Hounslow and Richmond Community Healthcare Alliance

Annual Report 2009-10

NHS

Hounslow and Richmond Community Healthcare

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1.1 Managing Director's Foreword

Managing Director's Foreword: 2009-2010: A transitional year

I am pleased to present the annual report for Hounslow and Richmond Community Healthcare Alliance for April 2009 to March 2010.

2009/10 was a year of change. A considerable amount of energy was put into developing a robust organisation that was ready to separate from the PCTs. This saw us successfully achieve APO (Autonomous Provider Organisation) status in April 2009. By October of the same year we were awarded DPO (Direct Provider Organisation) status by NHS London, having successfully met the Department of Health's criteria.

The achievement of DPO status reflected the robust finance and governance arrangements of the Alliance and prepared us for the next stage of more formal separation. The strength of these arrangements was confirmed when we were successfully registered without condition by the Care Quality Commission (CQC) having successfully met the CQC's Essential Standards of Quality and Safety.

However, the year was not just about organisational change. Like all healthcare organisations we continue to respond to unforeseen events. This year, thanks to robust planning we were able to respond successfully to the swine flu outbreak, running several anti-viral collection points and emergency vaccination clinics, and continued to provide care to our most vulnerable patients throughout the extremes of winter weather.

Similarly we continued to look for new opportunities to develop our services. We were successful in our bid to run a new GP practice at Teddington Memorial Hospital. The bid was particularly notable for being made in partnership with the Thames Health Collaborative (a group of local GPs) and the League of Friends of Teddington Memorial Hospital. The new practice opened on 1st March 2010.

The tripartite bid for the new GP practice reflects our successful partnership working with local stakeholders and we have continued to develop good working relationships with colleagues in the two local authorities and members of the Local Involvement Networks (LINks).

Overall 2009/10 was a challenging but successful year. We achieved significant organisational development whilst continuing to run existing services and develop new ones and I would like to take this opportunity to thank all Alliance colleagues, stakeholders and volunteers for their hard work, dedication and enthusiasm over the last year.

I hope that you will find the report useful and informative.

Richard Tyler
Managing Director

1.2 Introduction to the Alliance

This report outlines the main activities of Hounslow & Richmond Community Healthcare Alliance (the Alliance) for the reporting year April 2009 – March 2010. From the 1st April 2010, the Alliance became known as Hounslow and Richmond Community Healthcare (HRCH). However, as this report is for the financial year 2009/10, the organisation is referred to in it by its former name of the Alliance. This report also contains information from before the merger between Hounslow and Richmond provider services – this means that due to the different reporting systems some tables are not directly comparable – this will change in 2010/11.

The Alliance – a short history

In 2005 the Department of Health published *Commissioning a Patient-Led NHS* that directed Primary Care Trusts (PCTs) to separate their provider services from their commissioning functions. This was followed in January 2009 with the publication of *Transforming Community Services* which provided detailed guidance on the development of community provider organisations. The development of strong and high quality community services was also a key element of the NHS vision laid out in Lord Darzi's Next Stage Review.

In the context of these policies, and following two years of discussion and detailed examination of the different options available, both Hounslow and Richmond PCTs (NHS Hounslow and NHS Richmond) concluded that their provider arms were too small to function individually if they were to deliver the scale of change required by *Transforming Community Services.* In light of this, their respective boards agreed that the best option would be an alliance between the community services of NHS Hounslow and NHS Richmond. As a result, a management alliance between Hounslow and Richmond provider services came into effect on 1 April 2009.

The Alliance – aim, visions and values

In order to establish a clear strategic direction for the new Management Alliance a set of visions and values, and the aim for the organisation was set out. Following discussion and consultation with the Joint Provider Board, staff and partners, it was agreed that the aim of the Alliance should be to ***`improve the health and wellbeing of the population of Hounslow and Richmond through the provision of high quality community services'***.

In order to achieve this aim it was agreed that the Alliance would focus on services that:

- Promote healthy living;
- Deliver urgent and elective care previously delivered in hospital;
- Support patients with long term conditions;
- Provide rapid response and intermediate care to avoid unnecessary hospital admissions;
- Provide rehabilitation to reduce time spent in hospital, enabling people to live an active life.

The Alliance committed to the provision of services that would combine:

- High quality;
- Value for money;
- Productivity;
- Innovation;
- Borough based service delivery.

The values that were to underpin all activities carried out by the Alliance were identified as:

- The provision of high quality services;
- The retention and development of excellent staff;
- The involvement of patients and carers;

- A holistic approach to care.

The aim, vision and values of the Alliance were designed to allow the organisation to develop and strengthen, in order to be in a position that would allow it to fully separate from the PCTs and operate as a top quality stand-alone healthcare provider.

2. Finance Report

2.1 Accounts 2009-10

Financial Governance

These pages serve as a summary of the main financial statements of the organisation. Since each Provider Arm was still part of its respective PCT's financial returns the attached statements have not been reviewed by external auditors.

Financial Balance

Hounslow and Richmond Community Healthcare's total Revenue Income during 2009-10 was £55.4m. The majority of this was obtained through commissioning contracts with the two main PCTs, NHS Hounslow and NHS Richmond. Over and above this a number of service agreements were agreed with West Middlesex University Hospital NHS Trust, Kingston PCT, Sutton and Merton PCT, Wandsworth PCT, Ashford and St Peters NHS Trust, Ealing PCT, London Borough of Richmond, London Borough of Hounslow and the Department of Health which totalled £6.5m.

Hounslow and Richmond Community Healthcare planned a breakeven target, with expectations from both PCTs that this would be achieved. Although faced with a number of in-year financial pressures we were able to keep expenditure within the financial target and under spent by £37k.

Better Payment Practice Code

The NHS Executive requires that all NHS organisations pay their creditors in accordance with the CBI prompt payment code and government accounting rules; that is to pay their creditors within 30 days of receipt of invoice. Hounslow and Richmond Community Healthcare Alliance formed part of both NHS Hounslow and NHS Richmond's' respective targets of 95%, and achieved 78% overall in number of bills paid and 89% overall in value. This can be further split between non-NHS creditors (78% in number of bills paid and 87% value) and NHS creditors (68% number of bills paid and 91% value).

On the NHS Richmond side a Document Management System is being introduced during the first quarter of 2010-11, which will automate the distribution and approval of invoices plus provide an automatic follow-up and escalation of unauthorised invoices prior to the 30-day deadline. This will speed up the process and also automatically bring outstanding invoices to budget holders' and managers' attention.

Management Costs

Hounslow and Richmond Community Healthcare Alliance's management and administration costs totalled £5.4m against a combined weighted population of 372,380, which equates to a cost per head of £14.54. Since all provider arms are still going through the process of disaggregation from PCTs there are no real benchmarks to gauge this spend against.

Income and Expenditure statement for the year ended 31 March 2010

		2009-10 £000
Operating Revenue		
Clinical Revenue	Host PCTs	48,947
	Other PCTs	2,094
	Other NHS & Local Authority	3,011
	Other Revenue	354
		54,406
Non Clinical Revenue	Private Patient Revenue	75
	Education and Training	407
	Other Revenue	426
	LIFT Schemes	123
		1,031
TOTAL OPERATING REVENUE		**55,437**
Operating Expenses		
	Pay Costs	(37,275)
	Drug Costs	(251)
	Clinical Supplies & Services	(4,653)
	Other Costs (excl depreciation)	(3,463)
	Apportioned Overheads	(8,879)
	Contingency Reserve	(267)
	LIFT Schemes	(145)
TOTAL OPERATING EXPENSES		**(54,933)**
EARNINGS BEFORE INTEREST, TAX, DEPRECIATION AND AMORTISATION		**504**
	Depreciation	(447)
	Cost of Capital	(20)
NET SURPLUS/ (DEFICIT)		**37**

Balance Sheet as at 31 March 2010

		2009-10 £000
Non Current Assets		
	Plant, Property and Equipment	764
	Intangible Assets	54
	Total Non-Current Assets	**818**
Current Assets		
	Inventories	0
	NHS Trade Receivables	2,700
	Other Receivables	2,494
	Bad Debt Provision	(218)
	Cash and Cash Equivalents	19
	Total Current Assets	**4,995**
Current Liabilities (amounts due in less than one year)		
	Trade Payables	(3,444)
	Other Liabilities	(999)
	Untaken Annual Leave Provision	(120)
	Total Current Liabilities	**(4,563)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**1,250**
TOTAL ASSETS EMPLOYED		**1,250**
Financed by: Taxpayers Equity		
	General Fund	411
	Retained Earnings	37
	Revaluation Reserve	642
	Donated Asset Reserve	160
TOTAL TAXPAYERS EQUITY		**1,250**

Cashflow statement for the year ended 31 March 2010

	2009-10 £000
Opening Balance	0
Receipts	61,887
Payments	61,868
Net Movement	19
Closing Balance	**19**

Management Costs

	2009-10 £000
Management costs	5,416
Weighted Population	372,380
Management Cost per Head Of Population	**£14.54**

Better Payment Practice Code – measure of compliance

	2009-10 Number	2009-10 £000
Non-NHS Creditors		
Total bills paid in the year	12,020	15,083
Total bills paid within target	9,415	13,083
Percentage of bills paid within target	**78.33%**	**86.74%**
NHS Creditors		
Total bills paid in the year	312	23,353
Total bills paid within target	457	21,140
Percentage of bills paid within target	**68.27%**	**90.52%**

