Appendix 1. They are also available from the Foundation Trust Secretary/Head of Corporate Governance

b) Health, Safety and Fire Committee

This is chaired by the Chief Nurse and Director of Quality and its aim is to consider general policy matters relating to the health safety and related welfare of employees, contractors, visitors and members of the public, to ensure a safe working environment and to advise

Chelsea & Westminster Hospital NHS Foundation Trust accordingly. The terms of reference are available from the Foundation Trust Secretary/Head of Corporate Governance

c) Head of Clinical Governance
The Head of Clinical Governance is responsible for leading the implementation of all aspects of the Trust's Clinical Governance related objectives and has responsibility for the risk register and incident review register. The Head of Clinical Governance is also responsible for the Clinical Governance Support Team, which includes risk managers and clinical governance coordinators.

d) Risk Managers
The risk managers are responsible for maintaining and developing the incident reporting system, and supporting the divisions in the management of risks and incidents on the risk register and incident database in conjunction with the divisional risk leads. They also deliver training and education on risk management issues to staff, and provide advice and updates to staff on risk management issues. They support the divisions in their overall risk management responsibilities.

e) Health & Safety Consultant
The Health and Safety consultant provides advice on general Health and Safety and monitors and advises on safety performance.

The Health and Safety Consultant has a co-ordinating role in relation to general safety issues including delivering health and safety training, review of risk assessments and audit of the Trust Safety Management System.

The duties and responsibilities are:

- on a day-to-day basis to assist the Trust in ensuring, as far as is possible, that activities comply with the necessary legislation and to advise the management on safety matters, to ensure that the Trust's procedures for caring for the health, safety and welfare of its staff and students are of the highest standard and that the health, safety and welfare of the general public is not adversely affected by the Trust's activities;
    - to act as the Fire Safety Advisor as required by the NHS Firecode to support the Fire Safety Manager;
    - to act as the secretary of the Health, Safety & Fire Committee and follow up any recommendations made;
    - to provide training and instruction of staff and students in respect of safety and fire prevention, and to keep them conscious of the problems of safety, and of their responsibility for the safety of those with whom they work;
    - to carry out audits of each department at appropriate intervals and provide a report to department managers and safety committees;
    - to obtain, where appropriate, expert advice to ensure that the safety procedures in operation are of the highest necessary standard;
    - to act directly as advisor to managers and members of staff on safety matters and, where necessary, to obtain expert advice on their behalf;
    - to liaise on behalf of the Trust with the enforcing authorities on all safety & fire issues.

f) Patient Affairs Manager
The Patient Affairs Manager is responsible for ensuring that a speedy and effective response is made to all patient/user complaints, comments and suggestions regarding the service provision of the Trust, minimising the risk of complaints being referred for independent review and taking action or making recommendations arising from complaints where appropriate.

g) Head of Legal Services
The Head of Legal Services is responsible for the provision of legal advice and services to the Trust relating to healthcare and for handling clinical negligence and personal injury claims against the Trust.

h) Occupational Health Manager
The Occupational Health Manager will provide expert advice and support to the organisation in relation to assessing whether staff are fit to work, ongoing health surveillance, staff support and follow up of staff accidents and injuries.

i) The Director of Infection Control and Prevention and Infection Control Team
The Director of Infection Control and Prevention is responsible for advising the Chief Executive and Board on matters relating to infection control and prevention in line with national policy. The Infection Control Nurses are responsible for advising and training staff on all aspects of infection control and for monitoring and auditing relevant areas of risk. They are also involved with practice development aspects of infection control and surveillance.

j) Moving and Handling Advisors
The Moving and Handling Advisors are responsible for training and education on moving and handling, and prevention of injuries and back care, in accordance with manual handling legislation and professional codes of practice.

k) Local Security Management Specialist (LSMS)
The LSMS is responsible for reviewing security related risk assessments and will provide a quarterly report to the Health, Safety & Fire Committee of any risks identified as orange or above. The LSMS will lead Trust-wide security initiatives and will provide a monthly report to the Health, Safety & Fire Committee describing security-related activities experienced in the last month. The LSMS will initiate an investigation into all security incidents or allegations of crime and will support managers in discharging their duties in relation to any incident, as well as offering support to the victims of crime. The LSMS will report all allegations of criminal activity to the Police and will ensure that incidents of physical or verbal assault are reported to NHS Protect, in line with existing national guidance.

l) Organisational Learning and Development (OLD) Department
The OLD department is responsible for co-ordinating training for staff. This includes co-ordinating the corporate induction programme which includes risk management.

5.2.4 Division

a) Divisional Medical Directors and Operations Directors, Clinical Directors & General Managers, Chief Pharmacist and Head of Therapies
Divisional Medical Directors and Divisional Operations Directors, Clinical Directors & General Managers, Chief Pharmacist and Head of Therapies are responsible for ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility; and that all staff are made aware of the risks within their work environment and of their personal responsibilities. They will ensure that local risks are regularly reviewed in directorate/department meetings to ensure timely and systematic maintenance of the Trust risk register. They are responsible for implementing and monitoring any identified risk management control measures within their designated area(s) and scope of responsibility ensuring that they are appropriate and adequate. For risks where local control measures are considered to be inadequate, they are responsible for bringing these risks to the attention of the appropriate forum, usually the Risk Management Committee if local resolution has not been satisfactorily achieved.

b) Risk Leads
The Divisional Directors will nominate risk leads through their clinical directors. Risk leads are members of the Risk Management Committee and are responsible for disseminating information from the committee and reporting relevant matters into the committee e.g. directorate/department updates.

5.3 Risk Management Structure

The Trust governance structure is attached as appendix 2 (Trust Governance Structure). This illustrates the committee reporting structure and which committees report into the sub committees of the Board.

5.3.1 Overseeing risk

The main Board committees for overseeing risk are the Audit Committee and the Assurance Committee which report to the Board. The terms of reference are available from the Foundation Trust Secretary/Head of Corporate Governance. The Audit Committee is responsible for the systems of internal control, while the Assurance Committee focuses on assurance of safety, quality, the environment, patient and staff satisfaction and supporting systems. Minutes of the Audit Committee and Assurance Committees are available to the Board after each meeting and in addition, there is an Assurance Committee meeting summary identifying key areas. The Audit Committee and the Assurance Committee each produce an annual report of the areas that they cover.

.

The main committees with operational responsibility for risk management are the Risk Management Committee and the Health Fire and Safety Committee. The terms of reference are available from the Foundation Trust Secretary/Head of Corporate Governance. The Risk Management Committee reports to the Assurance Committee for risk through a quarterly report and to the Quality Committee through a monthly summary of the main items discussed at the Risk Management Committee.

The Health and Safety Committee reports to the Facilities Committee and to the Assurance Committee.

Other groups with a risk management remit which report to the Facilities Committee include Water Management, Sustainability and Waste Groups (see appendix 2)

5.3.2 Structure for the management of risk locally

The Trust has three clinical Divisions and corporate services. The Divisions and corporate services are represented at the Quality Committee, the Risk Management Committee, and the Health and Safety Committee.

Divisional structures

The overall Divisional structures are included in each Quarterly Quality Report and are available from the Head of Clinical Governance.

Within the Divisions risks are discussed in the following forums:

Women's Services, Neonatal and Young People's Services, HIV and Dermatology and Pathology

- Maternity Safety Meeting
- Maternity Outcomes Meeting
- Clinical effectiveness committees for gynaecology, neonates and paediatrics
- HIV/GUM/Dermatology Clinical Governance Board
- HIV/GUM and Dermatology Clinical Effectiveness Meetings
- Neonatal and Paediatric Services Policy and Performance Board
- Women's Services Policy and Performance Board
- Pathology Joint Governance Committee

Emergency and Integrated Medical Care

- Divisional Quality and Governance Meeting
- Divisional Sister's meeting,
- Medicine Divisional Board
- Medicine Directorate Board
- Stroke Clinical Governance Meeting
- ED Clinical Effectiveness Committee

Planned Care (to include Surgery and Clinical Support)

- Divisional Board – Quality

- Radiology safety committee
- Pharmacy Board
- Trauma & Orthopaedics -sub directorate meetings
- Plastics – sub directorate meetings
- Ophthalmology – Divisional Sisters and Matrons meeting
- General Surgery & Urology sub directorate meetings
- Burns sub directorate meetings
- ICU Board
    - ICU Clinical Incidents
    - ICU Clinical Governance Group

Corporate services

- Estates & Facilities have a bi-weekly Directorate Board.

5.4 Risk Management Processes

The risk management process is "the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk." Australian / New Zealand Risk Standards 4360:1999

5.4.1 Process for Assessing all Types of Risk

These are identified and assessed both in a continual systematic way throughout the organisation as well as ad hoc, using a risk matrix (appendix 2). Further details are described in the **'Procedure for Risk Assessment and the Risk Register'**

5.4.2 Authority of all managers with regard to managing risk

The authority of managers with respect to managing risk is described in the '**Procedure for Risk Assessment and the Risk Register.** In summary, risks graded red must be escalated to the Chief Executive. The responsibility for managing the risk and the implementation of action plans will be at Director level. The risk assessment and plan of action will be reviewed and monitored by the Trust Board. For risks graded orange the relevant Executive or Divisional Director is responsible for managing the risk and the implementation of action plans. The progress on risk reduction for Divisional risks is managed through the Divisional structures and processes. For corporate risks, the progress on risk reduction is managed through the Risk Management Committee or other relevant Trust Committee e.g. Capital Programme Board. For risks graded yellow and green departmental managers are authorised to manage locally.

5.4.3 Risks associated with the Trust Strategic objectives (Assurance Framework)

The Trust identifies its strategic objectives and the process for developing the Assurance Framework identifies the risks of failure to deliver these objectives, the controls and assurances in place and the gaps in control and assurance. Following this assessment, risks are graded by the appropriate lead director. Risk graded orange or red have action plans linked to the gaps in control and gaps in assurance. Risks are also identified through papers presented to the Board. The full Assurance Framework is approved by the Board and the Board then receives a quarterly report on orange and red risks only (Q1 Q2 and Q3 only as Q4 update is linked to the revised Assurance Framework for the following year) which contains an update on the action plans and any changes to the risks. The Board also receives a report on organisational, strategic, financial and reputational risks.

5.4.4 Local processes for managing risk

Divisional Directors, Clinical Directors, Divisional nurse leads and General Managers are responsible for ensuring that local processes follow the organisational strategy and policy as follows:

- By ensuring that staff within their areas report incidents, and these are followed up according to the grade and as specified in the incident reporting procedure (available on the Trust intranet)
- By disseminating learning through appropriate divisional meetings and Clinical Governance half days

- By participating in the annual comprehensive risk review
- By reviewing the incidents, complaints, claims and risk reports in the quarterly quality report, to ensure progress on action plans and learning
- By providing reports to the Risk Management Committee in order to share issues, progress and learning

5.5 Risk Assessments, the risk register and monitoring risks

Risks are monitored according to their grade with red risks being monitored quarterly by the Board, and orange risks being monitored quarterly through the Quarterly Divisional Reports (for divisional risks) and the Risk Management Committee (corporate and Trust-wide risks). The Assurance Committee receives a report on risks every quarter. The Board, through direct review of some risks and delegation of the review of other risks, has oversight of the organisation-wide risk register. Risks will be reported externally as appropriate. See 'Procedure for Risk Assessments and the Risk Register' available on the Trust intranet for more information

5.6 Adverse Incident Reporting and Investigation

Incidents are graded using the Trust risk grading system, outlined in the **Trust Procedure for the Management and Investigation of Incidents (**available on the Trust intranet). Red incidents are notified to the Chief Executive within one hour of the incident being identified. Incidents graded orange are notified to the Chief Executive and other key directors within twelve hours of the incident being identified. The Chief Executive will agree the panel for red incidents, and this may include a non-executive director and external members. Orange incidents are usually subject to a directorate-led review, although in some circumstances reviews may be chaired by an executive director or non-executive director. Incidents which meet the STEIS reporting criteria are reported within 48 hours of the incident being reported. The mechanism for external reporting of incidents to STEIS and other organisations is outlined within the Trust Procedure for the Management and Investigation of Incidents.

Following completion of incident investigations, summaries of the investigation and recommendations are agreed by the panel Chair and if reported externally by the executive trust lead. The report and recommendations are presented at either the Risk Management Committee or Preventing Harm Committee. They may also be presented at other committees if appropriate e.g. the Quality Committee in order to support Trust-wide learning or where the incident actions are more appropriately addressed.

The incident summary reports and recommendations are published on the intranet. A précis of the incident and the recommendations is placed on the incident review register, which tracks progress through to completion of the action. The register is updated as recommendations are achieved. Actions are reported every quarter in the Quality Report and reviewed at Divisional/Directorate Boards or other relevant meetings to ensure progress and identify any significant delays.

6. RISK AWARENESS TRAINING FOR SENIOR MANAGERS AND BOARD MEMBERS

All staff members including Non-executive Directors receive risk management awareness training as part of their induction. Participation in induction is recorded on a central learning database (OLM).

6.1 Board members risk awareness training

In addition to the Trust induction, new Board members, including Non-executive Directors receive additional risk awareness training from the Head of Clinical Governance as part of their local induction. The Foundation Trust Secretary informs the Organisational Learning and Development Department (OLD) when training is complete.

Ongoing training is provided through relevant Board papers and seminars. All board papers have a risk section on the Board cover which notes the risk identified in the paper. Any Board members that are not able to attend Board meetings receive a copy of the minutes and presentations through the circulation of Board papers.

Monitoring:

The Foundation Trust Secretary will:

- Liaise with OLD if required (e.g. to contact NEDs) if a new Board member fails to attend corporate induction (OLD will inform the Foundation Trust Secretary as part of routine follow up if required)
- Monitor attendance according to the local induction programme for Board members and follow up if any part of the programme is not attended, by re-arranging that part of the induction.
- Check after the first 3 months, that all Board members have received their induction according to the induction programme and advise individuals and the Director of Governance and Corporate Affairs of any gaps so that corrective action may be taken.
- Follow up on the completion of local training cards if required.
- Ensure that all papers are received by all Board members even if they are unable to attend the Board meeting.

6.2 Senior managers risk awareness training

Senior managers receive risk awareness training through corporate induction. This is delivered and followed up through the ORD as described in the Trust induction and mandatory training policy.