Dave Hawkins
Director of Finance and IM&T

Glossary of Financial Terms

Accruals	An accounting concept. In addition to payments and receipts of cash (and similar), adjustment is made for outstanding payments, debts to be collected, and stock (items bought, paid for but not yet used). This means that the accounts show all the income and expenditure that relates to the financial year.
Assets	An item that has a value in the future. For example, a debtor (someone who owes money) is an asset, as they will in future pay. A building is an asset, because it houses activity that will provide a future income stream.
Break-even (duty)	A financial target. Although the exact definition of the target is relatively complex, in its simplest form the break-even duty requires the NHS organisation to match income and expenditure, i.e. make neither a profit nor a loss.
Capital	In most businesses, capital refers either to shareholder investment funds, or buildings, land and equipment owned by a business that has the potential to earn income in the future. The NHS uses this second definition, but adds a further condition – that the cost of the building/equipment must exceed £5,000. Capital is thus an asset (or group of functionally interdependent assets), with a useful life expectancy of greater than one year, whose cost exceeds £5,000.
Capital charges	Capital charges are a device for ensuring that the cost associated with owning capital is recognised in the accounts. A charge is made to the income and expenditure account on all capital assets except donated assets and those with a zero net book value. The capital charge comprises depreciation, and a return similar to debt interest. This rate of return is set by the Treasury and is currently 3.5%.
Capital resource limit (CRL)	An expenditure limit determined by the Department of Health for each NHS organisation limiting the amount that may be expended on capital purchases, as assessed on an accruals basis (i.e. after adjusting for debtors and creditors).
Cost improvement programme	The identification of schemes to reduce expenditure/increase efficiency.
Current assets	Debtors, stocks, cash or similar – i.e. assets that are, or can be converted into, cash within the next twelve months.
Depreciation	The process of charging the cost of an asset over its useful life as opposed to recording its cost as a single entry in the income and expenditure records. Depreciation is an accounting charge (i.e. it does not involve any cash outlay). Accumulated depreciation is the extent to which depreciation has been charged in successive years' income and expenditure accounts since the acquisition of the asset.
Financial reporting standard (FRS)	Issued by the Accounting Standards Board, financial reporting standards govern the accounting treatment and accounting policies adopted by organisations. Generally these standards apply to NHS

	organisations.
Fixed assets	Land, buildings or equipment that are expected to generate income for a period exceeding one year.
General medical services	Medical services provided by general practitioners (as opposed to dental, ophthalmic and pharmaceutical services provided by other clinical professions).
Governance	Governance (or corporate governance) is the system by which organisations are directed and controlled. It is concerned with how an organisation is run – how it structures itself and how it is led. Governance should underpin all that an organisation does. In the NHS this means it must encompass clinical, financial and organisational aspects.
Healthcare resource group (HRG)	HRGs are the 'currency' used to collate the costs of procedures/diagnoses into common groupings to which tariffs can be applied. HRGs place these procedures and/or diagnoses into bands, which are 'resource homogenous', that is, clinically similar and consuming similar levels of resources.
Indexation	A process of adjusting the value, normally of fixed assets, to account for inflation.
Net book value	The value of items (assets) as recorded in the balance sheet of an organisation. The net book value takes into consideration the replacement cost of an asset and the accumulated depreciation (i.e. the extent to which that asset has been 'consumed' by its use in productive processes).
Overheads	Overhead costs are those costs that contribute to the general running of the organisation but cannot be directly related to an activity or service. For example, the total heating costs of a hospital may be apportioned to individual departments using floor area or cubic capacity.
Payment by results	A financial framework in which providers are paid according to the level of activity undertaken. Payment is based on a national tariff system.
Reference costs	NHS organisations are required to submit a schedule of costs of healthcare resource groups to allow direct comparison of the relative costs of different providers. The results are published each year in the National Schedule of Reference Costs.
Revenue	On-going or recurring costs or funding for the provision of services.
Tangible asset	A sub-classification of fixed assets, to exclude invisible items such as goodwill and brand values. Tangible fixed assets include land, buildings, equipment, and fixtures and fittings.
Variance	The difference between budgeted and actual income and/or expenditure. Variances are an accounting tool used to analyse the

cause of over/under spends with a view to proposing rectifying action.

Working capital — Working capital is the money and assets that an organisation can call upon to finance its day-to-day operations (it is the difference between current assets and liabilities and is reported in the balance sheet as net current assets (liabilities). If working capital dips too low, organisations risk running out of cash and may need a working capital loan to smooth out the troughs.

2.2 Statement on Internal Control 2009-10

i. Scope of responsibility

The Board is accountable for internal control. As delegated Accountable Officer, and Managing Director of the Provider Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The accountability arrangements surrounding my role comprise:

- Development of the organisation's Corporate Objectives.
- Preparation of the Operating Plan.
- Application of an annual budget, linked to the above.
- Regular reporting to the Provider Board on performance monitoring and any other key issues.
- Regular reviewing at the Board of the minutes of meetings held by the Integrated Governance Committee and Audit Committee.
- Regular reporting and review at Provider Executive Team meetings on operational matters.
- Engaging with NHS London, in various forms, to receive direction in matters relating to strategy to determine policy and identify, prioritise and manage risks.
- Working with a number of partner organisations, e.g. the London Borough of Richmond upon Thames and other neighbouring organisations and Trusts through networks and consortia.

ii. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives.

- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Hounslow and Richmond Community Healthcare Alliance for the year ended 31 March 2010.

iii. Capacity to handle risk

As Managing Director of the Hounslow and Richmond Community Healthcare Alliance I have overall responsibility for having in place effective systems of risk management and internal control. The key elements of risk management within the organisation comprise:

- A Risk Management and Board Assurance Strategy that outlines the risk management objectives, the structure, the assurance framework, roles and responsibilities, monitoring and reporting and communication of the strategy.

- The Assurance Framework, which for 2009-10 was based on the organisation's Corporate Objectives.

- Provider Executive Team meetings review finance, estates, security, health and safety, human resource and other related matters.

- The Integrated Governance Committee co-ordinates risk management and reports to the Board.

- The Audit Committee reviews strategic risk and seeks assurance on the internal control framework. In 2009-10 Community Health Services had a separate agenda on both NHS Richmond and NHS Hounslow's Audit Committees, but for 2010-11 will have its own independent Audit Committee.

- Directors have taken immediate responsibility for their Department's risks and the overall Assurance Framework.

- Risk management is included as part of the mandatory training programme.

Following the PCT and Provider services separation the approach to risk management was updated and a new Risk Management and Board Assurance Strategy adopted.

In addition during the course of 2009-10 the Serious Untoward Incident and Incident Reporting policy and process was also updated.

iv. The risk and control framework

The Alliance has an Integrated Governance Strategy, which has been ratified by the Provider Board. The strategy identifies:

- Aims and Objectives
- Responsibilities
- Board Assurance
- Committee Structure

- Risk Register

The Integrated Governance Strategy is underpinned by the Risk Management Procedure, which has been ratified by the Integrated Governance Committee. The procedure identifies:

- Objectives
- Structure
- Assurance Framework
- Roles and Responsibilities
- Monitoring and reporting
- Communication

Risk is identified in a number of ways, through review of the organisation's objectives and the risks to achieving them, through incidents and near misses reported, complaints and contacts with the Patient Advice and Liaison Service (PALS), and through risk assessments. Risk is evaluated by use of the 5 x 5 risk matrix with detailed descriptions of impact and likelihood to ensure consistency in risk scoring across the organisation.

The Provider Executive Team focuses specific attention on the strategic risk as well as primary operational risks. Key controls and sources of assurance are in place for each risk, with mitigating actions, and risk ratings are regularly reviewed to reflect action taken to address risk and changing circumstances.

There are a number of mechanisms in place which contribute to the risk and control framework to ensure that risk management is embedded in the activity of the organisation:

- Integrated Governance Strategy.

- Risk Management and Board Assurance Strategy.

- Various policies and procedures covering major issues of health and safety, fire, security, violence and aggression, lone working, infection control, etc.

- Integrated Governance Committee.

- Assessment of the sources and calibre of assurance (internal and external) available to the Board to understand and assess the nature and impact of key risks.

The Assurance Framework for 2009-10 was based on the organisation's Corporate Objectives. Risks to achieving the objectives were identified at both strategic and operational level and key controls were identified for each risk, or in the absence/weakness of a key control, an action plan. Sources of assurance, both internal and external were also identified, and action plans developed for any gaps in assurance. The development and ongoing review of the Assurance Framework provides evidence to support the Statement on Internal control by ensuring that the Alliance's risks are identified, managed, prioritised and regularly reviewed.

Public stakeholders are involved in managing risks which impact on them by providing feedback on services through a number of routes, e.g. patient surveys, contacts with the Patient Advice and Liaison Service (PALS) and complaints, to promote improvements in quality and accessibility which in turn can reduce risk. Users, carers and the public are also engaged in consultation regarding the re-design and reconfiguration of services.

Compliance with NHS Pension Scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Compliance with Equality, Diversity and Human Rights

NHS Richmond has in operation an Equal Opportunities and Management Diversity Policy. This policy complies with current legislation relating to the Race Relations Act 1976, Sex Discrimination Act 1975, Disability Discrimination Act 1995 and Employment

As an organisation hosted by NHS Richmond, the Alliance complies with the Equality Regulations 2003.

Disclosure on Standards for Better Health

The Alliance was not fully compliant with the core standards for better health. Non compliance areas have been highlighted under significant control weaknesses. Monitoring of these has been undertaken by the Joint Provider Board and assurance given to the Integrated Governance Committee.

v. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of Internal Control. My review is informed in a number of ways. Internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with an assurance statement for 2009-10. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed.

My review is also informed by the core standards self assessment declaration.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee and Integrated Governance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Provider Board is accountable for internal control. Assurance is provided to the Board on the processes for managing risk by:

- Reports to the Board from the Integrated Governance Committee and Audit Committee.
- Internal Audit which undertakes an agreed risk based annual programme of work to ensure that adequate internal controls and procedures are in operation.
- External Audit which oversees the financial integrity.
- The Assurance Framework for 2009-10 was reviewed regularly by the Integrated Governance Committee.

- The updated Assurance Framework for 2009-10 was reviewed and endorsed by the Provider Executive Team, the Integrated Governance Committee, the Audit Committee and the Board.

Throughout 2009-10 the Board received assurance from the following sources:

- Finance and performance management reports at every meeting.

- Review and sign-off of Hounslow and Richmond Community Healthcare Alliance final declaration of the level of compliance with the core standards identified in Standards for Better Health.
- Review of the minutes of the Integrated Governance Committee and Audit Committee and verbal reports from the Chairman of these Committees.
- Update on the introduction of major initiatives, e.g. the development of a GP-led health centre, the implementation of *Healthcare for London*, and progress towards the 18-week referral to treatment target.
- Action plans and on-going progress update on any serious untoward incidents. Further information is available on request in line with our data protection and freedom of information policy.
- Action Plans following serious untoward data security incidents. These are as follows:

Figure 1 - Serious Untoward Data Security Incidents 2009-10

Date of incident	Brief description of incident	Outcome – action taken or planned
October 2009	Letter incorrectly sent to the wrong patient with particularly sensitive health information. The letter was not checked by the responsible clinician prior to sending	The Standing Operating Procedure is currently being reviewed following the SI to ensure that instructions clearly state and can be easily understood for dictating, typing, formatting and checking. Sign off will be via the senior admin team under the guidance of their Professional Lead. The member of staff responsible for this incident was disciplined.

The following significant control issues have been identified for 2009/10.

During 2009-10 we received one limited assurance option over the controls in place around information governance from internal audit. Issues raised concerned the quality of the evidence in place to support the scores in the Information Governance Toolkit and the extent to which data flows throughout the organisation had been mapped. As of the end of the financial year the Internal Audit Team has revisited this area and conducted follow up testing. Confirmation has been received that all issues, raised, which resulted in the limited assurance opinion, have been remedied and that good progress towards implementing all of the recommendations raised had been taken.

An ad hoc CQC inspection report in May 2009 identified issues which, when considered together, constituted a significant lapse in assurance for Core standard: C4c – Decontamination. These issues and subsequent action taken and planned by the organisation are detailed below.

Figure 2 – Findings and Action Plan

Findings	Action Plan
1. There is no documented evidence that the Trust had a designated lead manager for the decontamination of reusable medical devices as required by Hygiene Code Duty 4b between April 2009 and March 2009.	Designated lead manager for the decontamination of reusable medical devices is now specified in the job description of the Director of Quality and Clinical Excellence whose role in decontamination is supported by the Head of Infection prevention and Control and the Associate Directors for the organisation, also with decontamination responsibilities outlined within their job descriptions.
2. The Trust did not audit the effectiveness of the arrangements for the decontamination of medical devices	Decontamination facilities are audited within all NHS Richmond premises as part of the rolling infection prevention and control audit programme. All sites have now been audited and action plans put in place to address any issues identified. Decontamination practice forms part of the reusable medical devices audit carried out by al services, with data collated and analysed through the Medical Devices Advisory Group (reporting to the Joint Integrated Governance Committee) that has now been set up. An action plan is in place, monitored by this group, to help ensure that practice around the use of medical devices is continually improved.
3. 63% of the clinical workforce did not attend infection control training in the year 2008-2009.	In 2009-10, 67% of the clinical workforce attended infection prevention and control training. Efforts are ongoing to ensure that this figure is increased further in 2010-11. Medical devices training, including targeted decontamination training, is to be made mandatory for all clinical staff in addition to infection prevention and control training this year.
4. Risk assessments of all medical devices were not done during the assessment year.	All service leads have been made aware of the importance of valid risk assessments and decontamination protocols on medical devices used within their services and are responsible for ensuring that these are carried out and documented. The completion and submission of these to the Clinical Risk and Audit Team will be monitored through the Medical Devices Advisory Group.

Following the creation of Hounslow and Richmond Community Healthcare Alliance the responsibility for the Standards for Better Health Declaration was delegated to the Joint Provider Board. Therefore at its meeting on the 24 November 2009, the Joint Provider Board was asked to make a declaration against the core standards.

Other than for the standards listed below, the Provider Board agreed to declare that Hounslow and Richmond Community Health Services are compliant against all standards. This resulted in a successful registration without any conditions being imposed.

Figure 3 – CQC Standards and Non-Compliance – Action Plan

Standard	Reasons for non-compliance	Action Planned /Taken
C2: Healthcare Organisations protect children by following the national child protection guidance within their own activities and in their dealings with other organisations.	The Joint Provider Board (JPB) agreed to declare that there was insufficient Assurance in respect of this standard. The JPB came to this decision because despite the fact that there was evidence to meet many of the key lines of enquiry, there was insufficient evidence relating to the required audits for the period concerned.	The action plan consisted of the following actions that have been completed. • Safeguarding children audits will be scheduled on a clinical audit forward planning programme • Audits will be registered with the audit department and be reported on appropriately • A training action plan will be drawn up to ensure all staff are trained at an appropriate level. Learning and Development will progress the training plan with senior managers who will identify those staff with training needs. • Learning and development are required to provide up to date record keeping with regard to staff attendance and evaluation of training sessions • Information sharing protocols to be updated by the Safeguarding Team and held centrally to enable all staff to access them The following actions are potentially outstanding but are being closely monitored to ensure compliance • Only a limited number of audits have taken place • There is only one part time named nurse in place as one has recently resigned • Safeguarding supervision remains an issue due to unforeseen limited capacity • Training, specifically at level 3, has not yet been achieved for all relevant staff.

C4b:*Healthcare ganisations keep atients and staff and sitors safe by having ystems to ensure that l risks associated with e acquisition and use medical devices are inimised*	The JPB agreed to declare that this standard was not met. The JPB came to this decision because there were a number of lines of enquiry within the standard for which there was no evidence. The following were considered to be significant lapses • The lack of training to ensure that medical devices are used safely • That no annual report (on medical devices) had been submitted to the Board • The amount of training for staff and users • No evidence that the medical devices register was being complied with • That service user experience was not taken into account in purchasing decisions and the use of medical devices	The action plan consisted of the following actions that have been completed. • The formation of an advisory group across the Alliance to include those involved in the use, commissioning, maintenance, decontamination and decommissioning of medical devices • Service user experience is represented across in house and Joint Integrated Equipment Stores provider. • Assessment and analysis of training needs to be undertaken for staff, users and carers • Training programme to be developed include: risk awareness and reporting adverse incidents; the procurement of medical devices; the safe use of medical devices; decontamination of devices; record keeping in effective device management; advising carers and users; maintenance and repair • Attendance and feedback sheets to be maintained. Copies of training packs etc to be kept as evidence • Development of a standardised Alliance template for staff competencies and assessments • Regular audit training programme including staff evaluation to be undertaken. • Inclusion of clinical audit programme for medical device management within organisations forward plans for 2010-11. The following actions are potentially outstanding but are being closely monitored to ensure compliance. • The development of an Alliance wide checklist/competency assessment is being drawn up but is yet to be completed. The development of an Alliance wide asset register template to include, storage, cleaning, decontamination, service and maintenance is being drawn up but has yet to be completed.

C4e: *Healthcare organisations keep patients staff and visitors safe by having systems to ensure that the prevention, segregation, handling and disposal of waste are properly managed*	The JPB agreed to declare that this standard was not met. The JPB came to this decision because there were a number of lines of enquiry within the standard for which there was no evidence. The following were considered to be significant lapses: • The provision of an action plan to deal with the results of the SSP audit • The level of staff training for the period concerned • The lack of evidence in respect of daily working practices • The lack of evidence in respect of waste segregation	The action plan consisted of the following actions: • SSP have been contracted to provide waste management training from 1 April 2010 onwards. The lead will address all outstanding training issues, including segregation of waste and correct use of sharps bins. • Service leads will also have responsibility for identifying the training needs of individual staff • Training will be delivered to senior staff administrators on the correct procedure for consignment notes (including the use of a central register) and associated legal responsibilities. A Trust wide standard will be established with regard to record keeping. • The Estates department will inspect all sites reviewing security concerns and make recommendations as appropriate. • Action plans drawn up in response to audits will be monitored by the Estates and Facilities Committee to ensure compliance. The following actions are potentially outstanding but are being closely monitored to ensure compliance • Discussions are ongoing regarding the SLA in respect of waste management with both NHS Richmond and NHS Hounslow • A recent sharps audit has highlighted a number of concerns that may still be outstanding • There may be some issues outstanding in respect of the safety of the bins at Teddington Memorial Hospital

C5d. *Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services*	The JPB agreed to declare that this standard was not met. The JPB came to this decision because there were a number of lines of enquiry within the standard for which there was no evidence. The following were considered to be significant issues: • The fact that only 7 audits were found to have taken place in the period (and that one of these was a PEAT audit) • That only 7 forward planners had been received • That there were no clinical audit forward planners that meet the definition of clinical audit or completed clinical audits have been received for children's universal services or the Walk in Centre or Outpatient Departments	The action plan consisted of the following actions have been completed. • Structures and systems will be put in place to monitor audit activity and offer support to clinical staff • Clinical Audit Strategy has been drawn up and will be implemented by 31 January 2010 • A Trust wide forward planner has now been established and all clinical services have identified clinical audits to be undertaken • Terms of Reference have been produced for a Clinical Audit and Effectiveness Committee • Clinical audit training has been prioritised within the organisation and is now part of induction training. Senior managers have also received clinical audit awareness training. • In conjunction with the Learning and Development Team, clinical audit workshops will be rolled out to all staff • Action plans arising from clinical audit will now be monitored by senior managers to ensure recommendations are implemented The following actions are potentially outstanding but are being closely monitored to ensure compliance • There are potentially gaps in the audit forward plan • There may have been slippage in the audit forward plan Only a limited number of audits have as yet been fully completed in line with audit standard.

Taking into account the above, I am satisfied that there are no further significant internal control issues, other than those identified above, and I would conclude that the culture of risk management has continued to be embedded across the organisation throughout the year and is firmly in place at 31 March 2010.

…… ……

Managing Director **Date**

3. Governance

3.1 Corporate Governance

Introduction

The Management Alliance (the Alliance) between Hounslow and Richmond provider services came into effect from 1 April 2009. The Alliance was established as a transitional phase in the move to complete merger of the two provider services and then complete separation and full externalization from the PCTs. A Joint Provider Board was set up with membership from the Non Executive Directors of both NHS Hounslow and NHS Richmond Boards to oversee the performance and development of both the Alliance and the community services provided. The Alliance also brought together a Joint Executive Committee of directors from both Hounslow and Richmond Community Services.

During 2009-10 provider services still remained part of the original PCTs, although the Boards of the PCTs devolved key areas of responsibility to the Joint Executive Committee and Joint Provider Board.

Joint Provider Board Members

Non-Executive Directors

Kathy Sienko	Non Executive Director – Hounslow PCT Chair
David Cahill	Non Executive Director – Hounslow PCT
Judith Rutherford	Non Executive Director – Richmond and Twickenham PCT
John Thompson	Non Executive Director – Richmond and Twickenham PCT

Executive Directors

Jo Manley	Chief Operating Officer - Hounslow Provider
Richard Tyler	Chief Operating Officer - Richmond and Twickenham Provider
Nikki Hill	Associate Director of HR & OD – Hounslow Provider
Rachael Moench	Director of HR & OD - Richmond and Twickenham Provider
Caroline White	Interim Director of Quality and Integrated Governance
David Hawkins	Acting Director of Finance

Creation of Key Committees

In March 2009 the Joint Provider Board approved the Integrated Governance Strategy and with it the creation of a number of committees, one of the most important being the Integrated Governance Committee (IGC) itself. The IGC also had a number of key sub-committees as follows: Infection Control; Medicines Management and Non Medical prescribing; Health and Safety and a Professionals Committee.

Risk management strategy

The risk management strategy was also approved at the March Board. It has been implemented over the year and has led to a significant improvement in risk management. Risk registers are now

routinely discussed at the Integrated Governance Committee and the Board Assurance Framework has been populated and will be discussed at board meetings.