In addition to the Trust induction, new senior staff (defined as 8a or above) receive additional risk awareness training by the Head of Clinical Governance or Risk Managers within the first three months. The Head of Clinical Governance identifies staff through the ' joiners report' provided by the Workforce Information Team.

Non attendance is followed up by the Head of Clinical Governance who will reschedule training and escalate if necessary in accordance with the Policy for Induction and Mandatory Training.

Monitoring
The Head of Clinical Governance monitors and reports on training provided on a quarterly basis. Any deficiencies identified will be recorded in the Risk Management Quarterly Report, which will be reported to the RMC. In addition monitoring is included as part of the audit of induction and mandatory training.

7. PROCESS FOR MONITORING THE EFFECTIVENESS OF THE RISK STRATEGY AND POLICY

7.1 Reporting Arrangements to the Board and High Level Committees

The monitoring of the systems of control within the Trust overall is monitored by the Audit Committee supported by internal audit, and the position expressed through the Annual Governance Statement which is approved by the Chief Executive and reported in the Trust Annual Report. The adequacy of the Annual Governance Statement is monitored by internal audit through the Head of Internal Audit Opinion.

The reporting arrangements of committees reporting to the Board for risk (Audit Committee and Assurance Committee) are monitored annually through a review of agendas and minutes to confirm that reports are occurring to the Board as specified in the terms of reference. Where deficiencies are highlighted, action will be taken by the Foundation Trust Secretary and chair of the reporting committee. A review is also undertaken for committees reporting to the Assurance Committee and for regular reports e.g. risk management report. Where deficiencies are highlighted, action will be taken by the Head of Quality and Assurance and chair of the reporting committee.

An annual review of reports from the Divisions and reporting committees to the RMC committee is undertaken to ensure that reporting is occurring as specified in the terms of reference or annual calendar. Where deficiencies are highlighted, action will be taken by the chair of the RMC.

The main risk committees which report to the Board, the Assurance Committee, and the Audit Committee undertake an annual review of committee effectiveness. Where deficiencies are

highlighted the relevant committee will develop recommendations to address them, and monitor implementation of any resulting action plans.

The Foundation Trust Secretary monitors terms of reference for Trust Committees quarterly to ensure that they meet the Trust requirements and are in date. Where deficiencies are highlighted these are addressed by the Foundation Trust Secretary, with escalation to the Director of Governance and Corporate Affairs as required.

7.2 Management of Risk Locally

An audit will be undertaken annually to determine whether the groups described in the policy as having a responsibility for risk still exist and whether risks are managed and discussed at these groups. A sample audit of agendas and minutes across the Divisions will be obtained to confirm this is the case.

7.3.1 Risk Management Awareness Training

See section 6.1 and 6.2

8. DISSEMINATION

The main features of this policy and strategy are communicated to all staff as part of the induction programme, at mandatory updates and the document is available on the intranet. Other existing communication methods such as 'Trust News' and the Risk newsletter are used to increase general awareness of risk management issues.

Acknowledgements
The Royal National Orthopaedic hospital for risk definitions

APPENDIX 1

Risk Management Committee
Terms of Reference

Aim: The risk management committee is a cross divisional multidisciplinary committee which aims to achieve a safer service for patients through reviewing incidents and risks, safety alerts, policies and procedures and their implementation, and through facilitating learning and changes in practice across the Trust.

Terms of Reference:

a) To consider trends in all incident reports, agree and identify further actions where appropriate.

b) To receive incident review reports ('orange' and 'red' incidents), to identify Trust wide actions where appropriate and ensure that learning is shared across the organisation by utilising divisional and corporate dissemination structures.

c) To review the trustwide and corporate recommendations from 'orange' and 'red' incidents on the review register for progress toward completion.

d) To review new risk assessments where the risk is graded orange or red, to validate risk grade and confirm appropriate actions are in place. Red risks are validated by the executive team prior to reporting to the Board.

e) To review orange and red risks from the Trust's risk register and to escalate risks or concerns as appropriate e.g. to the Quality Committee and Health and Safety Committee.

f) To monitor signals, identify leads and agree if action required. To monitor action agreed.

g) To note Central Alert System (CAS) alerts from the NPSA and NPSA Rapid Response Alerts and monitor any action required until compliance is achieved against action plans.

h) To receive directorate updates annually.

i) To receive progress reports from the following subcommittees quarterly or according to their meeting schedule:

- Decontamination committee
- Medical devices committee
- Radiation safety group
- Blood transfusion Committee
- Resuscitation Committee
- Maternity Risk Management Committee

j) To receive a report on review of assurance on completed actions from incidence and risks.

k) To identify issues to be specifically noted by the other appropriate Committees. This may include issues of particular interest or which require high level executive action.

l) To report to the Assurance Committee on risk management including Trust-wide incidents and risks

Key relationships
Senior Nurses and Midwives Advisory Committee
Health and Safety Committee
Quality Committee
Assurance Committee

Membership

- Head of Clinical Governance (Chair)
- Risk leads from each directorate (or deputies)
  Emergency and Integrated Medical Care
  Medicine, Dermatology, Therapies, Cancer, ED, AAU, Site Management and Emergency Planning and MDU
  Women's Services, Neonatal and Young People Services, HIV/GUM and Pathology
  NICU, Gynaecology, HIV, Maternity, Paediatrics
  Planned Care (to include surgery, clinical support and pharmacy)
  Radiology, Pharmacy, Burns, Anaesthetics, ITU, Imaging and Theatres
- Leads for each reporting committee
  - Trust Audit Lead
  - Risk Managers
  - Health and Safety Representative
  - Head of Legal Services
  - Patient Affairs Manager
  - Chief Pharmacist/representative
  - Director of Nursing/representative
  - Information Management and Technology Representative*
  - Critical care outreach team representative*
  - Human Resources representative*
  - Occupational Health Manager*
  - Deputy Director of Finance*
  - General Manager for Estates and Facilities*
  - Consultant in Infection Control*

* for relevant items only

Quorum
The Head of Clinical Governance, at least one representative from each of the Divisions plus at least one Risk Manager.

Frequency of meetings
Ten times a year

Attendance requirements
Two thirds of the meetings

Circulation requirements for papers
At least three working days

Reports to:
The Trust Executive Quality Committee
Assurance Committee

Committees which report to the Risk Management Committee and frequency

Name of committee	Committee Role
Maternity Safety Committee (quarterly)	Reviews safety risk management in maternity, including trends
Decontamination Committee (quarterly)	Develops Trust wide decontamination standards and strategies for meeting HTM compliance.
Medical Devices Committee (Quarterly)	Develops Trust wide standards for all medical devices purchased and strategies for reducing the risks associated with medical devices. Monitors the education programme for all staff using medical devices.
Resuscitation Committee (Quarterly)	Monitors resuscitation procedures, equipment and training and cardiac arrests in the Trust. Main reporting is to the Quality Committee.
Blood Transfusion Committee (quarterly)	Oversees and monitors the implementation of good transfusion practice by adhering to the guidance and recommendations on its functions as defined within the Department of Health's, Health Service Circular 2002/009.

Role of the Risk Management Committee
Members of the Risk Management Committee represent the relevant directorate/department.

Committee members are expected to:

- Actively participate in discussions pertaining to risk ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact across all of the directorates and departments.

- Disseminate the minutes from this meeting within the directorate/department and inform the relevant directorate committee(s) of issues discussed.

- Share the learning gained from directorate and corporate incident reviews within their directorate/department to ensure that organisational learning occurs.

- Feedback to other staff in the Division, particularly if unable to attend.

- Communicate to the Risk Management Committee risk issues and solutions discussed in the directorate meetings to support organisational learning.

- Present to the Risk Management Committee directorate/departmental progress on key issues including actions from incidents and risk assessments, using the committee pro forma

- Committee chairs are expected to report back on committee activities using the reporting pro forma.

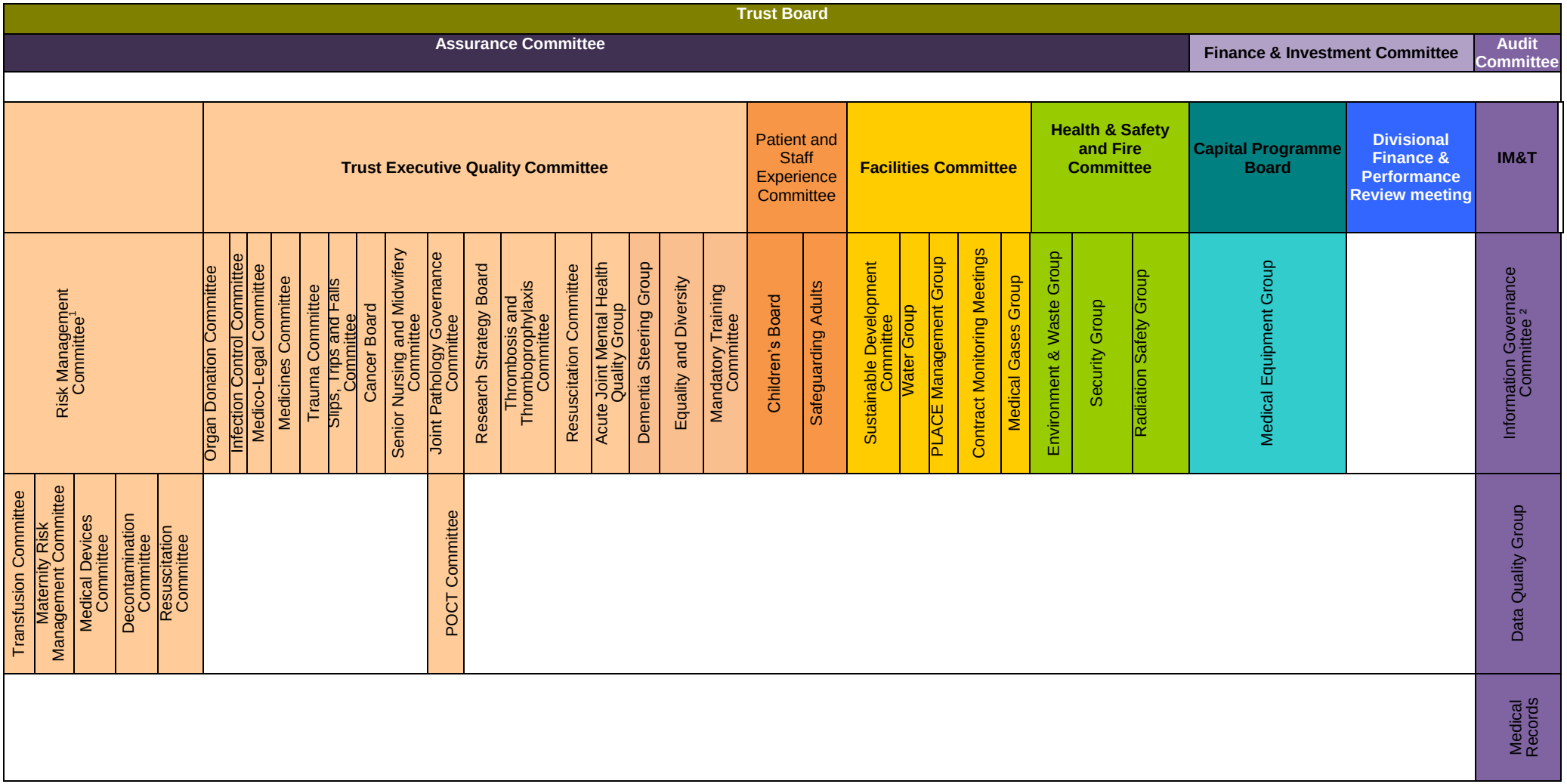
Other routine reports received by the committee
Reports from Divisions against an agreed pro forma yearly.

Approved by the Risk Management Committee July 2014.
Approved by the Trust Board [TBC]

Review date for the terms of reference August 2015.

Appendix 2 Trust Governance Structure

CURRENT GOVERNANCE STRUCTURE AS AT JULY 2014



[1] Reports to both Quality Committee and Assurance Committee as relevant
[2] Reports to both IMT and Audit Committee

Appendix 3 RISK REGISTER/RISK ASSESSMENT GRADING SYSTEM

Full instructions for use are available in the 'Procedure for Risk Assessments and the Risk Register' available on the Trust intranet.

Risks are defined in terms of consequence using table 1. If several consequences are applicable, the highest score is used to determine the consequence. Likelihood is determined from the likelihood tables.

Table 1: Descriptors for Consequence/ Impact

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
Achievement of corporate objectives	Barely noticeable effect.	Minor impact on achieving one or more objectives.	Moderate impact on achieving one or more objectives.	Major adverse effect on delivery of one or more key objectives.	Will not meet one or more key objectives.
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day) Short-term low staffing level that temporarily reduces service quality (> 1 day), where there is no disruption to patient care.	Ongoing low staffing level that reduces the service quality. Minor error due to ineffective training/ implementation of training	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training. Moderate error due to ineffective training/ implementation of training. Ongoing problem with staffing levels.	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training. Major error due to ineffective training/ implementation of training.	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis. Critical error due to ineffective training/ implementation of training.
Service/ business interruption (will depend on criticality of service)	Loss/interruption more than 1-8 hour.	Loss/interruption more than 8-24hours.	Loss/interruption more than 1-7 days.	Loss/interruption more than 1 week.	Permanent loss of service or facility.
Financial	Local management tolerance level.	Loss less than £0.5M.	Loss between £0.5m and £0.999m.	Loss between £1m and £4.9m.	Loss of more than £5m.

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
Complaint/Claim	Locally resolved verbal or written complaint.	Justified written or verbal complaint peripheral to clinical care.	Below excess claim. Justified written or verbal complaint involving lack of appropriate care.	Claim above excess level. Multiple justified written or verbal complaint involving lack of appropriate care.	Multiple claim or single major claim [TO QUANTIFY AT MEDICO LEGAL COMMITTEE]
Quality	Minor non-compliance with internal standards.	Single failure to meet internal standards or follow protocol.	Repeated failures to meet internal standards or follow protocols. Potential to affect external standards (e.g CNST, Health Care Standards). Failure to comply with IR(ME)R.	Failure to meet one or more external standards.	Affects achievement of a significant amount of external standards.
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty. Small number of recommendations which focus on minor quality improvement issues.	Breech of statutory legislation Reduced performance rating if unresolved. Recommendations made which can be addressed by low level of management action.	Single breech in statutory duty Challenging external recommendations/ improvement notice that can be addressed with appropriate action plan.	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Reputation	Rumours. No significant reflection on any individual or body. Media interest very unlikely	Damage to an individual and/or team's reputation. Some local media interest that may not go public. Local media—short term reduction in public confidence. Minor effect on staff morale.	Damage to a services reputation, or low key local media coverage. Local media—long term reduction in public confidence. Significant effect on staff morale.	Damage to an organisation's reputation with local or national media coverage. National Media less than 3 days. Major loss of confidence in organisation.	Damage to NHS reputation or national media coverage. National media more than 3 days. MP concern (questions in House). Severe loss of public confidence
Data security	Potentially serious breach. Less than 5 people affected or risk assessed as low e.g. files were encrypted.	Serious potential breach and risk assessed high eg. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality eg. up to 100 people affected.	Serious breach with either particular sensitivity eg sexual health details, or up to 1,000 people affected.	Serious breach with potential for ID theft or over 1,000 people affected.

Likelihood of exposure to this event

The likelihood of exposure to the risk is determined from table 2 by selecting from either the probability descriptors or the frequency descriptors, whichever is most accurate or appropriate

Table 2: Likelihood descriptors

	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Probability Will it happen or not?	This is likely to occur in 1% of occasions.	This is likely to occur in 20% of occasions.	This is likely to occur in 50% of occasions.	This is likely to occur in 80% of occasions.	This is likely to occur in 90-99% of occasions.
Frequency How often might it/does it happen in a defined period	Not expected to occur for years.	Expected to occur at least annually.	Expected to occur at least monthly.	Expected to occur at least weekly.	Expected to occur at least daily.
Frequency How often might it/does it happen in general	This will probably never happen/ recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur possibly frequently

The risk matrix - table 3 is used to map consequence score with likelihood score and this combination of consequence x likelihood will provide your risk grade. For example if the consequence is moderate (3) and the likelihood is almost certain (5), the result is Moderate (Orange).

Table 3: RISK MATRIX (RISK [R] = CONSEQUENCE [C] * LIKELIHOOD [L])

	CONSEQUENCE				
LIKELIHOOD	**1 Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare	**Green**	**Green**	**Yellow**	**Orange**	**Orange**
2 Unlikely	**Green**	**Green**	**Yellow**	**Orange**	**Red**
3 Possible	**Green**	**Yellow**	**Yellow**	**Orange**	**Red**
4 Likely	**Green**	**Yellow**	**Orange**	**Red**	**Red**
5 Almost Certain	**Yellow**	**Yellow**	**Orange**	**Red**	**Red**

Supporting paper 6.1

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Annual Workforce Monitoring Report

2013/2014

Trust Annual Workforce Monitoring Report.

Contents

List of Tables

1. Introduction

1.1 About this report

This report provides an overview of the Trust's workforce for the financial year 2013/14 whilst simultaneously addressing the equality and diversity workforce requirements of the Equality Act (2010) Specific Duties regulations. The report provides information to enable the Trust to meet it's statutory obligations under existing equality legislation terms of monitoring of the workforce and agreeing actions to address any issues of concern, and provides an overview of the key staff issues within the Trust.

The Trust established key HR targets for 2013/2014 and these targets are used to identify progress measurements for a number of the Trust's key indicators..e.g. turnover, vacancy and sickness rates analysed within the Annual report. The workforce composition is compiled by Divisions, pay and staff groups and provides the framework for the overall analysis.

The Trust employed a headcount of 3317 staff (3038.49 Whole Time Equivalents[1]) by the end of 2013/14.

For the purpose of the Equality Act 2010, public bodies including the NHS have a duty to publish particular workforce information related to staff who share protected characteristics and this information is available in this report. Full details of the Public Sector duty and the list of information we are required to publish can be found in Appendix 1.

1.2 Data Sources and General Reporting Principles

The data used in this report is sourced from

Electronic Staff Record (ESR)

NHS Jobs Records

OLM (Oracle Learning Management)

NHS Staff Survey

Within ESR certain protected characteristics may have data quality gaps, where staff have been given the option not to disclose. This is a common dynamic across most NHS organisations. With regard to formal procedures, particularly where the total number will be low, it may be imprudent to assess these as being statistically significant or a viable source for comparative analysis.

[1] These figures excludes host organisations like CLARHC, Regional Pharmacy and consequently their staff, small in number, do not form the cohort for analysis in this report.

The presentation of data within this report uses the ONS census 2011 and the Health and Social Care Information Centre (HSCIC) Oct 2013, monthly provisional statistics provided by NHS Employers in April, 2014. In rare instances where detailed information on protected groups is not available, alternative research may be cited e.g. Stonewall (UK lesbian, gay and bisexual charity).

1.3 Workforce Performance Metrics

The Trusts key Workforce Metric targets are outlined in the table below and are a referenced point for comparative purposes throughout this annual report.,

Table 1: Workforce Performance Metrics

Workforce Metric		2012/13 Out-turn	2013/14 Target	2013/14 Out-turn
Turnover rate		13.59/%	13.5%	**14.7%**
Vacancies	Total	8.34%	8%	**8.74%**
	Active	2.88%	3.25%	**3.02%**
Time to Recruit		74 days	70 days	**69 days**
Sickness rate		3.72%	3.5%◆	**3.44%**
Agency % of WTE		4.4%	3.15%	**4.0%**
Staff Engagement*		3.87*	>4.00	**4.10**
Non-Medical Appraisals		82%	90%	**85%**
Medical Appraisals**		-	-	**70%**
Mandatory training***		69%	85%	**77%**

Red – below/worse than both 2013/14 target and 2012/13 out-turn
Amber – below/worse than either 2013/14 target or 2012/13 out-turn
Green – above/better than both 2013/14 target and 2012/13 out-turn
NB Out- turn means average over year to date.
*Source 2012 & 2013 NHS Staff Surveys (weighted data)
**Medical appraisals were measured from October 2013 onwards. Targets were not set for 2013/14 whilst the new electronic appraisal system was being embedded at The Trust.
***Mandatory training represents % of completed relevant training within refresher period
◆2013/14 target was reduced from 3.7% to 3.5% in October 2013

2. Workforce Report 2013/14

2.1 Divisional

By the end of 2013/14 the Trust employed a headcount of 3317 staff (3038.49 Whole Time Equivalents) with the largest staff compliment in the Women, Childrens and Sexual Health Division with a headcount of 1226 (1,088.20 wte) representing 17% of the workforce, the smallest being the Management Executive and Corporate Service Division with a headcount of 311.

In January 2014, the Trust staff in post position stood at 3064.54 WTE (whole time equivalents) with the substantively employed workforce increasing by 110.61 WTE (3.74%) since January 2013. This is the highest substantive workforce since the Trust opened.

Further details of other Divisions for comparisons on number are provided below.

Table 2 Divisional Headcount

Division	2013/14		2012/13		Headcount		WTE	
	Headcount	WTE	Headcount	WTE	Difference	Difference %	Difference	Difference %
Clinical Support Services	960	880.37	828	759.25	132	15.94%	121.12	15.95%
Management Exec & Corporate Services	311	297.98	391	374.43	-80	-20.46%	-76.45	-20.42%
Medicine,Surgery & Private Patients	820	765.94	775	731.60	45	5.81%	34.34	4.69%
Womens, Childrens and Sexual Health	1226	1088.20	1198	1065.47	28	2.34%	22.73	2.13%
Total	**3317**	**3032.49**	**3192**	**2930.75**	**125**	**3.92%**	**101.73**	**3.47%**

Significant increases in Clinical Support and decreases in Management Executive and Corporate Services are partly due to the movement of Adult Outpatients (approx. 90 staff) from one Division to another.

2.2 Pay Bands/ Grades

The highest number of staff are employed at Band 5 with a headcount of 705, followed by staff in Band 6 with a headcount of 550. Staff at senior levels of the Trust at Band 8 levels and above in total account for a headcount of 236 staff being one of the smaller numbered groups.

Table 3: Pay Bands/Grades Headcount

Grade	2013/14 Headcount	2013/14 WTE	2012/13 Headcount	2012/13 WTE	Headcount Difference	Headcount Difference %	WTE Difference	WTE Difference %
Band 2	235	213.75	235	211.67	0	0.00%	2.08	0.98%
Band 3	260	239.78	237	217.82	23	9.70%	21.96	10.08%
Band 4	260	244.58	263	244.84	-3	-1.14%	-0.26	-0.10%
Band 5	705	668.76	673	639.42	32	4.75%	29.34	4.59%
Band 6	550	493.66	534	482.51	16	3.00%	11.15	2.31%
Band 7	369	328.12	370	333.33	-1	-0.27%	-5.21	-1.56%
Band 8A	148	131.20	144	130.98	4	2.78%	0.22	0.16%
Band 8B	54	51.47	48	45.25	6	12.50%	6.22	13.74%
Band 8C	26	24.18	27	25.38	-1	-3.70%	-1.20	-4.73%
Band 8D	7	7.00	6	6.00	1	16.67%	1.00	16.67%
Band 9	1	1.00	3	3.00	-2	-66.67%	-2.00	-66.67%
Local non-AfC	14	13.02	12	10.62	2	16.67%	2.40	22.60%
Assoc Spec	14	9.21	15	11.03	-1	-6.67%	-1.82	-16.48%
Clinical Assistant	5	1.06	6	1.18	-1	-16.67%	-0.12	-10.08%
Consultant	260	230.83	239	209.75	21	8.79%	21.08	10.05%
Jnr Doc	320	296.73	298	285.86	22	7.38%	10.87	3.80%
Specialty Doctor	30	21.11	28	19.98	2	7.14%	1.14	5.68%
Trust Grade	58	56.90	53	52.01	5	9.43%	4.89	9.40%
GMP	1	0.13	1	0.13	0	0.00%	0.00	0.00%
Total	**3317**	**3032.49**	**3192**	**2930.75**	**125**	**3.92%**	**101.73**	**3.47%**

Amongst the professional groups, nursing and midwifery account for the largest staff cohort at the Band 5 level with a headcount of 533 which represents 75% of all Band 5 level staff (includes Administrative and Clerical)and at the Band 6 level with a headcount of 366 representing 66% of all staff on this band.

Table 4: Nursing & Midwifery Headcount

N&M	2013/14 Headcount	2013/14 WTE	2012/13 Headcount	2012/13 WTE	Headcount Difference	Headcount Difference %	WTE Difference	WTE Difference %
Band 5	533	503.38	501.00	471.85	32.00	6.39%	31.53	6.68%
Band 6	366	324.34	354.00	313.62	12.00	3.39%	10.71	3.42%
Band 7	202	179.26	195.00	175.42	7.00	3.59%	3.84	2.19%
Band 8A	59	55.97	62.00	57.91	-3.00	-4.84%	-1.94	-3.36%
Band 8B	20	19.33	19.00	18.11	1.00	5.26%	1.22	6.73%
Band 8C	6	6.00	9.00	9.00	-3.00	-33.33%	-3.00	-33.33%
Band 8D	1	1.00	1.00	1.00	0.00	0.00%	0.00	0.00%
Total	**1187**	**1089.28**	**1141.00**	**1046.92**	**46.00**	**4.03%**	**42.36**	**4.05%**

2.3 Professional/Staff groups.

Amongst the Medical and Dental staff groups the majority of medical staff with a headcount of 290 are to be found in the Women, Children's and Sexual Health Division, followed by the Medicine, Surgery and Private Patients with a headcount of 279.

Table 5: Medical and Dental Headcount by Divisions

Division	Headcount	%
Clinical Support Services	113	16.42%
Management Exec & Corporate Services	6	0.87%
Medicine,Surgery & Private Patients	279	40.55%
Womens, Childrens and Sexual Health	290	42.15%
Total	**688**	

Medical staff in training form the last largest number at the junior doctors pay grade accounting for a headcount of 320 representing 46.51% of all medical staff whilst consultants have a headcount of 260 making it the second largest medical staff group at nearly 38% .

Table 6: Medical and Dental Headcount by Divisions and years

	2013/14		2012/13		Headcount		WTE	
M&D	Headcount	WTE	Headcount	WTE	Difference	Difference %	Difference	Difference %
Assoc Spec	14	9.21	15	11.03	-1	-6.67%	-1.82	-16.48%
Clinical Assistant	5	1.06	6	1.18	-1	-16.67%	-0.12	-10.08%
Consultant	260	230.83	239	209.75	21	8.79%	21.08	10.05%
Jnr Doc	320	296.73	298	285.86	22	7.38%	10.87	3.80%
Specialty Doctor	30	21.11	28	19.98	2	7.14%	1.14	5.68%
Trust Grade	58	56.90	53	52.01	5	9.43%	4.89	9.40%
GMP	1	0.13	1	0.13	0	0.00%	0.00	0.00%
Total	**688**	**615.98**	**640**	**579.95**	**48**	**7.50%**	**36.04**	**6.21%**

All other non-medical staff groups are listed and presented in the Table 7 below, illustrating that Nursing and Midwifery registered form the largest staff group with a headcount of 1187, this is followed by medical and dental staff at 688. Additional Clinical Service staff category group includes what are generally referred to as Healthcare Assistants and other nursing and midwifery support, dental nurses, phlebotomists, services technicians, neonatal hearing screeners and other technical /support staff. Healthcare Assistants account for a headcount of 253 employees in the Trust and are paid at Band 2 and 3 levels. Healthcare Assistants also include Doulas and Maternity Assistants.

Table 7: Professional/Staff Groups Headcount

Staff Group	2013/14 Headcount	2013/14 WTE	2012/13 Headcount	2012/13 WTE	Headcount Difference	Headcount Difference %	WTE Difference	WTE Difference %
Add Prof Scientific and Technic	166	151.54	176	163.84	-10	-5.68%	-12.30	-7.51%
Additional Clinical Services	382	347.57	341	309.53	41	12.02%	38.04	12.29%
Administrative and Clerical	649	614.00	634	597.11	15	2.37%	16.88	2.83%
Allied Health Professionals	228	198.52	214	189.18	14	6.54%	9.34	4.94%
Healthcare Scientists	17	15.60	46	44.23	-29	-63.04%	-28.63	-64.73%
Medical and Dental	688	615.98	640	579.95	48	7.50%	36.04	6.21%
Nursing and Midwifery Registered	1187	1089.28	1141	1046.92	46	4.03%	42.36	4.05%
Total	**3317**	**3032.49**	**3192**	**2930.75**	**125**	**3.92%**	**101.73**	**3.47%**

Commentary

During 2013/14, there were a number of organisational developments which led to an overall increase in whole time equivalents from 2930.75 wte (2012/13) to 3032.49 wte (2013/14). The overall increase in consultant staff increased from 209.75 (2012/13) to 230.83 (2013/14) were due to increases in consultant posts in radiology, theatres, and across paediatrics subspecialties such as Accident & Emergency, dentistry, urology, orthopaedics, ophthalmology and neurology.) In addition there were four newly appointed consultants in Acute Paediatrics and two new NICU consultants appointed to provide residential cover.