Figure 4 - HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE ALLIANCE - BOARD REGISTER OF INTERESTS, 2009-10

Name and position	**Any Executive or Non-Executive Directorship of a company**	**An interest* or position held in any firm, company or business which is trading with the Trust or likely to be considered a potential trading partner with the Trust**	**An interest in an organisation providing health and social care services to the NHS**	**A position of authority in a charity or voluntary organisation in the field of health and social care**	**Any connection with any organisation, entity or company considering entering into a financial arrangement with the Trust including but not limited to lenders or banks**
Kathy Sienko (Chair)	Director, Able2 Rehabilitation Solutions Limited since 2004; Director of Consulting Operations, Cerner UK Limited	Provides case management services on behalf of insurance and legal sectors. Does not undertake rehabilitation case management services to the NHS; Cerner UK Limited. Provider of Health IT solutions to the NHS	NED – NHS Hounslow	Trustee, First Hand Foundation. Cerner charity focused on the needs of children and young people	None
Judith Rutherford NED	Anderford Ltd 2007 to date executive director	Anderford is unlikely to trade in the health sector and I will declare it if this happens	NED – NHS Richmond	January 2009 - Director of the London Skills and Employment board as an employee of the London Development Agency.	None
John Thompson NED	None	None	NED – NHS Richmond	Lay member of the Executive council of the College of Optometrists	None
David Hawkins Acting Director of Finance	None	None	None	None	None

Name and position	Any Executive or Non-Executive Directorship of a company	An interest* or position held in any firm, company or business which is trading with the Trust or likely to be considered a potential trading partner with the Trust	An interest in an organisation providing health and social care services to the NHS	A position of authority in a charity or voluntary organisation in the field of health and social care	Any connection with any organisation, entity or company considering entering into a financial arrangement with the Trust including but not limited to lenders or banks
Nikki Hill Associate Director of HR & OD	None	None	None	None	None
Jo Manley Chief Operating Officer (Hounslow)	None	None	Husband works at WMUH in Information Dept	None	None
Rachael Moench (Director of Human Resources)	None	None	None	None	None
Richard Tyler (Managing Director)	Director – Norbiton Consulting Ltd	None	None	None	None
Caroline White,	Director, Oakview Management Company Ltd - a private residential management company	Director, First Access Solutions Ltd - a consultancy offering interim management, training, coaching and development services	None	Associate Consultant, Royal College of Nursing Consultancy Services Non-Executive Committee Member, Clinical Strategy Committee, Princess Alice Hospice, Esher	None

3.2 Information Governance

Introduction

Information governance (IG) is the way in that information (in particular personal and sensitive information) relating to patients, clients and employees is handled by the NHS.

For the year 2009-10, an information governance support service was provided to the Alliance by NHS Hounslow and NHS Richmond under a temporary service level agreement (SLA) with the PCTs. The SLAs covered the following areas: records management and access to health records; data protection; freedom of information requests; Caldicott Guardian support and guidance; information governance training (including proactive promotion of best practice sessions at induction and open days; advice and guidance on information governance issues and incidents; policy development; preparation for and completion of the annual information assessment using the IG toolkit

Areas for improvement

Data loss:

There were two incidents that that involved the direct loss of confidential patient information by staff. In April 2009 there was the loss of a USB memory stick. The memory stick was lost within Heart of Hounslow Health Centre and contained identifiable information In May 2009 a hand written log sheet containing the names and addresses of patients disappeared from within the A&E Unit at West Middlesex hospital. The log sheet belonged to an Alliance service.

In both these cases the loss of information was reported to the Information Commissioner's office (ICO). Following this work then commenced with the ICO to ensure that appropriate measures were put in place to prevent a re-occurrence of future data losses.

In July 2009 the ICO declared that it was satisfied with the measures taken by both the Alliance and NHS Hounslow and that it would be taking no further enforcement action.

Achievements:

Information Governance Toolkit – version 7

The information governance toolkit is an online system that allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. Following a self-assessment Richmond PCT, covering both commissioner and provider services, was 70% with the score for Hounslow PCT being 74%.

Archival storage of patient and corporate records

Data encryption: Richmond PCT has now completed its data encryption activities with the restrictions now being placed on the use of USB sticks. Only encrypted sticks issued by the IT Team may be used to download data.

Freedom of Information

During 2009 both PCTs continued to employ their own provider functions. Therefore Freedom of Information requests that were made were dealt with by the respective PCT processes and are reported separately in this section.

Richmond and Twickenham PCT

A total of 27 requests were received during the period April 2009 – March 2010 for the Provider Arm. The number of Freedom of Information (FOI) requests received by Richmond and Twickenham PCT varies month to month, but overall there has been a significant upward trend with a 350% increase over last year during the same period. The majority of requests generated came from commercial companies.

The type of requests that were received are as follows:

• Osteoporosis Approach • Future Organisation of Provider • Provider Services • Counselling & Physiotherapy Waiting Times • Pressure Area Equipment, Beds and Hoists Contract • Parking at TMH • Continuing Care • Estates – capital budget	• OT Team contacts • Estates Maintenance • Companies Contracted to CHS • Walk-In Centre/ GP Led Centre • Catering Complaints and Contract • Physiotherapy Services • WIC meeting 4 hour target

The Freedom of Information Publication Scheme, which was last updated and approved in February 2009, is still valid and in line with the Information Commissioner's Guidance. It is published on the NHS Richmond website under the Freedom of Information portal.

Hounslow PCT

A total of 31 requests were received during the period April 2009 – March 2010 for the Provider Arm of NHS Hounslow.

The types of requests received were as follows:

• Future Organisation of Provider • Provider Services • Hand Hygiene policy • Spend on staff • Staff Away days • End of Life Care • Wound therapy	• Employment of illegal immigrants • Public Interest Disclosure Act • Compromise Agreements • Chlamydia testing

Freedom of Information introduction and classes of information is published on the Hounslow PCT website.

Future objectives

On 31 March 2010 the SLA with Hounslow came to an end. The Associate Director of Corporate Affairs of Hounslow & Richmond Community Healthcare is reviewing the arrangements for information governance and a new structure will be put into place.

4. Workforce

Introduction

We are committed to providing a responsive and innovative working environment plans so that we attract and maintain committed and motivated staff. During 2009-10 the focus of Human Resources/Organisational Development service was on ensuring the correct organisational structure is in place, and engaging staff to facilitate a smooth transition and commitment to the new organisation.

Objectives/Targets and Achievements for 2009/10

Objective One: Establishing the correct structure for the new organisation

- The corporate structure has been consulted upon and agreed. A strong Board and senior management team have been recruited

Objective Two: Developing strong leadership and vision for the organisation

- The newly appointed members of the senior management team have developed the vision and values of the Alliance and these have been publicised to staff.
- During 2010-11 strong leadership from the senior management team will be required to ensure the focus on achievement is maintained whilst work on the final end state of the organisation is also progressed.

Objective Three: Maintain a focus on the productivity agenda

- Sixteen members of staff are undertaking productivity projects across the organisation. They are supported by external expertise in 'Lean Thinking'.
- HR staff proactively monitor sickness absence rates and assist managers in dealing with this.

Workforce characteristics

Figure 5 – Staff numbers

Number of staff	Total for the Alliance	Hounslow based staff	Richmond based staff
Whole time equivalents	905.00	432.39	472.61
Headcount	1109	515	594

The Alliance has supported staff to achieve their work-life balance by enabling them to work flexibly where possible. For many staff this means that they work part time hours, hence the headcount figure being greater than whole time equivalents. Staff are also making use of other flexible work arrangements such as term time only contracts the annual staff survey shows that over three-quarters of staff reported that they work flexibly (77% in Richmond and 80% in Hounslow).

Sickness Absence

The table below shows that the level of sickness absence varied from 3.3% in August to 4.3% in October and December. The overall level was 3.7%. There are a number of contributors that have to be considered and which could potentially have had a much higher impact. Swine flu or H1N1, although not as severe as first anticipated, did impact staffing levels during the later part of 2009 and early 2010.

The organisation strives to achieve the lowest possible rate of absence, and when compared to the rates for PCTs, London sector and Trusts in England we are still achieving a rate lower than average.

For the period April 2009 to December 2009 the average sickness absence rate for Trusts in England and PCTs was 4.6% and 3.9% for London.

Figure 6 – Average Sickness Rates

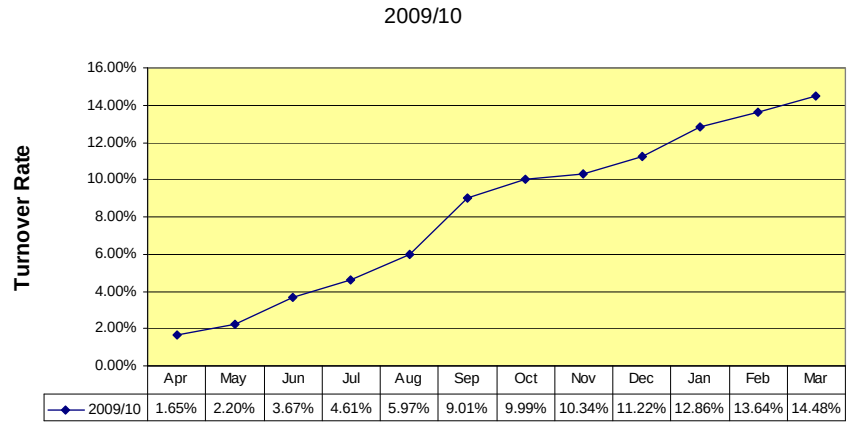
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative Rate
Monthly Rate	3.6%	3.7%	3.5%	3.9%	3.3%	3.5%	4.3%	3.8%	3.8%	4.3%	3.5%	3.5%	3.7%

Turnover

We aim to reduce turnover rates by providing excellent learning and development opportunities to our staff. Continued improvements in the appraisal system, access to training and development opportunities and addressing highlighted issues within the staff survey results are all contributing to improved staff satisfaction.

The organisation's cumulative turnover rate for the year is 14.48%. Benchmarking data is not currently available but in recent years the national average rate has been between 13-14% which would make the Alliance slightly higher than average.

Figure 7 - Turnover



Vacancy Rates
Vacancy rates varied from a high of 16.7% in April to 12.1% in November. At the end of the year the rate was 12.7%. It is positive to see a reduction in turnover rates in the second half of the year.

Figure 8 – Vacancy Rates

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Rate	16.7%	15.5%	15.1%	15.0%	13.8%	14.2%	13.0%	12.1%	12.8%	12.8%	13.0%	12.7%

What we achieved in 2009-10

The main priorities over the last year have been to develop a strong infrastructure for the new organisation whilst continuing to deliver ongoing improvements to the working lives of employees. This will ensure that we continue to attract and retain motivated staff across the organisation. In order to do this we have achieved the following:

- Agreed and recruited to the corporate structure of the Alliance
- Developed the values of the organisation based on consultation with staff
- Commissioned a productivity programme and supported 16 members of staff in developing action plans to realise productivity improvements across the services in the Alliance. Outputs from these projects will begin to impact early in 2010-11. The staff are continuing to be supported and work collaboratively by participation in ongoing action learning sets and advanced skills development workshops. Learning from this first cohort of staff will be used to refine the next productivity programme in September 2010.
- Sickness levels have been monitored closely and reported back to managers to enable them to target both long term and short-term sickness. The HR department has also been working closely with Occupational Health to put appropriate arrangements in place to support staff returning to work following periods of long term absence.
- To improve the effectiveness of management at line, middle and senior levels management development training opportunities have been significantly increased in Richmond. This has been through the introduction of a comprehensive management development programme. Hounslow has extended its management development training through the extension of the Introductory Certificate in Management to cover a wider range of key management skills. Managers across the Alliance have also had extensive opportunities to develop in areas such as project management, social marketing, and influencing and presentation skills.
- We have continued to drive to improve good management through a sustained focus on increasing the proportion of staff with appraisals throughout the year. In 2010-11 we will also be working with staff and managers to enhance the effectiveness of appraisals.
- The Alliance continues to support the development of pre registration nursing students through the provision of high quality placements. Evaluations have been very positive, highlighting the support that our mentors offer to students. We also support specialist practitioner students including health visitors and district nursing.