Nursing and admin numbers were increased as a result of increasing service needs: – seven additional beds were opened Medicine and Surgery Division, four were in A&E as a result of winter pressures, and the remainder were in MDU which were linked to ambulatory care.

The Opening of Dean Street Express in the financial year led to the employment of 11 new staff, chiefly nurses at Bands 5 and 6 and 1 additional Consultant.

The transfer of approximately 90 posts from Management Executive to Clinical Support Division, accounts for the significant increase and decrease in the Headcount and WTE establishments of both Divisions detailed in Table 2: Divisional Headcount.

2.3 Workforce Composition by Protected Characteristics

2.3.1 Ethnicity

44.14% of staff identified as White British (excluding other white categories) whilst 50.05% of staff are identified as BME (including non-British white). The total from any White background comprise 59.93% of the workforce.

Table 8: Ethnicity Headcount

Ethnicity	%	Headcount
A White - British	44.14%	1464
B White - Irish	4.25%	141
C White - Any other White background	11.37%	377
CQ White ex-USSR	0.03%	1
CW White Other Ex-Yugoslav	0.03%	1
CY White Other European	0.12%	4
D Mixed - White & Black Caribbean	0.78%	26
E Mixed - White & Black African	0.45%	15
F Mixed - White & Asian	0.75%	25
G Mixed - Any other mixed background	1.54%	51
H Asian or Asian British - Indian	5.76%	191
J Asian or Asian British - Pakistani	0.69%	23
K Asian or Asian British - Bangladeshi	0.81%	27
L Asian or Asian British - Any other Asian background	5.61%	186
M Black or Black British - Caribbean	4.70%	156
N Black or Black British - African	7.05%	234
P Black or Black British - Any other Black background	0.96%	32
R Chinese	1.36%	45
S Any Other Ethnic Group	3.74%	124
SC Filipino	0.03%	1
Undefined	3.41%	113
Z Not Stated	2.41%	80

Table 9: Ethnic Groups by Headcount

Ethnicity	%	Headcount
White	59.93%	1988
BME	34.25%	1136
Not stated/defined	5.82%	193

Apart from the majority, *White – British* (1,464), the highest numbered Ethnic group is *White – Any other white Background (377)* followed by *Black or Black British – African (234).* The highest combined BME groups amount to over a third of the workforce at 35.2%,are *Black or Black British* at 18.81%, and *Asian or Asian British* at 12.87% with *Mixed – White/Caribbean/Black African/Asian* accounting for 3.52%

The national picture provided by the Health and Social Care Information centre (HSCIC) published in Oct 2013, shows that the ethnic composition of the NHS is as follows: *White* 79%, *Black or Black British* 5%, *Asian or Asian British* – 8%, *Mixed* -1%, other 1% and 6%

unknown. The Trust workforce in comparison presents a more ethnically diverse workforce than is the case nationally.

ONS details of the Royal Borough of Kensington and Chelsea population are presented in Table 10 below

Table 10: Population of Royal Borough of Kensington and Chelsea

Royal Borough of Kensington and Chelsea (2011)	
Ethnicity	%
White British	39.30%
White Other	30.70%
Mixed	5.70%
Asian	10.00%
Black	6.60%
Other Ethnic Groups	7.20%

When comparing the Trust's staff composition against the population of the Royal Borough of Kensington and Chelsea, then the Trust's *White British* employees at 44.14% is higher than the local *White British* population of RKBC at 39.3%. The Borough's *White British* population has decreased from 50% in 2001 to 39.30% in 2011. The Trust *Black or Black British* employees are also higher at 12.71% which is twice the representation of the boroughs where the *Black* ethnic group presents at 6.6%. Employees from *White – other* (including Irish) account for 15.8% of the workforce and considerably lower than Boroughs *White Other* population presenting at 28.9%. The census notes that the White other group has increased from 25% at the time of the last census to nearly 30% in 2011. It also notes that 28% of all Borough residents arrived in the UK between 2001 and 2011. It also notes that North American born residents account for 6% of the Borough population, and is one of the highest proportion of North American groups within England and Wales. ONS census 2011 also finds that the *Arab* population is at 7%, noting that Arab residents are classified as within "*Other Ethnic Group*". The Trust's ethnic monitoring data does not have an *Arab* category and the *Any other Ethnic Group* is small presenting at 3.74% of the workforce.

Amongst the Trust's professional groups, nationally there are significantly higher percentages of BME staff in medical positions across the NHS with HSCIC reporting that the medical and dental staff composition is as follows; *White* 55%, *Asian or Asian British* at 26% and *Black or Black British* 3%. The Trust Medical workforce records total *White* at 63.08%, BME at 32.85% whilst within *BME* group the total *Asian* groups account for 18.89% of the medical workforce.

At the Consultant level, HSCIC reports nationally that consultants account for 63% *White* and 27% *BME* groups whilst the Trust consultant body is relatively similar at 70% white and 27.31% *BME*.

In non-medical categories, *White* represents over 50% of the workforce across all professional staff groups, with the exceptions Healthcare Scientists and Additional Clinical Services.

Table 11: Ethnicity by Professional/Staff Groups

Administrative and Clerical	%	Headcount
White	57.16%	371
BME	35.75%	232
Not stated/defined	7.09%	46
Allied Health Professionals	**%**	**Headcount**
White	81.14%	185
BME	11.40%	26
Not stated/defined	7.46%	17
Healthcare Scientists	**%**	**Headcount**
White	47.06%	8
BME	47.06%	8
Not stated/defined	5.88%	1
Additional Clinical Services	**%**	**Headcount**
White	43.72%	167
BME	48.95%	187
Not stated/defined	7.33%	28

Medical and Dental	%	Headcount
White	63.08%	434
BME	32.85%	226
Not stated/defined	4.07%	28
Nursing and Midwifery Registered	**%**	**Headcount**
White	61.16%	726
BME	33.19%	394
Not stated/defined	5.64%	67

Across the Bandings, BME groupings are highest at Band 2 (51.91%), Band 3 (53.08%), Band 4 (33.08%), Band 5 (36.88%) and Band 6 (31.09%). Again, HSCIC nationally records that the percentages for the NHS are at 84% White and at 10% for Black and Asian groups across Bands 1-4. The corresponding figures at the Trust are 46% *BME*, and 47% *White (all backgrounds)*.

Table 12: Ethnicity by Bands

Grade	White %	BME %	Not stated/ defined %
Band 2	42.13%	51.91%	5.96%
Band 3	37.31%	53.08%	9.62%
Band 4	60.00%	33.08%	6.92%
Band 5	53.48%	36.88%	9.65%
Band 6	65.09%	31.09%	3.82%
Band 7	69.65%	26.83%	3.52%
Band 8A	85.14%	12.16%	2.70%
Band 8B	81.48%	16.67%	1.85%
Band 8C	84.62%	15.38%	0.00%
Band 8D	71.43%	28.57%	0.00%
Band 9	100.00%	0.00%	0.00%
Local non-AfC	85.71%	7.14%	7.14%
Assoc Spec	50.00%	35.71%	14.29%
Clinical Assistant	80.00%	20.00%	0.00%
Consultant	70.00%	27.31%	2.69%
GMP	100.00%	0.00%	0.00%
Jnr Doc	59.06%	36.25%	4.69%
Specialty Doctor	53.33%	40.00%	6.67%
Trust Grade	60.34%	36.21%	3.45%

HSCIC nationally reports that at Bands 8A-9 *White* groupings are at 86% and *Black and Asian* at 6%. Analysis of Trust figures excluding host organisations e.g. Regional Pharmacy, CLARHC etc., shows a similar trend with a total of 235 staff on band 8, of which 197 (83%) are white and 33 (14%) from a BME group and 5 are not stated. There is only one Band 9 in the Trust, but there a few others on Band 9, employed by Regional Pharmacy, CLARHC and Imperial Healthcare.

2.3.2 Gender

74.16% of the workforce is female which is similar to the national picture with HSCIC reporting that female staffs comprise 77% of the NHS workforce. In the Trust, the percentage of females is at a higher percentage than males across all non-medical bandings with the exception of Band 9, of which there is only one post within the organisation (excluding CLARHC, Regional Pharmacy). HSCIC reports that between Bands 1 – 7 inclusive, male staff comprise less than 20% of the NHS Workforce

At Chelsea and Westminster, males present at a higher percentage at the consultant level, with 59% male and 41% female. It should be noted that may alter in future years as the current cohort of junior doctors, comprises of 66% female and 34% male. Women are also more represented at other medical pay bands and account for 80% of clinical assistant, 67% of Speciality doctors and 52% of Trust doctors.

Table 13: Bands by Gender

Non medical	Female	Male	Female %	Male %
Local non-AfC	8	6	57%	43%
Band 2	165	70	70%	30%
Band 3	189	71	73%	27%
Band 4	200	60	77%	23%
Band 5	606	99	86%	14%
Band 6	448	102	81%	19%
Band 7	297	72	80%	20%
Band 8A	114	34	77%	23%
Band 8B	32	22	59%	41%
Band 8C	20	6	77%	23%
Band 8D	6	1	86%	14%
Band 9	0	1	0%	100%

Table 14: Medical Grades by Gender

Medical Grade	Female	Male
Associate Specialist	4	10
Clinical Assistant	4	1
Consultant	107	153
GMP	0	1
Jnr Doc	210	110
Specialty Doctor	20	10
Trust Grade	30	28
Total	**375**	**313**

2.3.4 Disability Status

The percentage of staff who indicated that they are disabled is 1.81%, whilst the percentages that have declared that they do not have a disability is 51.31%, and those not declaring a disability is 46.88%.

Table 15: Disability Headcount

Disability	%	Headcount
No	51.31%	1702
Not disclosed	46.88%	1544
Yes	1.81%	60

It should be noted that disabled data is captured at the point of entry into the workforce, and data is not subsequently captured routinely during the postholder's tenure. According, to "Disability in the United Kingdom, Papworth, 2010" the majority of disabled people (83%)

acquired their disability during their working lives. A number of research studies indicate that disabled employees are not always clear on why they should share information on disability, nor do they see the need to do so, if working without the need for adjustments. The vast majority of disabled people were worried about repercussions either now or in the future, so therefore do not see the need to disclose if their work was unaffected by their disability.

As the Trust's workforce comprises 58% staff under the age of 40, with the highest percentage of new joiners amongst the 20-24 age group, a total of 26.68% of all new joiners, then they are consequently less likely to have had illness leading to a disability, such as cancer, depression etc. at the point of entry into Trust employment. Once in post, staff are not required to update their status, nor provide any other monitored information, and may only be willing to provide such information if there is a practical reason such as an adjustment need. In fact, the percentage of all new starters for the period analysed, shows that 89.05% declared they did not have a disability, with 7.95% not making any declaration, leaving 3% of new joiners declaring a disability. Studies commissioned by the Equality & Human Rights Commission and Disability organisations show that disabled people are more likely to face discrimination in society, so this may be a contributing factor for not advising on disability status at entry into employment. Therefore our existing workforce has probably a much higher % level of disability which they may not necessary feel the need to disclose for monitoring purposes. Government figures suggest that disabled people make up 12.9% of the public sector workforce and 11% of the private sector *(Labour Force Survey, Quarter 2, 2012).*

The analysis reinforces our continued commitment to our status as a Two Ticks employer.

2.3.5 AGE

Table 16: Age Headcount

Age Band	%	Headcount
Under 20	0.18%	6
20-24	7.08%	235
25-29	19.20%	637
30-34	17.24%	572
35-39	15.41%	511
40-44	12.15%	403
45-49	10.85%	360
50-54	8.65%	287
55-59	5.16%	171
60-64	2.68%	89
65+	1.39%	46

The average age of Trust employees is 38 ¾ years. The age group which forms the highest percentage (19%) of workforce is in the age band 25-29 years. The lowest percentage (0.18%) of the workforce is staff under 20 (Headcount = 6) followed by the over 65 age

group at 1.39%. The low numbers of under 20s would indicate that most new appointees are at the graduate level/ or work experienced level, as opposed to entries at school leaver trainee/cadet level. It should be noted that the number of applications received from the over 50 age group forms 8% of all applications (22,422) received within 2013/14 period and 32 new starters over the age of 50 were appointed, against a total of 566 new appointees for the period 2013/14 .

The majority of the workforce (58.95%) are under the age of 40, with those in their twenties comprising approximately quarter of the workforce (26.28%). The national picture according to the Health and Social Care Information Centre (HSCIC) presents 53% of the NHS workforce as under the age of 44, and according to the Trusts monitoring, Chelsea and Westminster presents at 71% of the workforce under the age of 44. According to HSCIC, 47% of the NHS workforce is over the age of 45, whilst it presents at approximately 20% at Chelsea and Westminster. 43 is the average of women working the NHS, which is the same as for men. The predominately youthful character of the Trust's workforce with the average age at just over 38, will require consideration of different approaches to retain them Different ways of working and greater use of social media to deliver services and innovation should be encouraged, as the majority of the workforce are now accustomed to it from an early age, – mobile phones were launched in 1985, just under 30 years ago. Similarly policies will need to be reviewed to ensure the needs of a younger age profile are appropriately supported and represented. According NHS research, the benefit packages most highly valued by 40 year olds, are housing/mortgages, career progression, work-life balance and school funding, the development of a reward packages will need to be more reflective of these needs, which could lead to improved retention and decreased turnover.

The highest number of applications (26%) came from applicants aged 25-29 and this group has a high "success rate and is evidenced the number of joiners (total 215) during 2013/14.This perhaps reflects that the advantageous position of Chelsea and Westminster, as teaching hospital and thus an attractive employer for those seeking their first professional position within the Health sector.

The age profile of leavers indicates that the highest rate of 44% is amongst those in the 25 to 34 age group (comprising of 24.32%, between age 25-29 and 20% for those between 30-34). The Trust main reasons for turnover are promotion and relocation and the high concentration of leavers within the age span 25-34 is considered as partly due to staff wishing to further their career breadth at different Trusts but also staff starting families and relocating to affordable accommodation outside Chelsea and inner London.

Staff aged 55 years and over only account for 9% of the total workforce, there has been a slight decrease of 1 % (10% -2012/13) on the previous year. The repeal of the default retirement age of 65 in 2011 should permit more staff to remain in employment for longer, and consequently, that coupled with the changes to state pension age and NHS pensions (plus ageing populations) should result in a gradual increase in the overall numbers of staff in age groups over 55 in future years.

2.3.6 Religious Belief

Table 17: Religion by Headcount

Religion	%	Headcount
Jainism	0.06%	2
Judaism	0.15%	5
Sikhism	0.36%	12
Buddhism	0.54%	18
Hinduism	1.69%	56
Islam	2.89%	96
Other	3.68%	122
I do not wish to disclose	5.37%	178
Atheism	5.70%	189
Christianity	27.25%	904
Undefined	52.31%	1735

Only 42.32% of staff have disclosed their belief, and of these 27.25% have defined this as Christianity, which is the largest declared faith group. The majority of staff 52.31% are categorised as *undefined* in terms of a belief system. 5.37% have chosen not to disclose their belief and 5.70% have identified themselves as atheists. Other faith groups represent significantly below 5%. The national census 2011 for the Royal Borough of Kensington and Chelsea local population indicates 54.2% Christian, 20.6% no religion and 10.00 % Islam. 2.69% of staff in the Trust identify their belief system as Islam. The majority of respondents state that they do wish to advice or do not indicate their belief system religious or otherwise.

2.3.7 Sexual Orientation

Table 18: Sexual Orientation by Headcount

Sexual Orientation	%	Headcount
Bisexual	0.12%	4
Gay	1.90%	63
Heterosexual	41.94%	1391
I do not wish to disclose my sexual orientation	3.50%	116
Lesbian	0.24%	8
Undefined	52.31%	1735

The records for sexual orientation indicate that the majority of staff at 52.31% are undefined. Heterosexuals accounts for 41.94%. Combined estimation for people identifying as LGB (Lesbian, Gay or Bisexual) is 2.02%, which we believe is under-reported and is lower for the national estimation by Stonewall for population identifying as LGB (Lesbian, Gay or Bisexual) is between 5-7%.There is no population census record comparator as the national 2011 ONS census did not ask for sexual orientation status.

As members of Stonewall's Diversity Champions Programme, the Trust participated in last year's Workplace Equality Index, which provides a definitive guide to Britain's most gay-

friendly employers across all sectors. The results indicated that we had moved up 31 places in the rankings (291 out of 369 members). Staff and patient engagement were the key areas we excelled in this year. Stonewall were impressed with how we engaged with our LGBT patients and community, evidenced in particular through work within the HIV/GUM Directorate. Our staff engagement scores amongst LGBT staff were consistently well above average across all respondents, with staff recommending that the Trust was a supportive place to work for LGB staff.

The Trust ran a number of activities during LGBT month in February 2014 and the aim of this campaign was to promote the importance of health, wellbeing as well as inclusion amongst staff during Lesbian, Gay, Bisexual and Transgender (LGBT) History Month. Presentations were held to raise staff awareness of LGBT issues for staff and patients.

We have developed and/or promoted a number of equality and diversity resources available to staff and managers e.g. guidance on Access to Work, Stonewall reports, and Transgender information from Terence Higgins Trust and also facilitated a number of events to encourage staff are comfortable with respect to disclosure.

3. Joiners

3.1. Divisions

The majority of appointments in 2013/2014 at a headcount of 216 were to the Women, Childrens and Sexual Health Division representing 38% of new appointees.

Table 19: Joiners by Division

Division	Joiners	Joiners (12/13)	Difference
Clinical Support Services	156	124	32
Management Exec & Corporate Services	60	61	-1
Medicine,Surgery & Private Patients	133	121	12
Womens, Childrens and Sexual Health	216	186	30
Total	**565**	**492**	**73**

3.2. Pay Bands/ Grades

During 2013/14 total headcount of 565 staff (excluding rotational training doctors and honorary staff) joined the Trust. The hospital appointed nearly 200 Band 5s (the majority were registered nurses and midwives) accounting for 35.22% of all appointments New joiners to other bands across the bandings were in general well below 15% with Band 2 representing 14.16% of all appointments.

Table 20: Joiners by Pay Band 1

Grade	Joiners	% of all Joiners
Band 2	80	14.16%
Band 3	57	10.09%
Band 4	26	4.60%
Band 5	199	35.22%
Band 6	55	9.73%
Band 7	31	5.49%
Band 8A	19	3.36%
Band 8B	7	1.24%
Band 8C	2	0.35%
Local Non-AfC	5	0.88%
Consultant	39	6.90%
Specialty Doctor	3	0.53%
Trust Grade	42	7.43%
Grand Total	**565**	

Table 21: Joiners by Pay Band 2

Grade	Joiners	Joiners (12/13)	Difference
Band 2	80	79	1
Band 3	57	42	15
Band 4	26	24	2
Band 5	199	139	60
Band 6	55	54	1
Band 7	31	42	-11
Band 8A	19	11	8
Band 8B	7	2	5
Band 8C	2	2	0
Band 9	0	1	-1
Local Non-AfC	5	2	3
Assoc Spec	0	1	-1
Consultant	39	27	12
Specialty Doctor	3	4	-1
Trust Grade	42	62	-20
Total	**565**	**492**	**73**

3.3. Professional/Staff groups.

Amongst the staff groups, nursing and midwifery registered constituted 40.53% of all new joiners, followed by Additional Clinical service at 18.76%. Additional Clinical staff group includes Healthcare Assistants, and other nursing and midwifery support staff generally at the Band 2 or 3 levels.

Table 22: Joiners by Professional/Staff Groups 1

Staff Group	Joiners	%
Add Prof Scientific and Technic	18	3.19%
Additional Clinical Services	106	18.76%
Administrative and Clerical	83	14.69%
Allied Health Professionals	41	7.26%
Healthcare Scientists	4	0.71%
Medical and Dental	84	14.87%
Nursing and Midwifery Registered	229	40.53%

Table 23: Joiners by Professional/Staff Groups 2

Staff Group	Joiners	Joiners (12/13)	Difference
Add Prof Scientific and Technic	18	35	-17
Additional Clinical Services	106	87	19
Administrative and Clerical	83	66	17
Allied Health Professionals	41	30	11
Healthcare Scientists	4	3	1
Medical and Dental	84	94	-10
Nursing and Midwifery Registered	229	177	52
Total	**565**	**492**	**73**

The majority of appointments in 2013/2014 at a headcount of 229 were to the Nursing and Midwifery registered group, an increase of a headcount of 52 from the previous year.

3.4 Joiners by Protected Characteristics

The ethnicity profile for new starters in 2014 is very similar to the record for the previous year, with generally an increase in application across the staff groups from the various ethnic groups, with the overall total number of applications increasing from 20,829 (2012/13) to 22,424 (2013/14).

The profile of ethnicity status for new starters in 2014 is very similar to the record for previous years.

Table 24: Joiners Ethnicity

Joiners Ethnicity	%	Headcount
White	55.65%	315
BME	31.80%	180
Undefined	12.54%	71

Joiners - Ethnicity	2013-14	2012-13
White	55.65%	67%
BME	31.80%	27%
Undefined	12.54%	5%

70% of new starters record that there are heterosexual, with 20% registering as “undefined” and approx. 6% stating they do not wish to disclose their sexual orientation.

Approximately 81% of new starters were under the age of 40, with age band 20-24 being the highest cohort at 26.68%. From age 55 upwards the number of appointees falls significantly with a total of 11 people appointed out of total of 566 appointments made in the period.

The percentage of new staff declaring that they do not have a disability amounts to almost 90% with almost 8 % choosing not to declare. 3% of new starters do declare a disability.

4. Leavers

4.1 Divisions

During 2013/14 the total number of leavers from the Trust was a headcount of 555 with Womens, Childrens and Sexual Health Division accounting for 40.27% of leavers.

Table 25: Leavers by Divisions 1

Division	Leavers	% of Leavers
Clinical Support Services	149	26.85%
Management Exec & Corporate Services	58	10.45%
Medicine, Surgery & Private Patients	122	21.98%
Womens, Childrens and Sexual Health	226	40.72%
Total	**555**	

Table 26 Leavers by Divisions 2

Division	Leavers	Leavers (12/13)	Difference
Clinical Support Services	149	136	13
Management Exec & Corporate Services	58	66	-8
Medicine,Surgery & Private Patients	122	127	-5
Womens, Childrens and Sexual Health	226	220	6
Total	**555**	**549**	**6**

4.2. Pay Bands / Grades

Leavers on pay Band 5 constituted the majority of the pay band group at 30.63% as presented in the table below:

Table 27: Leavers by Pay Bands 1

Grade	Leavers	% of all Leavers
Band 2	62	11.17%
Band 3	38	6.85%
Band 4	33	5.95%
Band 5	170	30.63%
Band 6	95	17.12%
Band 7	49	8.83%
Band 8A	20	3.60%
Band 8B	10	1.80%
Band 8C	4	0.72%
Band 8D	2	0.36%
Local Non-AfC	3	0.54%
Associate Specialist	1	0.18%
Clinical Assistant	3	0.54%
Consultant	23	4.14%
Specialty Doctor	3	0.54%
Trust Grade	39	7.03%
Grand Total	**555**	

Table 28: Leavers by Pay Bands 2

Grade	Leavers	Leavers (12/13)	Difference
Band 2	62	60	2
Band 3	38	43	-5
Band 4	33	34	-1
Band 5	170	145	25
Band 6	95	95	0
Band 7	49	50	-1
Band 8A	20	16	4
Band 8B	10	4	6
Band 8C	4	6	-2
Band 8D	2	1	1
Band 9	0	1	-1
Local Non-AfC	3	3	0
Assoc Spec	1	0	1
Clinical Assistant	3	0	-3
Consultant	23	19	4
Specialty Doctor	3	4	-1
Trust Grade	39	68	-29
Total	**555**	**549**	**6**

4.3. Professional/Staff Groups

The majority of leavers were in the nursing and midwifery staff group accounting for almost 40% of all leavers.

Table 29: Leavers by professional Groups 1

Staff Group	Leavers	% of Leavers
Add Prof Scientific and Technical	34	6.13%
Additional Clinical Services	85	15.32%
Administrative and Clerical	105	18.92%
Allied Health Professionals	39	7.03%
Healthcare Scientists	2	0.36%
Medical and Dental	69	12.43%
Nursing and Midwifery Registrered	221	39.82%
Total	**555**	

Table 30: Leavers by Professional Groups 2

Staff Group	Leavers	Leavers (12/13)	Difference
Add Prof Scientific and Technic	34	28	6
Additional Clinical Services	85	81	4
Administrative and Clerical	105	96	9
Allied Health Professionals	39	39	0
Healthcare Scientists	2	7	-5
Medical and Dental	69	91	-22
Nursing and Midwifery Registered	221	207	14
Total	**555**	**549**	**6**

Reasons for leaving are broadly attributed to natural turnover with Voluntary Resignation – other, promotion and relocation.

Table 31: Leavers and Reasons for Leaving

Reason for Leaving	%	Headcount
Voluntary Resignation	78.92%	438
End of Fixed Term Contract	10.81%	60
Retirement*	7.03%	39
Dismissal	2.52%	14
Employee Transfer	0.72%	4
Total		**555**

(*Includes of one death in service following ill health retirement)

4.2 Leavers by Protected Characteristics

The total number of leavers was 555 for 2012/13, with Voluntary Resignation accounting as the main reason for leaving at 79%.

The highest group of leavers were from the age range 20-40, representing 70% of the total leavers with the highest percentage at 24.32% coming from the 25-29 age group. More staff aged between 20-29 joined the Trust than any other age group. Analysis of the leavers Pay band percentages, shows that highest rates are in Band 5 (30.63%) and Band 6 (17.12%). In contrast the number of new starters for these combined age bands amounted to 79%.

Table 32: Age Bands and Headcounts

Age band	%	Headcount	
Under 20	0.90%	5	
20-24	12.43%	69	
25-29	24.32%	135	
30-34	20.00%	111	
35-39	13.51%	75	
40-44	8.83%	49	
45-49	5.23%	29	
50-54	5.77%	32	
55-59	4.32%	24	
60-64	3.06%	17	
65-69	1.26%	7	
70+	0.36%	2	
Total		555	

Further analysis of 104 exit questionnaires received over 2013/14 financial year showed that 'Promotion/Career Development' was the most common reason for leaving, with 79% of employees rating their experience of working at the Trust as either Good or Excellent and 80% stating that given the right opportunity would return to the Trust. More in-depth analysis continues to be conducted for Band 2 Healthcare Assistants and Band 5 Nurses whose turnover rates remain the areas of most concern. Human Resources working with senior Nurses recently carried out a series of listening events to understand these staff experience and identify ways in which we can improve retention. These events will continue throughout 2014 and help inform the retention strand of the People & OD strategy currently in development. An action plan on HCA recruitment is being worked on jointly by Nursing and HR colleagues

The majority of leavers indicate that their resignation is voluntary due to a variety of reasons including relocation, promotion but essentially the majority (35.50 %) do not provide a specific reason.

It should be noted that 30 staff retired on age grounds, with a further 9 staff retiring for other reasons. The total number of staff in the age range 55-64 is 260, and year on year analysis does not indicate an increase in numbers, despite the amendments to the Employment

Equality (Repeal of Retirement Age Provisions) Regulations (2011) to encourage staff remain in employment past 60.

Further analysis of leavers and joiners by sexual orientation, religion and disability cannot be gleaned due to the significant proportion of staff having not disclosed their protected characteristic.

5. Recruitment Analysis

The total number of applications received via NHS jobs for 2013/14 was 22,424, of these 5596 were shortlisted and 731 appointments were made.