Figure 9 – 2010-11 Plans and Targets

Plans	Targets
TUPE transfer operational staff to the Alliance	Staff transferred by May 2010.
Transfer the Alliance to organisational end state	Undertake consultation on the transfer of the organisation by October 2010 Affect transfer to new organisation by May 2010
Undertake organisational development interventions to ensure that the Alliance rapidly develops into a high performing organisation	Agree the key OD interventions for the next year by June 2010 Review OD Strategy 2009 by September 2010 Develop and agree a common approach to performance management by December 2010 Review effectiveness of implementation by April 2011
Provide workforce development to deliver service transformation	Workforce development plan developed by September 2010. Learning and development plan reviewed to facilitate changing roles by October 2010
Develop and implement an action plan in response to staff survey findings	Action plan developed by May 2010.
Provide an HR/ OD service to NHS Hounslow and NHS Richmond	Agree and monitor provision against service level agreements. Agree longer term requirements for HR/OD and develop a plan to transfer to new arrangements
Implementation of a talent management strategy	To have established a talent management board and policy
Reduction in sickness absence	Maintaining a sickness absence rate below 3.5% for the year.
Increased uptake of statutory and mandatory training	Enhanced reporting capabilities following move to a combined Oracle Learning Management System Achievement of target attendance rates

5. Quality

5.1 Patient Safety

5.1.1 Clinical Risk Management Annual Report 2009-10

Overview

Throughout 2009-10 we have worked to raise the profile of patient safety and the management of risk throughout the organisation to encourage a culture where reporting rates of untoward incidents increase and incidents are discussed openly. Through increased reporting and open discussion we are able to learn from errors and reduce the chance of them happening again in the future. The organisation has focused on ensuring individuals at all levels and in all roles report patient safety incidents, whether or not patient harm occurred or not. In line with the National Patient Safety Agency's *Seven Steps to Patient Safety*, action has been taken to improve awareness of patient safety amongst all staff groups.

The aim of the risk management programme, within the provider arm, has been to make the effective management of risk an integral part of everyday management practice. To achieve this, it is intended that a comprehensive and cohesive risk management system will be put in place, underpinned by clear accountability arrangements throughout the organisational structure.

The service has been successful in encouraging a culture, where reporting rates increase and incidents are discussed openly, thereby learning from errors and reducing the chance of them happening again in the future. The organisation has focused on ensuring individuals at all levels and in all roles report patient safety incidents, whether or not patient harm occurred. In line with the National Patient Safety Agency (NPSA) *Seven Steps to Patient Safety,* action has been taken to improve awareness of patient safety among all staff groups. (The seven steps are Building a safety culture; leadership; risk management activity; reporting; working with patients and the public; learning the right lessons and implementing solutions). Throughout the organisation, reporting of all incidents and near misses regardless of severity is mandatory.

Achievements

- The Clinical Risk Team worked with professionals across Hounslow and Richmond to ensure that as an organisation we are achieving high standards of care for our local

- The team identified a number of training areas that needed to be addressed and have implemented and monitored action plans over 2009-10. In Richmond there were low uptake levels amongst staff for Root Cause Analysis (RCA) Training and incident investigators. In Hounslow it was noted that the numbers of staff trained within the provider services had dwindled due to staff changes. A programme of RCA training was therefore commenced to build up numbers as part of the Personal Development Prospectus. The team have been working with staff to increase the numbers of staff trained in Root Cause Analysis in order to meet the requirement of the Serious Untoward Incident (SUI) Framework by September 2010.
- During 2009 -2010, the Clinical Risk Management Team has supported professionals in Provider Services, to achieve high standards of care, in line with local and national priorities. The risk management organisational structure is robust and supports the implementation of risk management throughout the organisation. To support this, the Provider Board ratified the Risk Management Strategy in March 2010. A policy for the Management of Incidents and Serious Untoward Incidents was also ratified in March 2010 and is currently under review, to meet requirements of the NPSA Framework *for the Reporting of Serious Incidents*.
- The improvement of risk registers.

Risk Registers

Following a review by the Clinical Risk Management team, it was agreed that both the Board Assurance Framework (BAF) and risk registers needed to be improved. Extensive training on risk registers was delivered and further support has been identified as required.

Incident Reporting

Slips, trips and falls incidents still provide the largest category of reported incidents and a review of slips trips and falls is being undertaken at Teddington Memorial Hospital. The dissemination of learning from incidents and the robust monitoring of action plans is high on the agenda of the Clinical Risk Management Team

Being Open

The development of a Being Open Policy has now been initiated with Hounslow and Richmond Community Healthcare Alliance. The role of Senior Clinical Counsellors has been written into the job descriptions of specific senior roles within the organisation. A bespoke training package has been developed by Kingston University, to train the Senior Clinical Counsellors in accordance with NPSA requirements. *Being Open* training is an ongoing rolling programme and all staff are encouraged to prioritise this.

Central Alerting System (CAS) Alerts

In December 2009, the NRLS requested the closure or status of all open CAS alerts across all London PCTs. The teams for both PCTs had to review a total of 288 open CAS alerts dating back to 2004. The deadline set by the NRLS was achieved and all CAS alerts are now very closely monitored and scrutinised, to ensure compliance with requests regarding actions required.

Data from NPSA SUI London and local reports

The figures for reporting clinical incidents to NPSA have fluctuated over the years and cannot be attributed to any one reason. The aim is to see evidence of an increase in figures, to reflect the robust training and awareness of incidents in the organisation. It is anticipated that as a result of the implementation of the principles of being open, and the embedding of a fair safety culture within the organisation, the reporting of all incidents will significantly increase.

Figures 10 & 11: NHS Richmond Clinical Incidents

Clinical Patient Related Incidents Exported to NPSA					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Clinical Incidents 2007/2008	55	48	51	45	199
Clinical Incidents 2008/2009	37	37	45	58	177
Clinical Incidents 2009/2010	77	48	81	48	254

Clinical Incidents by Category 2009/2010					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Accident that may result in personal injury	6	1	4	3	14
Violence and Aggression	1	1	5	1	8
COSHH	0	0	0	0	0
Diagnosis / Treatment	8	3	7	0	18
Drug / Medication	2	5	4	2	13
Electrical	0	0	0	0	0
Equipment	5	0	1	1	7
Slip, trip, fall	43	35	55	39	172
Healthcare Records	10	1	4	1	16
Infection Control	0	1	0	0	1
Information Governance	0	1	0	0	1
Security	0	0	1	0	1
Contact with sharps or needles	0	0	0	0	0
Staffing issues	2	0	0	0	2
Fire Incident	0	0	0	1	1
Vandalism	0	0	0	0	0
Totals:	77	48	81	48	254

Figures 12: NHS Hounslow Clinical Incidents

Hounslow Clinical Incidents by Category 2009/2010					
	Q1	**Q2**	**Q3**	**Q4**	**Total**
Injury/ Ill Health Staff, Contractors	6	5	2	4	17
Injury/ Ill Health Patient	1	4	3	1	9
Medical Records	4	11	6	3	24
Medicine	12	14	24	10	60
Needlestick & Sharps	2	1	2	3	8
MRSA	0	0	0	0	0
Other Clinical Related Incidents including	11	4	18	16	49
Clinical Waste	1	0	0	0	1
Medical Devices/Equipment	0	0	1	1	2

Access, Admission, Transfer and Discharge	6	12	10	7	35
Grade 2 & above Pressure Sores	0	1	0	8	9
Treatment and Procedures	1	2	5	3	11
Violence, Abuse, Harassment & Bullying	4	8	2	3	17
Informal Complaints	1	0	0	0	1
COSHH	0	0	0	0	0
Health and Safety	3	1	4	0	8
Totals	**52**	**63**	**77**	**59**	**251**

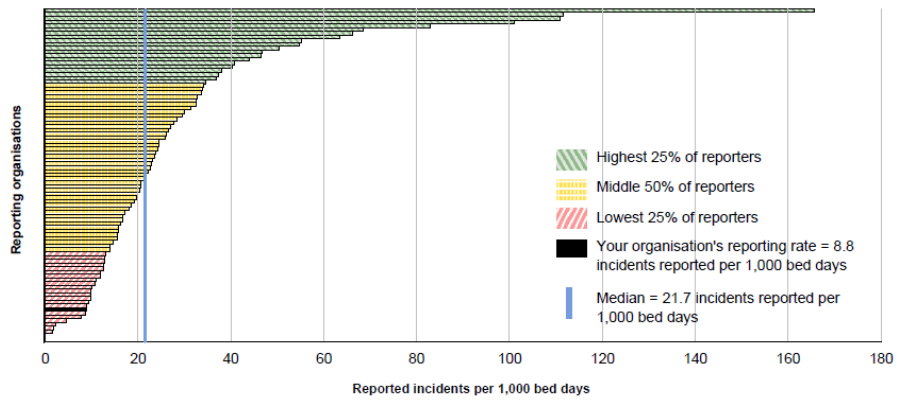
Benchmarking data (trends/comparative local, sector, London &/or national)
The main benchmarking tool for Incidents is released through the National Patient Safety Agency (NPSA). This report gives a retrospective report of patient safety incidents downloaded on to their system through the patient risk teams. The reports are published on the NPSA website in March and September of each year.

Each PCT is clustered into groups of similar service provision. The NPSA uses standard benchmark grouping, as used by other parts of the NHS. NHS Hounslow is clustered in a total of 85 Primary Care Organisations (PCO) – No inpatient Provision and NHS Richmond – a total of 89 PCO with Inpatient Provision. To see the names of all organisations within each group, please visit www.nrls.npsa.nhs.uk.

NHS Richmond: NPSA Reports 2009

Figure 13: Comparative Reporting Rate (source: NPSA)

The comparative reporting rate summary below provides and overview of incidents reported by our organisation to the National Reporting and Learning System (NRLS) between 1 April 2009 and 30 September 2009. 105 incidents were reported during this period.



Note: a discrepancy in the reported figures of incidents was highlighted to the NPSA and the National Reporting and Learning System in March 2010 as the trend of incidents for the 3 reports currently available per 1,000 bed days has ranged from 6.89, 91.9 and back to 8.8. This has been investigated and the figures will be amended.

Figure 14: NHS Richmond NPSA NRLS report Feb 2010 (April 2009 – September 2009).