In March 2014, the Trust staff in post position stood at 3038.25 wte (whole time equivalents) with the substantively employed workforce increasing by 89.23 WTE (3.02%) since March 2013. The greatest increase was seen in the Medicine & Surgery Division (31.03 WTE)

Recruitment analysis by protected characteristic has not changed significantly in the last few years. The highest number of applications in 2012/13 (4774) and 2013/14 (5493) continue to be received from the *Black or Black British – African* ethnic group. The group represents a quarter (25%) of all shortlisted applicants and comprise 10% of all appointments. *White – British* accounts for 18.33% of all applications and 44.87% of all appointments.

Table 33: Recruitment Analysis and Ethnicity

Ethnic origin	Applications	Shortlisted	Appointed
WHITE - British	4111	1342	328
WHITE - Irish	428	136	29
WHITE - Any other white background	3117	653	98
ASIAN or ASIAN BRITISH - Indian	2233	387	32
ASIAN or ASIAN BRITISH - Pakistani	765	123	6
ASIAN or ASIAN BRITISH - Bangladeshi	703	124	16
ASIAN or ASIAN BRITISH - Any other Asian background	1522	357	51
MIXED - White & Black Caribbean	209	61	10
MIXED - White & Black African	187	43	1
MIXED - White & Asian	116	34	6
MIXED - any other mixed background	266	71	15
BLACK or BLACK BRITISH - Caribbean	1214	353	30
BLACK or BLACK BRITISH - African	5493	1400	69
BLACK or BLACK BRITISH - Any other black background	348	99	4
OTHER ETHNIC GROUP - Chinese	190	49	6
OTHER ETHNIC GROUP - Any other ethnic group	1047	265	20
Undisclosed	475	99	10
Total	22424	5596	731

Across the professional staff groups, *Black or Black British African* comprises 12.83% of employees in Additional Clinical Services areas and 9.77% amongst the registered nursing and midwifery groups. Amongst other staff groups the percentages are less than 5%.

The data seems to suggest that the type of role a candidate applies for is attributed to different career choice for different ethnic groups and other factors such as education and training which affects choices. It is worth noting that the 'success rate' of applicants by ethnicity has varied over the last few years, which suggests that applicants are fairly appointed against the person specification of each post and not due to their ethnic background. We still continue to employ a diverse workforce which is positive, but it is difficult to draw conclusions from this analysis without looking at recruitment activity across London to gauge whether the minor changes are statistically significant.

A total of five applications were from individuals under 18, which would suggest that advertised posts are generally not aimed at a school leaver level. The majority of applications and appointments (29.49%) are made to the age group 25–29, and a significant percentage of appointments are also made to age groups 20-24 (20.44%) and age group 30-34 (18.52%).

24% of applicants under 40 + age range were shortlisted and 28% of applicants over 40 were shortlisted probably due to experience .There were very few applications received from the age range 60+ and there were two appointments made from this age range.

Applicants identifying as Atheist, Christian or Islam had the most likelihood of being shortlisted and appointed.

6.41% of applicants declared a disability impairment, and they accounted for 4.81% of appointees. Given that equality fields other than disability are not known by those shortlisting, there is no evidence of any form of discriminatory conduct with regard to recruitment in any of the protected groups but there is positive evidence in the area of meeting disability equality duty.

6. Turnover

6.1. Divisions

Voluntary turnover increased on last year to 14.70%, which is significantly above the target of 13.50%. This turnover is above a previous 3 year average of 14.42%. The rate was highest in the Womens, Childrens and Sexual Health Division at 16.69%.

Table 34: Turnover by Division

Division	Turnover	Turnover (12/13)	Difference
Clinical Support Services	14.13%	14.01%	0.12%
Management Exec & Corporate Serv	13.07%	9.02%	4.05%
Medicine,Surgery & Private Patients	16.14%	14.91%	1.23%
Womens, Childrens and Sexual Healt	16.96%	14.13%	2.83%
Trust	**14.70%**	**13.59%**	**1.11%**

6.2 Pay Bands / Grades

Turnover rates is highest amongst the Additional Clinical Services (healthcare assistant) staff group at 18.40% and for Band 2 (excluding local non – Afc which comprise a total of 14 staff) at 26.87%, closely followed by those staff at Band 8D at 26.67% as illustrated in the tables below, although it should be noted that numbers in Band 8D pay levels are a headcount total of 7 staff.

Table 35: Turnover by Pay Bands

Grade	Turnover
Band 2	26.87%
Band 3	10.60%
Band 4	9.09%
Band 5	24.16%
Band 6	14.50%
Band 7	10.34%
Band 8A	13.75%
Band 8B	13.59%
Band 8C	13.11%
Band 8D	26.67%
Band 9	0.00%
Local non-AfC	31.58%
Medical	11.36%

6.3 Professional /Staff Group

Table 36: Turnover by Professional/Staff Groups

Staff Group	Turnover	Turnover (12/13)	Difference
Add Prof Scientific and Technic	15.08%	16.23%	-1.14%
Additional Clinical Services	18.40%	16.63%	1.76%
Administrative and Clerical	11.50%	8.92%	2.58%
Allied Health Professionals	15.32%	15.51%	-0.19%
Healthcare Scientists	10.52%	12.45%	-1.93%
Medical and Dental	11.18%	13.36%	-2.18%
Nursing and Midwifery Registered	16.16%	13.87%	2.29%
Trust	**14.70%**	**13.59%**	**1.11%**

7. Vacancy

7.1. Divisions

Womens, Childrens and Sexual Health Division had the highest rate of vacancies at 12.39% while the tables below show that rates across the Divisions were highest for additional clinical staff group at 18.37% and for pay band 2 at 26.55%. In many cases, however, there has been a deliberate strategy not to recruit to vacancies in order to hold budgets for Cost Improvement Programme (CIP) purposes, where that is safe to do so.

Table 37: Vacancy by Divisions

Division	Vacancy rate	Vacancy rate (12/13)	Difference
Clinical Support	6.20%	6.84%	0.64%
Mgt Exec	7.50%	8.40%	0.90%
Medicine & Surgery	10.24%	7.80%	-2.44%
Womens, Childrens and Sexual Health	12.39%	7.83%	-4.56%
Trust	**9.64%**	**7.64%**	**-2.00%**

Average vacancy rates slightly increased in 2013/14 from 8.34 %(2012/13) to 8.74%, but still below a three average of (9.87%) and just above the Trust target of 8%. Increases are registered across the Divisions with the highest annual increase in Womens, Childrens and Sexual Health from 7.64% (2012/13) to 12.39% (2013/14).

7.2. Pay Bands /Grades

Table 38: Vacancies by Pay Bands 1

AfC Grade	Vacancy rate	Vacancy rate (12/13)	Difference
Band 2	26.55%	19.15%	7.40%
Band 3	17.42%	14.28%	3.13%
Band 4	11.77%	10.13%	1.64%
Band 5	9.10%	14.57%	-5.48%
Band 6	16.43%	10.75%	5.68%
Band 7	2.84%	1.38%	1.46%
Band 8A	1.36%	-4.17%	5.54%
Band 8B	8.13%	2.22%	5.90%
Band 8C	5.19%	-6.32%	11.52%
Band 8D	12.51%	-22.00%	34.51%
Band 9	0.00%	27.00%	-27.00%

7.3. Professional /Staff Groups

Table 39: Vacancies by Professiona/Staff Groups 2.

Staff Group	Vacancy rate	Vacancy rate (12/13)	Difference
Add Prof Scientific and Technic	5.54%	-1.38%	-6.92%
Additional Clinical Services	18.37%	12.66%	-5.71%
Administrative and Clerical	13.27%	9.86%	-3.41%
Allied Health Professionals	-2.24%	-0.65%	1.59%
Healthcare Scientists	17.15%	1.68%	-15.47%
Medical and Dental	-3.08%	-2.58%	0.50%
Nursing and Midwifery	12.90%	12.46%	-0.44%

Nursing and Midwifery vacancies increased over the previous year (12.46% for 2012/13) ending the year at 12.90%. The Trust continues to monitor “active “vacancies, which are posts that the organisation is actively trying to fill. Two working shortlife groups have been set up to develop retention strategies for Nursing and Midwifery Bands 5-8a.and also for Healthcare Assistants at the Band 2 and 3 levels.

8. Sickness

8.1 Divisions

The division with the highest sickness rate for 2013/14 is Clinical Support Services at 4.10%. All Divisions with the exception of Clinical Support registered a decrease on the same period last year. YTD sickness absence was below the target for the year which following a review was reduced to 3.5%. The QIPP project which begun in 2012, continued through 2013/4, supporting this reduction. HR is currently reviewing the issue of non-reporting and will be implementing changes to improve compliance.

Table 40: Sickness by Division

Division	Sickness %	Sickness % (12/13)	Difference
Clinical Support	4.10%	3.12%	0.98%
Mgt Exec	2.40%	3.75%	-1.35%
Medicine & Surgery	2.98%	3.63%	-0.65%
Womens, Childrens and Sexual Health	3.48%	4.18%	-0.70%
Trust	**3.44%**	**3.73%**	**-0.29%**

The Trust average sickness rates for the year decreased to 3.44% which is just below the Trust target for 2013/14 of 3.5% and is also below a four year average of 3.72 %. Health and Social Care Information Centre reports that the sickness rate is 2.92% for 2013/14. The continued downward trend demonstrates the continued success of a number of sickness

absence management initiatives which were launched in 2012/13, including the requirement that managers complete a 'Return to Work' interview after each absence. The returns from these are gathered centrally, allowing HR to monitor the process more effectively.

8.2. Pay Bands/Grades

Analysis by grade suggests that staff in Bands 2-6 have a significantly higher absence rate than the Trust average of 3.44%, with staff in Bands 2 having the highest rate at 6.67%, chiefly consisting of long term absence periods.

Table 41: Sickness by Pay Bands

Grade	Sickness	2012/13	Difference
Band 2	6.67%	6.90%	-0.23%
Band 3	5.71%	6.03%	-0.32%
Band 4	5.79%	6.05%	-0.25%
Band 5	4.86%	4.91%	-0.05%
Band 6	3.90%	3.78%	0.12%
Band 7	3.40%	3.10%	0.31%
Band 8A	2.52%	1.87%	0.65%
Band 8B	2.77%	2.02%	0.76%
Band 8C	0.68%	0.74%	-0.06%
Band 8D	0.07%	0.85%	-0.78%
Band 9	0.00%	0.00%	0.00%
Medical	0.38%	0.61%	-0.24%
Non AfC	0.38%	0.78%	-0.40%
Trust	**3.44%**	**3.73%**	**-0.29%**

8.3 Professional/Staff Groups

The sickness absence rate for all medical staff is at 0.37%, which is significantly low for a complement of staff (Headcount of 688) that is higher than for all *Administrative and Clerical staff* (Headcount of 649) where the majority of bands are reporting absences above 0.50% demonstrating that reporting absence for Medical staff remains an issue within the Trust.

Table 42: Sickness by Professional/Staff Group

Staff Group	Sickness	2012/13	Difference
Add Prof Scientific and Technic	4.78%	3.54%	1.24%
Additional Clinical Services	5.93%	6.10%	-0.18%
Administrative and Clerical	4.71%	4.78%	-0.07%
Allied Health Professionals	2.69%	2.17%	0.52%
Healthcare Scientists	2.26%	2.31%	-0.05%
Medical and Dental	0.37%	0.61%	-0.24%
Nursing and Midwifery	4.35%	4.56%	-0.21%
Trust	**3.44%**	**3.73%**	**-0.29%**

9. Length of Service

The average length of service for staff is 5.81 years which is lower than last year's average of 6.31 years, indicating an increase in staff turnover in year. However, excluding Junior doctors (average is 0.87 years) the average length of service increases to 6.31 years.

Staff aged between 55-59 have the longest average length of service at 12.02 years, with the length of service averages similar for both females and males (5.91 and 5.49 respectively) . *Black or Black British* ethnic groups have the longest years of service at 11.54 years.

Table 43: Length of service by ethnicity

Ethnic Code	Avg LoS
A White - British	6.14
B White - Irish	6.59
C White - Any other White background	5.28
CQ White ex-USSR	1.57
CW White Other Ex-Yugoslav	2.66
CY White Other European	0.63
D Mixed - White & Black Caribbean	5.81
E Mixed - White & Black African	6.03
F Mixed - White & Asian	5.15
G Mixed - Any other mixed background	4.40
H Asian or Asian British - Indian	4.07
J Asian or Asian British - Pakistani	3.98
K Asian or Asian British - Bangladeshi	1.69
L Asian or Asian British - Any other Asian background	6.13
M Black or Black British - Caribbean	9.24
N Black or Black British - African	5.72
P Black or Black British - Any other Black background	11.54
R Chinese	4.78
S Any Other Ethnic Group	6.02
SC Filipino	0.40
Undefined	0.81
Z Not Stated	5.99

Administrative and Clerical staff groups have the longest service period averaging at 7.84 years, followed closely by Healthcare Scientists at 7.07 years. Medical and dental have the shortest period (4.08 years) demonstrating the impact of fixed term short training junior doctors contracts (average LOS is 0.87 years) and junior doctors form a significant cohort (320 wte) of the medical and dental staffing establishment.

Amongst the Divisional staff Medicine, Surgery and Private Patients have the shortest average length of service at 5.26 years followed by a narrow margin by Women, Children's and Sexual Health Division at 5.72 years. The Division with the longest average service is Management Exec & Corporate Services Division at 6.53 years.

10. Professional Registration – delivering a safe workforce

2216 Trust staff are required to hold registration with a professional body eg. GMC (General Medical Council), NMC(Nursing Midwifery Council). The Trust monitors these registrations on a regular basis and engages with staff and managers to ensure that up to date registration is maintained in line with the Trust procedure for Checking Professional Registration. During 2013/14 there was a total of 25 lapses in registration and these were managed in accordance with the Procedure for Checking Professional Registrations.

During 2013/14, the procedure was reviewed to prevent those professional clinical staff who allow their registration to lapse from assuming any duties but be placed on unpaid leave to permit them the opportunity to register, and prevent them undertaking any duties whilst being unregistered. Line managers will advise employees who have lapsed their registration that they will be placed on unpaid leave for the period of non registration to enable them to arrange registration, and advise HR and Payroll accordingly.