Type of incidents reported by our organisation

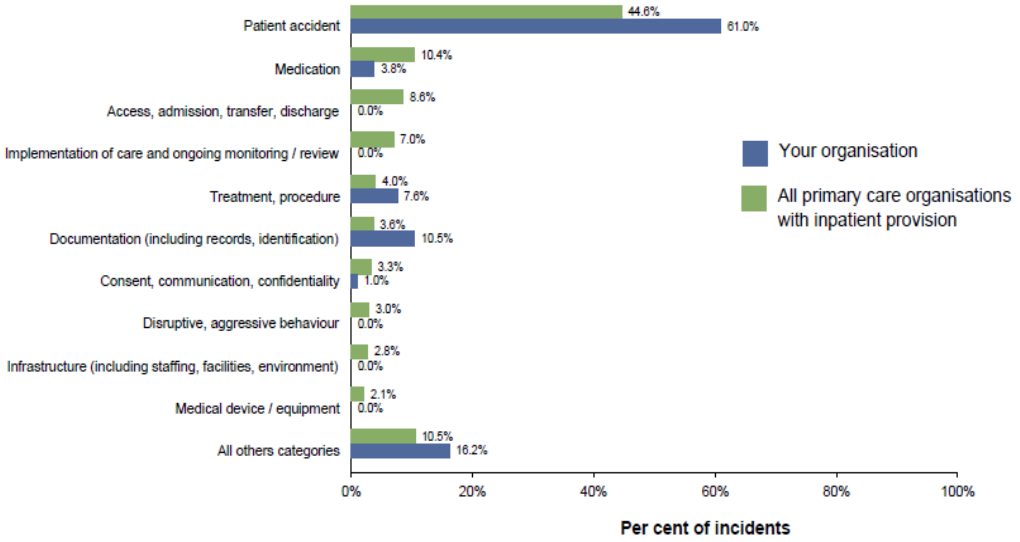
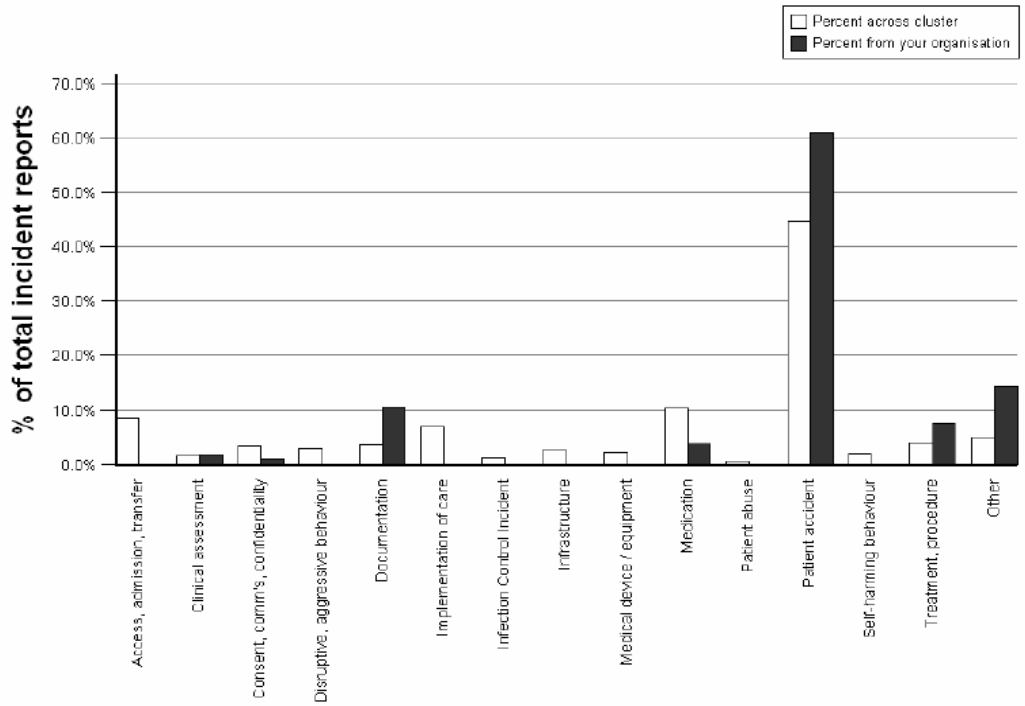


Figure 15: Incident Type (shows comparison of the types of incident that occurred in NHS Richmond organisation and in other organisations in the cluster). (source: NPSA)



NHS Hounslow: NPSA Reports 2009

Figure 16: Comparative Reporting Rate (source: NPSA).

The comparative reporting rate summary below provides and overview of incidents reported by our organisation to the National Reporting and Learning System (NRLS) between 1 April 2009 and 30 September 2009. 91 incidents were reported during this period.

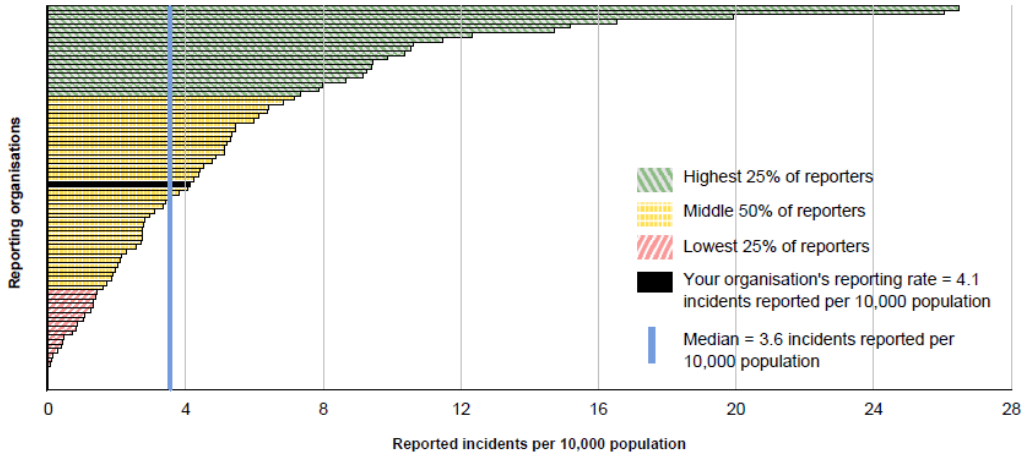


Figure 17: NHS Hounslow NRLS Report Feb 2010: types of incidents reported (April 2009 – September 2009) (source: NPSA)

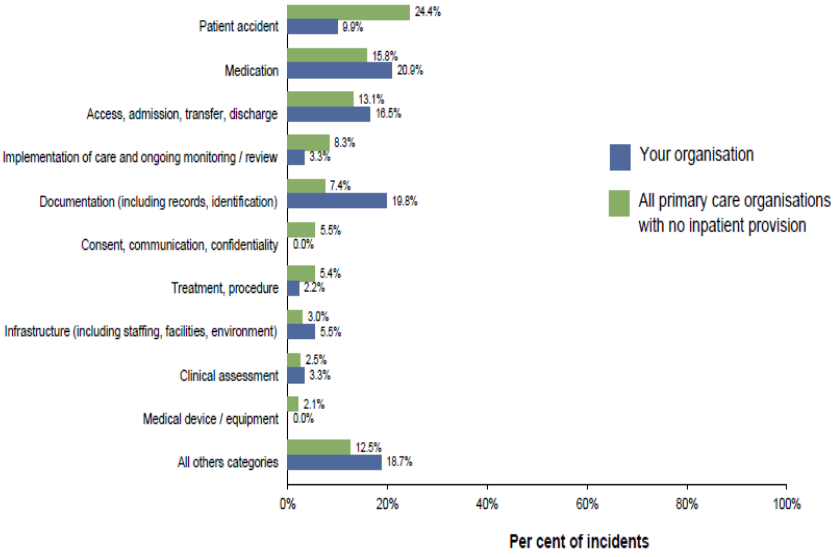
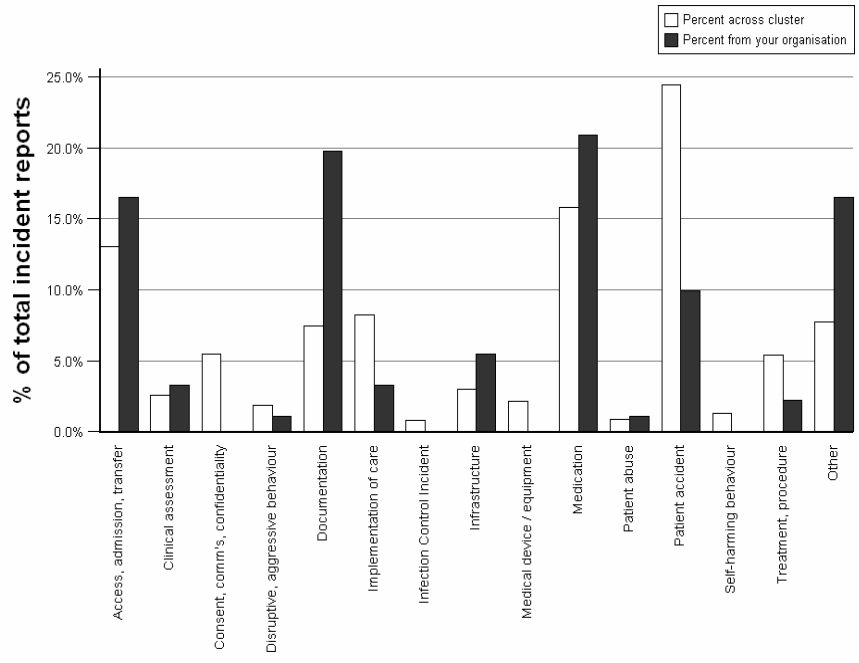


Figure 18: Incident type: Comparison of types of incident that happened in HPCT organisation and in other organisations in the cluster. (source: NPSA)



Serious Untoward Incidents (SUIs)

An SUI can be defined as something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service. SUIs are not exclusively clinical issues, for example, an electrical failure may have consequences that make it an SUI.

During 2009/10 Hounslow Community Healthcare reported 10 SUIs compared with 4 SUIs that were reported in the preceding year. Richmond Community Health Services reported 9 SUIs compared with 1 SUI in the previous year.

The reason for the increased number of SUIs was because of raised awareness, both of reporting of incidents in general and recognition of the definition of an SUI. The raised awareness was created externally through NHS London and internally through training and changes in managerial understanding.

Investigations following these incidents led to the following actions/recommendations:

- An audit of all staff to establish knowledge of information governance issues; a review of information governance training; a review of the Caldicott code of conduct and a review of staff use of electronic device usage.
- A review of organisational processes, policies and procedures and the training programme relating to the Tissue Viability Service.
- A review of the emergency escalation process for child protection and awareness raising of staff child protection issues.
- Action plans were put in place to maintain a safe health visiting service, and an open and transparent culture for staff.
- Awareness raising of the NHS zero tolerance policy, and policies and procedures around violence and aggression were widely communicated.
- Information governance training was made more robust and effective, and clear policies and procedures put in place for checking of clinical letters. Protocols were put in place to

- All referrals to safe haven faxes must be followed-up with a telephone call.
- Ward staff reminded on the importance on customer care, boundaries and respecting individual needs of patients. Staff trained in the importance of adhering to safeguarding policy.
- All staff to attend specifically designed training on customer awareness and violence and aggression and conflict resolution. PALS service to notify service leads when a complaint received.
- Supervision training for all staff working in a supervisory capacity in relation to safeguarding children was highlighted and now takes place. Need for practitioners to use robust risk assessment tools highlighted.
- All staff reminded to be constantly aware that patients with a level of confusion can be at risk of absconding.
- A designated clinician on site is now responsible for management and audit of the fridge at Teddington Health and Social Care Centre. Clear leadership now in place following a review of district nursing teams.

Looking to the future

Future targets for the team include the successful Implementation of Datix Web. The implementation of Datix Web across the Alliance will improve reporting of incidents. Other targets include a single incident report with trend analysis across Hounslow and Richmond; the implementation of a robust action plan monitoring programme; CAS alerts system across the Alliance; 10% of staff to be trained by September 2010, to achieve a pool of multi disciplinary teams to carry out RCA investigations at short notice; Embedding of the principles of *Being Open* in the organisation and senior clinical counsellors trained; Board level commitment and public statement embracing the principles of *Being Open* and the completion of the Manchester Patient Safety Framework assessment tool across the organisation.

5.1.2 Safeguarding Adults and Children

Introduction

The Alliance believes that safeguarding children, young people and vulnerable adults is 'Everyone's Business'. We are committed to ensuring that the risk of physical, sexual or emotional harm to all children, young people and vulnerable adults is minimised and have been working hard to ensure that all patients and service users are cared for safely.

Following the tragic death of 'Baby P' the Care Quality Commission (CQC) was asked to undertake a review of all NHS Trusts, which was carried out in February 2009. This safeguarding children's review provided the Alliance with an opportunity to look at its local arrangements for safeguarding children and to focus on the key areas that we identified as needing strengthening.

In order to ensure safeguarding was given the priority and focus it required within the new provider organisation, a new Assistant Director for Safeguarding position was created and appointed to in March 2010. The new Assistant Director will lead on all aspects of safeguarding children and vulnerable adults, ensuring minimum standards are not only maintained, but also improved upon.

What we achieved in 2009-10

Safeguarding Children Priorities
Following the safeguarding review outlined above, the Alliance identified two areas of practice that required strengthening:

- Safeguarding training
- Safeguarding audit

Safeguarding Training
The safeguarding review demonstrated that it was not possible to show evidence that staff had undertaken appropriate safeguarding training due to two main issues:

- There was a lack of clarity as to what level of safeguarding training staff needed to undertake
- There was no clear process for staff training undertaken externally, to be notified to the organisation's Organisational Development Team and subsequently recorded electronically.

As a new provider organisation working across two boroughs, it was essential to ensure one consistent process across both areas for staff booking and confirming attendance on safeguarding training courses.

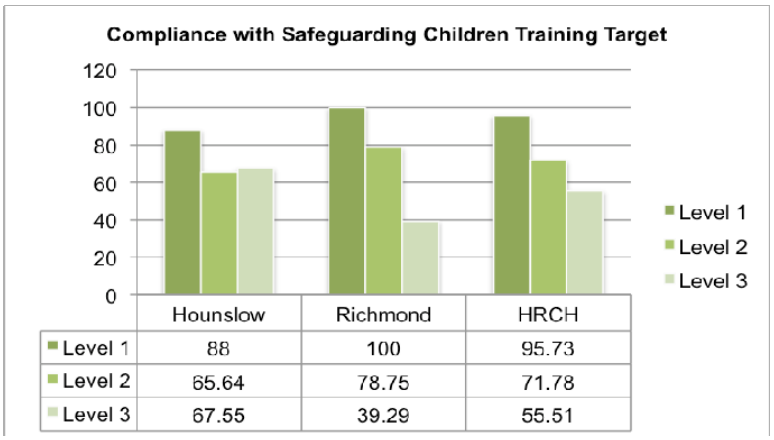
In addition, it was essential that staff were clear as to the level of training they needed to undertake for their role and responsibility for safeguarding and that there were sufficient safeguarding training courses to meet the need for all staff to be trained by the 31 March 2010.

During the year, safeguarding training has been a priority for the Alliance and the safeguarding team have delivered the following number of level 1 and 2 courses:

Figure 19: Number of courses delivered

Through the prioritisation of staff attendance at the above courses it was hoped that the organisation would achieve its target of 85% of all staff having had the safeguarding children training they needed for their role and responsibility. The data for staff compliance with training at the level necessary for their role and responsibility is as follows:

Figure 20: Compliance with Safeguarding Children Training Target



	Hounslow	Richmond	HRCH
Level 1	88	100	95.73
Level 2	65.64	78.75	71.78
Level 3	67.55	39.29	55.51

The level 1 target of over 85% of all employees having received this training has been achieved, with current figure reaching 95.73%. It was apparent that although good progress had been made with improving the % of staff trained at level 2, the organisations target of 85% had not been achieved. Additional level 2 training sessions have been commissioned and the data will be re-evaluated at the end of June 2010.

In addition to the in-house training provided to staff as outlined above, staff that work predominantly with children and their families are required to undertake training on a multi-agency basis. Both Richmond and Hounslow Borough Councils provide this and work is ongoing to ensure that there are sufficient courses commissioned to meet the needs of all staff working in both the Hounslow and Richmond localities.

Commissioning of services
The under 5 population for Hounslow is significantly larger than that of Richmond – Hounslow 14,247 to Richmond 11,828; children aged 5 to 16 years 32,508 and 22,225 in the respective boroughs.

Two commissioners, NHS Hounslow and NHS Richmond, currently commission Universal Services (services for those aged 0-18) separately. NHS Hounslow has taken account of the recruitment issues and worked with the Assistant Director for Children and Families for Hounslow to commission core services focussed on new birth contacts, safeguarding children and child protection. NHS Richmond has commissioned services to meet the 'Healthy Child Programme' (2009) as well as safeguarding and child protection.

The Healthy Child Programme (HCP) has a series of routine contacts with families from the antenatal period; new birth; 6 – 8week; 8months to 1year; 2 to 3 years and 3 to 4 years. This combined with targeted visits for those defined as having additional vulnerabilities identified through the HCP. A further HCP in relation to children aged 5 to 19 years was issued in November 2009 and the school nurse team are working toward this programme of targeted and supportive work in Richmond.

Staffing

Both health visiting services employ a skill mixed approach to service delivery with the use of health visitors (band 6 and 7), staff nurses (band 5) and nursery nurses (band 4), Hounslow also utilises the skills of support workers whilst Richmond has only recently received administrative support to the teams.

Figure 21: Staffing Levels in Hounslow and Richmond

Area	Health Visiting	Vacancies	Staff/ Community Staff Nurse	Vacancies	Nursery Nurses	Vacancies	Support Workers	Vacancies	Admin support	Total staffing
Hounslow	25.89	7.74	16.44	4.19	10.44		11.88			52.77
Hounslow LA funded	2									
Richmond	24.7	3	2	1	13.4	0	0		4.4	44.5
Richmond LA funded	0									

Richmond has a separate establishment for school nursing of 11.22wte with a remit to work within schools with children aged 5 to 16years. This team delivers the weight management, HPV, school screening and HPV programme.

These challenges are being managed by prioritising the new birth contact against a caseload with high numbers of children who have a CP plan and who are families identified with children in need.

Safeguarding and Workforce

Health visiting services across London have been identified as having lower than average staffing than some other parts of the country due to recruitment and retention difficulties.

The trade union (Community Practitioners And Health Visitors - UNITE) recommendations for staffing indicates that health visitors should have caseloads of approximately 350 families per

whole time equivalent, however this fails to take account of skill mix within teams and deprivation within caseloads leading to larger or smaller caseload sizes. Caseload sizes in Hounslow range between 600 to 900 whereas Richmond ranges between 350 to 600 with significantly different demographic factors.

Children Subject to a Child Protection Plan

As of 31 March 2010 there were 189 children in Hounslow subject to a child protection plan and 45 in Richmond. In addition to these families, Health Visitors and School Nurses also work with children in need where there are safeguarding concerns requiring additional support. In Hounslow there were 209 children in need cases and 251 in Richmond.

Child Protection Supervision

Hounslow and Richmond Community healthcare has an experienced safeguarding team, who not only provide formal child protection supervision on a quarterly basis to all staff working with children and their families, but are available for support and advice on a daily basis as required. This support is essential in ensuring high standards of safeguarding practice are maintained and that our staff feel fully supported in their safeguarding children practice.

Looking to the future

From 1 April 2010, the safeguarding teams have merged as one across Hounslow and Richmond, under the new Assistant Director of Safeguarding. A comprehensive work programme has been developed for the year, which will incorporate audit activity and supervision. The programme will be monitored on a quarterly basis by the Safeguarding Committee as well as report directly to the Board.

5.1.2.1 - A Day in the Life of the Assistant Director for Safeguarding, Debbie Daly

No day has been the same for Debbie Daly since she joined the Alliance in March. Her role is to safeguard adults and children from abuse in all its forms, making sure there are a number of systems, committees and Boards to achieve this.

“My days can be completely unpredictable but it’s a varied and worthwhile job. It’s very rewarding because good safeguarding practice can make a real difference,” says Debbie.

“On a typical day I start out by planning upcoming meetings, such as the Safeguarding Committee meeting that brings together all the senior managers for Children and Adult Services and Clinical Quality, as well as the Designated and Named Professionals for Safeguarding. We meet to make sure we are maintaining high safeguarding standards across the whole organisation.”

“Safeguarding audits are also an important part of our work – mid morning I might meet with some Health Visitors to investigate whether we have enough staff to protect local children. In Richmond we’ve had some problems with maintaining optimum staffing levels in the Health Visiting service – to fix this we’ve put in place action plans to ensure that our clients are not exposed to any risks, by prioritising families in greatest need and employing skill mix staff to support our Health Visiting teams.”

“I might take a call about an injured child and need to co-ordinate an urgent response, with important decisions to be taken about the child and its siblings. In cases like this we usually have a

number of options from family support up to and including intervention, such as a child protection plan or, as a last resort, removing the child from the home."

"After lunch I had my regular meeting with school nurses in Richmond, which gives them a chance to raise and discuss any safeguarding issues they have encountered. Before I head home I plan some training which I am due to deliver to staff next week, in order to increase their knowledge and awareness of safeguarding issues. Safeguarding is the responsibility of all staff within the organisation and it is important that everyone is aware of their role and what action they need to take if they suspect that there is a risk of abuse to a client."

"Tomorrow I am due to attend an Adult Safeguarding Board away day with the aim of improving standards for adult protection. Vulnerable adults include elderly and frail people, people with learning disabilities and mental illness and who rely on others - the often forgotten members of our society. Unlike children, whose rights are enshrined in laws such as the Children's Act, there is more limited protection in the case of vulnerable adults. My role involves close partnership working with our two neighbouring borough councils (Richmond and Hounslow) and other key stakeholders such as the acute trusts; police, commissioners and schools. We have Safeguarding Boards for Adults, and a separate Board for Children in both Hounslow and Richmond boroughs. These bring together representatives from all agencies that offer services to children, their families and vulnerable adults."