11. Pay

The Trust average salary is £30,975 per annum (£30,839 excluding junior doctors) and if one excludes the few annual salary outliers in terms of a high payments then the median Trust salary is £27,901 which equates to the top of a Band 5 grade. The mean average salary for the country is lower at £26,500 (confirmed by the Office for National Statistics for year ending April 2012). A breakdown of the median basic salary of employees highlights that White Staff earn the highest average salary over BME staff. Although there are few men in the Trust they earn the highest average salary compared to women. Staff aged between 40-54 continue to maintain the highest average salary; in contrast staff aged below 20 earn the lowest. It is worth noting that junior doctors were included in this analysis.

12. Flexible Working

From the analysis of staff working flexibly 686 or 20.68% of staff reported working flexibly, it appears that part-time working is the most popular flexible working arrangement. Allied Health Professional staff (35%) and Nursing and Midwifery (21.99%) have the most flexible working arrangements in place. Staff in the age range 35-60 have more flexible work arrangements generally over 25% across all age groups, whilst staff in the age range 20 to 34 are most likely to be working full time. Females tend to more arrangements in place, possibly reflecting caring responsibilities outside the workplace.

No further conclusions can be drawn from other protected characteristic details such as religion or sexual orientation.

13. Promotion

There was a total of 170 promotions in the Trust, of which 25% BME staff were promoted. BME staff total 35% of the workforce. The majority of promotions were evidenced in the age range 30-40, collectively totalling 118 promotions. Gender analysis shows little statistical significance and is mainly proportionate to the current numbers in the with 26% of men achieving promotions, and 73% women.

Table 44: Promotion by Ethnicity

Ethnicity	Headcount	%	% of workforce
White	123	72.35%	59.93%
BME	40	23.53%	34.25%
Undisclosed	7	4.12%	5.82%
Total	**170**	**100%**	**100%**

The majority of promotions, illustrated in the table below took place onto the Band 6 grade, which is largely comprised of nursing posts.

Table 45: Promotion by Ethnicity

Promoted to	White	BME	n/a
Band 3	6	5	4
Band 4	9	2	1
Band 5	15	9	
Band 6	51	8	1
Band 7	21	9	
Band 8A	11	3	
Band 8B	2	1	
Band 8C	3	2	
Band 8D	2	1	
Consultant	1		1
Trust Grade	2		
Total	**123**	**40**	**7**

Disabled staff achieved 5.29% of promotions, which is slightly higher than their reported rates in the workforce at 2%. The percentage of those promoted and not disclosing a disability is at 31.76%.

No conclusions may be drawn from religious belief figures, with the numbers of those achieving promotion and not disclosing their beliefs (23) almost equating to those declaring Christianity (22).

14. Learning and Development

14.1 Appraisal

The Trust appraisal completion rate as measured by the NHS Staff Survey in 2013/14 was 84% against the annual target of 90%, this is a small increase of 2% from 82% in 2012/1.

Analysis of data by protected characteristics indicates that appraisal completion rates were slightly higher for men at 85% (whilst women were at 84%), older employees in the age range 30+ . In contrast, staff from *Nursing & Midwifery* (81%) and *Additional Clinical Services* (76%), and staff from Black ethnic groups (ranging from 76% to 84%) had slightly lower appraisal completion rates. This could be explained by the fact that there are proportionately more BME staff in lower bands or in clinical roles compared to White staff. Further investigation is needed to understand the reasons for the lower appraisal rate in order for recommendations to be made.

Appraisals for medical staff was at 89%, which is near the Trust target of 90%, this is a improvement to completion of the previous year, which is staff group which has improved its completion rate. This is probably due to the introduction of a new IT system in 2013/14 for capturing of medical staff appraisals.

During April, 2014 a new Trust Appraisal system was introduced to link with the implementation of annually earned increments reflecting changes to Agenda for Change terms and conditions introduced last year. Incremental progression is now conditional on not only demonstrating satisfactory performance in year, but also evidence of demonstrating the Trust values and behaviours of which respect is a key one.

14.2 Mandatory Training

Mandatory training figures for 2013/14 was at 70% which is 10% increase in compliance compared to last year, but is still 6% below the 85% target set for the year . Health and Safety training stands at 74% (compliance rate of staff trained within the two year refresher period across all staff groups)

Black ethnic categories have a lower attendance for mandatory and non mandatory training and further analysis will be undertaken to understand the reason for this.

Table 46: Mandatory Training by Ethncity

Ethnicity	Courses	%
White	12216	59.63%
BME	6958	33.96%
Undefined	1314	6.41%

86% of staff who accessed professional Development training came from a white background.

In addition, the Staff Survey Results (2013) Key finding 26 for "Percentage of staff having equality and diversity training shows that in the last 12 months a decrease from 49% (2012) to 47%(2013) in receipt of training. Consequently, the Learning Resource Centre are reviewing provision, along with the mandatory requirement for all staff to receive Equality and Diversity Training every 4 years. Equality and Diversity Hotspots have been identified and new arrangements for targeting these areas/department/ staff groups will be developed during the summer months of 2014.

15. Bank and Agency

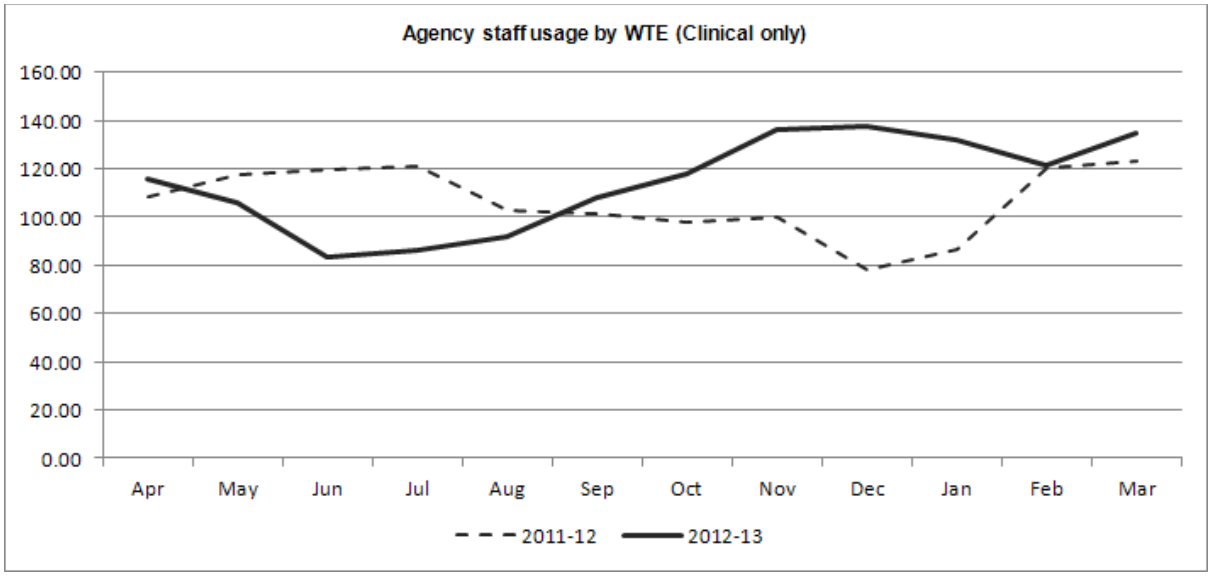
15.1 Bank and Agency Usage

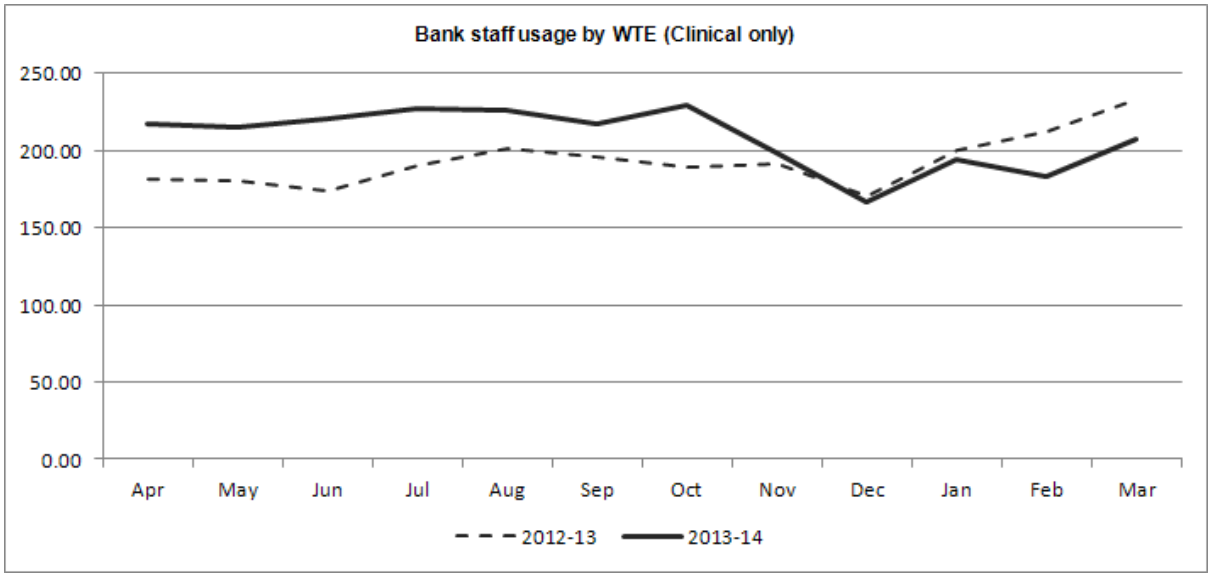
Table 47:Bank and Agency Usage by WTE

Year	Agency WTE
2011-12	1275.28
2012-13	1369.38
2013-14	1361.02

Year	Bank WTE
2011-12	2071.03
2012-13	2318.95
2013-14	2501.78

2013/14 has seen a continued increase in the usage of Bank and Agency staff, however usage this has been a decrease in the later months of the financial year following the institution of a Bank and Agency Nursing focus group which on monthly basis regularly monitors usage throughout the Divisions.





The highest usage of bank and agency staff remains with Nursing and Midwifery staff and in general the Bank and Agency usage is lower that the Trust vacancy rate.

15.1 Bank and Agency by Protected Characteristics

The majority of bank and agency staff were female at 69% and male at 31%, the age profile of the Bank staff are illustrated in the table below. Agency staff personal information is retained by their employer.

Table 48: Bank and Agency Usage by Ethnicity and age bands

Age group

Age Band	Bank	Substantive
Under 20	1.00%	0.18%
20-24	12.00%	7.08%
25-29	22.00%	19.20%
30-34	19.00%	17.24%
35-39	17.00%	15.41%
40-44	9.00%	12.15%
45-49	8.00%	10.85%
50-54	5.00%	8.65%
55-59	3.00%	5.16%
60-64	2.00%	2.68%
65+	3.00%	1.39%

Bank Staff Ethnicity

White – 33% (whilst Trust staff figures are at approx. 60%)
BME – 26% (Trust staff figures are at approx. 34%)
Undefined – 41% (Trust staff figures are at 6%)

16. Employee Relations and Protected Characteristics

The total number of formally completed employee relations cases in 2013/2014 was 71. 46 (63.38%) cases were the result of disciplinary action, 19 (26.76%) due to capability/ poor performance and 7 (9.86%) related to bullying and harassment, essentially grievances .

The chart and tables below indicates the percentages for ethnic groups involved in Employee Relations procedures set against the Trust staff profile for the same groups.

Table 49: Employee Relations by Ethnicity

Employee Relations - Ethnicity	% of ER cases	Trust profile
White	30%	60%
BME	65%	34%
Not Stated	6%	6%

Table 50:Employee Relations cases by Banding and Ethnicity

Grade	B&H	Capability	Disciplinary	% of Total Cases	Trust Profile
Band 2	14.29%	42.11%	22.22%	26.76%	7.08%
Band 3	0.00%	21.05%	15.56%	15.49%	7.84%
Band 4	28.57%	10.53%	8.89%	11.27%	7.84%
Band 5	28.57%	15.79%	20.00%	19.72%	21.25%
Band 6	14.29%	5.26%	8.89%	8.45%	16.58%
Band 7	0.00%	0.00%	13.33%	8.45%	11.12%
Band 8C	0.00%	5.26%	0.00%	1.41%	0.78%
Consultant	0.00%	0.00%	6.67%	4.23%	7.84%
Specialty Doctor	14.29%	0.00%	4.44%	4.23%	0.90%

Ethnic Code	B&H	Capability	Disciplinary	% of Total Cases	Trust Profile
A White - British	28.57%	10.53%	24.44%	21.13%	44.14%
B White - Irish	0.00%	10.53%	2.22%	4.23%	4.25%
C White - Any other White background	0.00%	0.00%	6.67%	4.23%	11.37%
D Mixed - White & Black Caribbean	14.29%	5.26%	0.00%	2.82%	0.78%
E Mixed - White & Black African	0.00%	0.00%	2.22%	1.41%	0.45%
G Mixed - Any other mixed background	0.00%	5.26%	0.00%	1.41%	1.54%
H Asian or Asian British - Indian	14.29%	10.53%	4.44%	7.04%	5.76%
M Black or Black British - Caribbean	0.00%	0.00%	13.33%	8.45%	4.70%
N Black or Black British - African	28.57%	26.32%	22.22%	23.94%	7.05%
P Black or Black British - Any other Black background	0.00%	0.00%	2.22%	1.41%	0.96%
S Any Other Ethnic Group	14.29%	15.79%	6.67%	9.86%	3.74%
Z Not Stated	0.00%	5.26%	6.67%		
L Asian or Asian British - Any other Asian background	0.00%	10.53%	6.67%	7.04%	5.61%
J Asian or Asian British - Pakistani	0.00%	0.00%	2.22%	1.41%	0.69%

16.1 Bullying and Harassment

Of the total number of formal cases, 6 involved women and 1 man. This is similar to the position of the 2012/13 period during which there were 8 cases (again 6 women and 2 men). No further considerations can be drawn from this other than women raised more bullying and harassment concerns compared to men over a two year period however proportionately correlates with the gender ratio employed 75:25.

The majority of the Bullying and Harassment cases occurred in the age groups 25-29 (28.57%) and similarly in age group 40-44 (28.57%). *White-British* made up 28.57% of cases, this ethnic group representing 44.14% of the Trust staff profile and *Black or Black British–African* made up 28.57% cases, with this ethnic group representing 7% of the Trust staff profile. The staff group with the highest percentage of cases are registered nurses and midwives at 42.86%. Band 5 forms the largest pay group with Bullying and Harassment cases at 28.57%. Band 5 nurses and midwives are the largest band/staff group in the Trust forming 16% of staff, and the second largest is Band 6 nurses and midwives at !!%.

Religion and sexual orientation were largely undisclosed for these two protected characteristics (with rates of over 70% undisclosed) therefore yielding no significant considerations. Similarly 57.14% cases did not disclose their disability status, so we are unable to draw any analysis from these rates.

16.2 Disciplinary

The number of disciplinary cases for the period 2012/13 were 45 and in 2013/14 were 46. This year 68.89% were from women and 31.11 % from men. The majority of cases were represented by *Black or Black British – African and Black Caribbean* comprising over 35% of all disciplinary cases, whilst *White British* comprised 24.44% of cases. Other ethnic groups

account for significantly less than 15% of disciplinary cases. The disciplinary rates across the age groups is generally below 15%, so no particular conclusions can be drawn as similar rates apply across age groups

Band 2 pay group had the highest number of cases at 22.22% followed by Band 5 at 20%.

No conclusions can be drawn for a number of protected characteristics as the **undisclosed** rates are high with 68.89% for disability, 71% for religion, 68.89% for sexual orientation.

16.3 Capability

The total number of cases is 19 of those 89.47% were female and 10.53% are male. Staff in the age group 55-59 accounted for 26.32% of cases. The majority of the cases at 26.32% were represented by *Black* or *Black British Caribbean*, followed by other ethnic groups at 15.79% and *White British* and *White Irish* groups each at 10.53%.

16.4 Employee Relations Conclusions

BME staff, particularly from *Black African and Black Caribbean* ethnic groups still continue to be disproportionately affected compared with White colleagues. When comparing this to the staff group profile of the Trust, staff in junior bands (Bands 2 = 18 cases, Band 3 =11 cases Band 4= 8 and Band 5 = 16 cases) or *Nursing and Midwifery staff* (23)and *Additional Clinical Services i.e.HCAs*(22) were disproportionately involved in ER cases. The total number of staff dismissed from the Trust were 9 of which 3 were *White* and 6 from *BME or other Backgrounds*

The Bullying and Harassment Staff survey Results 2013/14 have now been analysed, especially in relation to last year's figures and the identification of hotspots. Last year, a follow up action led the Equality and Diversity Lead, along with HR colleagues to run Staff Focus Groups in areas/departments deemed to have the worse scores in terms of Bullying/Harassment/Victimisation and Discrimination. Over 17 hotspot areas (approx 200 staff) were visited to discuss outcome and develop action plans. This year's results indicate that the local action plan from this exercise for many areas have been successful, with 10 areas/departments (out of 17) no longer featuring for these findings in 2013 survey.

Following the release of the Staff Survey results for 2013, NHS employers convened a roundtable to discuss the survey findings inviting representative for major hospitals in London (as London hospitals present the highest Bullying and Harassment rate nationally) and to further consider other research, along with survey findings and ways forward. A number of hospitals participated including St. Bartholomews and the Royal London, Imperial Healthcare, to discuss results and methods to address. Following on from this, Chelsea and Westminster has agreed to share information on Bulllying and Harassment, Disciplinary and sickness absence figures to assist in the development of initiatives, one of which includes the consideration of unconscious bias impact in the workplace leading to bullying and harassment claims.,

17. Next Steps

A People Strategy has now been developed for the Trust to support the Trust's Business Strategy and to address some of the issues raised in this report. Actions on equality and diversity issues specifically are in Appendix 2, and the following highlights some of the actions in more general terms:

Continuing to work towards meeting our key staffing metrics, thereby reducing our reliance on agency staff and manage our activity within staffing budgets.

Use this report's findings to help design solutions to address high turnover amongst Band 5 nurses and Healthcare Assistants, initially through shortlife working groups

Band 5 notice period, extended from 4 to 8 weeks, and it is hoped that this will help with retention and decrease turnover for this group, permitting the opportunity for the individual to reconsider and to explore more fully the reasons for leaving.

Exit interviews carried out via Survey monkey, now revised the timing of sending out of these surveys to coincide with the receipt of termination forms, to allow the opportunity to receive more responses prior to staff leaving and explore more fully leaving reasons.

"Spotlight surveys" conducted in recruitment and retention hotspot areas, now include a question regarding a member of staff's future intentions, asking them why they may be thinking of leaving. Findings are reported on, and these are sent to local managers, to assist them in making real time changes to take action and make improvements.

Saturday recruitment and selection days were introduced for Bank Band 5 Nurses and Healthcare Assistants, intended to help towards improving vacancy rates.

Attendance at External Recruitment Fairs are planned for, eg, RCN exhibitions in Manchester and London to help increase supply of nurses.

Incentives have been trialled in hotspot shortage areas of speciality nurse vacancies. e.g. NICU and Midwives. Incentive payments/vouchers are paid for extra shifts over peak periods. Higher rates of payments were made during pressurised periods e.g. winter.

Recruitment and selection practices being reviewed to ensure that the Trust values are fully embedded at every stage of the recruitment pathway and that we are recruiting staff who are supportive and demonstrate behaviour that is consistent with the Trust values.

Work will continue with improving data collection by protected characteristics that are not currently collected on a regular basis from staff and also patients. Attention will also be focused on collaboratively working with member of the Patient and Staff Experience Committee and Health watch to engage with more effectively with all our patients.

Continuing to consult with staff to understand this report's findings particularly around bullying and harassment, employee relations and the Staff Survey findings using a variety of methods such as 'pulse surveys' and focus groups.

Continuing to engage and build relationships with staff and newly formed external partners such as Healthwatch and Clinical Care Commissioning Groups to hear the views of patients and staff from different protected groups.

Continue to host speaking events to raise awareness of different equality issues across all protected characteristics and challenge current thinking.

Improvements to workforce information and metrics. A small group will review themes and trends relating to turnover or employee relations for example, and agree solutions for improvement in a timely manner, rather than waiting for the data to be provided annually through the Annual Workforce Monitoring Report.

Launch the first staff Friends and Family test survey presenting an opportunity to staff to feedback on what they think about the care the Trust provides and working here. The aim is to strengthen the voice of people working in the NHS and develop a positive listening and learning culture to support service improvement.

Developing a Staff Health and Wellbeing strategy that will support staff in balancing work and other responsibilities outside of work to generally improve physical and mental wellbeing. The Trust will follow up on similar previous initiatives such as the fast-track direct referral to physiotherapy service and our mini health MOTs for staff.

New Appraisal system introduced to link with the implementation of annually earned increments - now conditional on not only demonstrating satisfactory performance in year, but also evidence of demonstrating the Trust values and behaviours. Satisfactory appraisal also includes ensuring that all staff meet their mandatory training requirements, of which equality and diversity training is one.

18. Conclusion

The Trust met its statutory obligations to monitor and report on equality and diversity issues and provides assurance that action is being taken and planned to address issues of note.

As a result of this workforce analyses, the Trust can be satisfied that there are no significant areas of concern which are unique to this organisation, although there are a number of issues which continue to be raised which require further understanding and investigation and/ or specific action to address with external partners.

The Trust performance for a number of HR metrics shows continued improvement with regard to sickness at 3.44% (below target of 3.5%), appraisals at 84%, mandatory training 77%, Time to Recruit at 69 days. However, challenges are still faced in the area of turnover which is above the target at 14.70%. Staff engagement levels remain high, despite the challenging environment, and the development of the People Strategy should help to address some of the remaining issues.

Appendix 1: Overview of Equality Legislation

The Public Sector equality duty came into force in April 2011 (s149 of the Equality Act 2010) and as public authorities such as NHS organisations are required in carrying out their functions to have due regard to the need to achieve the objectives set under section 149 of the Equality Act to:

- Eliminate discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

To ensure transparency and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations require public authorities, to publish information to demonstrate compliance with the general duty. This information must include, in particular, information relating to people who share a protected characteristic who are its employees and people affected by its policies and practices. This specific duty requires the Trust to publish relevant proportionate information showing compliance with the Equality Duty and also to prepare and publish one or more objectives that it thinks it needs to achieve to further any of the aims of the general equality duty and these are identified in section 17 of this report..

For the purposes of the Equality Act (Specific Duties) regulations the Annual workforce report 2013/14 provides an analysis of the equality and diversity monitoring information, the Trust collects on protected characteristics of its employees and integrate this information with the general workforce operational information. The headings in bold indicate the suggested information that the regulations propose are published annually, whilst the subheadings indicate that which the Trust legally holds via equality monitoring and also how the information will be presented in the 2013/2014 Annual Workforce Report.

Overall Workforce Composition by protected characteristics

By salary pay band, and professional group. Page 7, para: 2.2

Recruitment and Retention by protected characteristics

Recruitment analysis -applications, shortlisting. Page 26, para: 5

Starters and leavers. Pages 19 para: 3.4 and Page 22, para: 4.2.

Length of service. Page 32 , para: 9

Gender Pay gap and Pay Equality

Pay and Promotions. Page 34, para:11

Flexible Working and different protected characteristics.

Flexible working by bands and professional groups. Page 33, para 12

Learning and Development Opportunities and outcomes for protected characteristics

Appraisals. Page 35 para 14.1

Mandatory training and equality and diversity training. Page 35.para 14.2

Grievance and disciplinary issues for staff with different protected characteristics.

Grievance Policy usage: Page 39: para 16.1

Bullying and Harassment Policy usage. Page 39; para 16.1

Disciplinary Policy usage. Page 39 , para 16.2

Managing Capability (poor performance) Policy usage. Page 40, para. 16.3

Appendix 2: Equality Objectives, Progress and Next Steps

1 Objectives

The Equality Act 2010 (Specific Duties) Regulations which came into force on 10th September 2011, requires public bodies to prepare and publish one or more specific measurable equality objective at least every four years which will help them in the furtherance of the three aims of the Equality Duty (see Section 2: Overview of Equality Legislation) .

The following is a summary of the objectives set previously and which continues to be the framework for the work plan as set out in the recommendations/next step section.

Objective 1: Improve equality data collection and usage across all protected characteristics. The Trust continues to review its IT systems, identifying the gaps in information quality that need addressing in order to improve the patient experience e.g. improved recording of protected characteristics.

Objective 2: Continue to develop and promote an organisational culture that supports the principles of equality. Some of the developments that promote these principles are outlined in the recommendations below e.g. Staff survey feedback sessions, staff focus groups and the development of local action plans to address concerns.

Objective 3: Effectively communicate with, engage, and involve all of our stakeholders in equality. The Equality and Diversity continues to work alongside Senior colleagues on number of groups e.g. Stroke Forum, Learning Disability Steering Group to review and make recommendations on service improvements especially with respect of transfer of patients with protected characteristics to hospital.

Objective 4: Strengthen equality and diversity communications and resources across the Trust. A number of initiatives are outlined in recommendations, including participating in ENEI and Stonewall Benchmarking exercises, along with Stonewall's Health Champions programme.

2 Progress with Equality and Diversity

Trust representative participated in a Londonwide Equality and Diversity Roundtable event in April, 2014 along with diverse Equality and Diversity leads from NHS employers, Imperial college, Barts and the London, Royal Marsden, Heads of Engagement and Equality and Diversity Lead for London and ACAS Head of Equalities to network in identifying common Bullying and harassment themes and solutions. A number of recommendations and tools will be considered for adoption into our E&D Plan and to redesign solutions during 2014/15.

For the first time this year, the Trust participated in the ENEI (Employers Network for Equality and Inclusion) in March, 2014. This enabled us to benchmark ourselves with other companies and organisations. The benchmarking tool was completed and submitted on 4th April. The key areas for assessment being workforce, organizational commitment, organizational improvements, and integrating equality, diversity and inclusion, external

relations and suppliers .The results were released in May 2014 and the Trust achieved Bronze Standard, of the three which were Gold Silver and Bronze. The outcomes will further assist us in diagnosing areas for improvement and further developing the Equality and Diversity Plan.

The Patient and Staff experience committee(PSEC), formally assumed the work of the Equality and Diversity Steering group, as there are strong links to the Trust 'Respectful' value and as such Equality and Diversity work could be better integrated and evaluated as part of the work of the PSEC committee. The Patient and Staff experience Committee will amend their Terms of reference to incorporate this change, and it will be taken to the Patient and Staff Experience committee meeting for final sign off.

The Trust has recently been successful in an application to become a Stonewall Health Champion by May 2015. During this course of the programme,, Stonewall will provide a free one-year support package on Lesbian, gay and bisexual equality. As a champion, the Trust will receive stonewall consultancy support, a free needs assessment based on Stonewall health research, and access to NHS specific training on sexual orientation equality, and support with benchmarking exercise.

The Trust's Feel Good February campaign led included several presentations on LGBT matters, including health inequalities experienced by LGBT. The sessions were well attended and were reported on in the April edition of the Trust Newsletter to ensure continued awareness on these specific issues.

3 Next Steps with equality and diversity

Share this report's findings with the Senior Nursing and Midwifery Committee to develop staff group specific actions from this report and Staff Survey findings to address staff group trends.

Continue to review HR policies and procedures such as sickness, special leave to ensure fit for purpose and taking into consideration the principles of equality whilst at the same time addressing organisational costs and issues that arise due to staff absence.

Developing a series of local staff surveys to measure staff engagement and provide further analysis of the areas of concern identified in the annual national Staff Survey. The results of these surveys will be analysed in conjunction with patient surveys and areas of improvement identified.

Complete a comparative analysis of our results for bullying and harassment in 2013 Staff survey, against last year; to evaluate whether the focus group work helped to reduce the likelihood of staff feeling bullied and harassed. Share findings and work with NHS employers and other London NHS organisations where bullying and harassment are also of concern leading to the development of a toolkit of shared resources.

Finalise and roll out the diversity resource booklet to increase staff knowledge of different equality issues across all protected characteristics.

We will continue to identify strategies to improve compliance in Mandatory Training, and review Corporate Induction, to ensure comprehensive coverage and it is fit for purpose.

Participation in the Employer's Network for Equality and Inclusion benchmarking survey will not only allow us to learn from others but also assist in the development of a 2014/15 equality workplan across all the protected characteristics across all protected characteristics.