"To give a real life example, | previously supported a member of staff working with a family where Mum was not coping, the children were neglected and losing weight and with a poor attendance record at school. However following a year of working with them, providing intensive support and working with appropriate charities (who provided beds and cleaned the house), the children are now thriving in school, the family has remained together and the future looks brighter."

"Of course the downside of the job is where severe abuse of a child or an adult ends in injury or death. This is of course is very upsetting to me and all staff. Contrary to the public view the situation is not getting worse and there has fortunately not been a significant increase in the number of child deaths through child abuse. But there has been a big increase in public awareness. Many if not most of child deaths are in cases not originally known to the service. However, we need to be vigilant to ensure that not only do we avoid the situation deteriorating; we also make sure that we eliminate all forms of abuse against children or vulnerable adults."

5.1.3 Infection Prevention and Control

For further reading, the full Infection Prevention and Control Annual Report for 2009/10 is available on the Alliance website – www.hrch.nhs.uk. .

Hounslow & Richmond Community Healthcare has a dedicated Infection Prevention and Control (IPC) Team responsible for achieving IPC standards through audit, training, surveillance and providing advice to staff and patients to minimise the risk to patients of acquiring a healthcare associated infection (HAI). To meet this objective the team works to an annual plan of which the key work areas of 2009-10 are set out below. Progress is reported to the Joint Provider Board through the organisation's Infection Prevention and Control Committee.

In November 2009, the Care Quality Commission (CQC) carried out an unannounced inspection of the inpatient unit at TMH. No evidence was found that the Alliance had breached the regulation to protect patients, workers and others from the risks of acquiring a HAI and of the 17 measures inspected there were no concerns about 16. For the other measure regarding the decontamination of equipment, an area for improvement was identified and recommendations were made. Following this, an extensive review of the inpatient unit was carried out by the IPC Team in conjunction with the clinical lead for the unit and an action plan was produced to address the issues identified by the CQC, mainly concerning the fitness for use and cleaning of commodes. This was actioned immediately, with CQC recommendations put into place, and continues to be monitored closely by the IPC Team with regular auditing and spot checks carried out. In December the CQC contacted the organisation who was able to give full assurance that the area for improvement had been addressed. In January 2010 both Richmond and Hounslow registered with the CQC that the Alliance was compliant with The Code of Practice.

5.1.3.1 Day in the life of: Bobbie McNulty, Infection Prevention and Control Nurse

Infection prevention and control is taken very seriously by the Alliance, and Bobbie McNulty is one of the team in charge of making sure that we all follow best practice and protect our patients. Bobbie started working for NHS Richmond in March 2009, before moving across to the Alliance and joining the Infection Prevention and Control Team. Before that she had a long and varied career including working as a practice nurse and teaching.

"There's no thing as a typical day, but I normally start by checking my emails. We receive a large volume of routine and patient specific enquiries, ranging from questions about a specific infection or virus through to the treatment of a patient or the correct way to decontaminate a piece of equipment. I answer these in line with official guidance" says Bobbie.

"A lot of my work revolves around audits such as hand hygiene compliance – these are undertaken to make sure that the organisation complies with local policy, relevant legislation and guidance. If it's a hand hygiene audit I actually watch how clinicians clean their hands and make sure its being carried out at both the right time and the right way. I also check facilities such as basis, soap, hand cleansing gel, towels and foot operating bins. If anything is not right, I help staff make the necessary changes."

Bobbie also makes environmental audits, making sure that the facilities we work out of such as health centres are clean, that equipment is cleaned between each patient, that laundry schedules are in place and that staff are aware of their responsibilities.

Training is an important part of making sure staff know about infection prevention control. "I deliver mandatory annual infection prevention and control training sessions for staff. We also attend team meetings to provide training when invited to do so. We are working with the newly formed Infection Control Link Practitioners' group who are nominated representatives from each clinical area across Richmond and Hounslow and are being trained and supported to be infection prevention and control advocates and carry out hand hygiene compliance audits in their own areas or within their teams."

Bobbie says that working together with colleagues in acute hospitals and our commissioners is important to make sure that patient's concerns about issues such as MRSA and other avoidable healthcare acquired infections are alleviated.

"To achieve this we work to the Health and Social Care Act 2008 *Code of Practice* and make sure that infection prevention and control is everyone's business."

5.1.4 Medicine Management and Prescribing

Introduction

Medicines management can be defined as "…a system of processes and behaviours that determines how medicines are used by the NHS and patients. Good medicines management means that patients receive better, safer and more convenient care. It leads to better use of professional time and enables practitioners to focus their skills where they are most appropriate. Effective medicines management also frees up resources which means that NHS money can be used where it is most effective. Good medicines management benefits everyone" *(*Modernising Medicines Management. A guide to achieving benefits for patients, professionals and the NHS. National Prescribing Centre, 2001*)*

As the provider arms of Hounslow and Richmond came together in April 2010, the organisation being newly established has a small team defining the work plan for the forthcoming year and identifying systems and processes by which it will be monitored.

What we achieved in 2009-10

A Medicine Management and Non Medical Prescribing Committee has been established and met twice in November and February. Its role is to promote the safe, effective, evidence based and economic use of medicines. The Committee will support the development of non-medical prescribing (i.e. nurses, pharmacists, therapists, etc.) and ensure risk management systems around medicines management are in place.

Both Hounslow and Richmond have policies and procedures regarding safe use, prescribing, administration, recording, storage and disposal of medicines. There are also polices and procedures relating to controlled drugs and non-medical prescribing. These will be unified in the coming year.

Evidence for the Care Quality Commission relating to medicines management was collated from the two parent commissioning organisations, allowing both provider arms to achieve registration without condition with the Care Quality Commission.

Patient group directions (PGDs) have been reviewed and updated as part of an ongoing rolling programme. A PGD is a legal document that enables patients to receive prescription only medicines from authorised practitioners without the need to see a prescriber. It makes care more

accessible for example in GP practices or nurse led services such as the walk in centre, or family planning.

Non-medical prescribing is prescribing undertaken by healthcare professionals (i.e. not doctors and dentists) including nurse's therapists. All qualified district nurses and health visitors can now prescribe from a limited community practitioner formulary. In addition some nurses and therapists have undertaken an additional qualification to become independent or supplementary prescribers. In the Alliance there are currently 113 community practitioners and 23 independent prescribers

All medicine related incidents are investigated and reported. Action plans are implemented to prevent recurrence and learning is shared. Quarterly reports are reviewed at The Medicine Management Committee and learning outcomes shared. . It is planned to align the reporting process across Hounslow and Richmond for 2010-11.

Audits have been conducted and more have been included in the forthcoming programme. For example, community clinics in Hounslow were audited twice for safe storage of medicines. In response to the National Patient Safety Agency Reports and Alerts, further audits were conducted. An example includes Oxygen Safety in Hospitals. Following this plans were implemented to meet the actions required.

Looking to the future
The initial work undertaken to March 2010 has informed the work plan for 2010-11. The Prescribing and Medicines Management Team will support the managers in meeting Care Quality Commission Medicine Management Outcome 9.

The team will be carrying out an exercise to unify and audit all of the current medicine related policies and procedures across Hounslow and Richmond.

The Medicine Management and Non Medical Prescribing Committee will continue to support non-medical prescribing the organisation. The provider patient group directions will continue to be reviewed and updated. A non-medical prescribing forum will be set up in 2010/11 that will concentrate on providing non medical prescribers with opportunities to receive specialist peer review and training.

A training programme relating to medicine management will be planned and delivered to support safe legal and effective use of medicines.

Audits will be undertaken as part of the quality agenda to ensure that the Alliance continually improves on medicines management and the quality of care provided.

5.2 Patient Experience

Patient experience is at the heart of what we do as an NHS provider, embracing the quality of care we provide and also every contact made with the patient. If a patient has a bad experience this not only affects the patient, but also has a knock on effect on our reputation with their family, friends and acquaintances. It can also have an impact on staff morale and therefore recruitment and retention of staff. Finally, we need to show that we have listened to our patients and used the information they have given us to drive improvements to our service.

Within the Alliance, feedback from those who use our services is measured in several different ways, ranging from the Patient Advice and Liaison Service (PALS), complaints, queries, patient satisfaction surveys and audits, patient related outcome measures, and received compliments.

During this period complaints and PALS services for the provider services were provided through Service Level Agreements (SLAs) with the respective PCTs. The amended National Complaint Procedure published in April 2009 prompted a review of the existing policies and procedures in both organisations. We have now established quality performance metrics as part of the CQUIN process and have a set up a process within the Alliance for investigation and response to complaints. There is active encouragement to resolve complaints locally before recourse to the National Ombudsman.

The Patient Experience Strategy was ratified in April 2009 and sets out the following eight areas to focus on:

- Environment
- Communication
- Ability to feedback
- Ability to play a part in shaping and influencing services
- Quality of information available to patients regarding their treatment
- Support for family and carers
- Performance
- Media reports

The number of complaints and compliments received is reported monthly as part of the Strategic Health Authority performance metrics and quarterly as part of the contract management process with commissioners, including trend analysis.

5.2.1 Patient Advice and Liaison Service (PALS)

In 2009/10 PALS received 158 queries in Richmond and 142 Hounslow. The most common enquiries made about provided services usually concern how to access a particular service.

Under the SLA Hounslow PALS has developed an outreach programme, which has proved a successful tool for supporting minority communities to access healthcare. Examples of the locations where outreach work is carried out are:

- The Sri Guru Singh Sabha Gurdwara
- The Civic Centre
- Heart of Hounslow Centre for Health, Brentford Health Centre, Chiswick Health Centre and Feltham Centre for Health.
- West Thames College
- Health Promotion work with various teams throughout the Alliance.
- Outreach for asylum seekers
- Outreach at a Mosque event.

The Patient Experience Team has also made visits to:

- Local Involvement Network meetings
- Various patients' homes to assist them in queries relating to healthcare
- Feltham Town Centre

Some of the events/meetings that PALS have participated in are:

- Carers Week

- Equality Impact Assessment
- Multi Cultural Conference
- “Finding a Voice” Event
- North West London PALS Meetings
- The Alliance Corporate Induction
- The “Fit for Purpose” Consultation
- The Big Health Check Up for Learning Disabilities

Examples of PALS work carried out in Richmond during the year include a new ‘Easy Read’ A5 size PALS Leaflet, printed and distributed to Community Groups and appropriate clinical settings. The PALS Officer continues to make quarterly visits to a community group on the Edgar Road Estate. This is a good opportunity to provide updated information and answer queries about their health services and signpost to other services where necessary. PALS were also promoted at the ‘Full of Life Day’ for older people and the Learning Disability event at York House. The PALS Officer also attended the Big Health Check Up day in January, meeting with clients, promoting PALS and distributing the new ‘Easy Read’ leaflet to all attendees, residents, carers and support staff.

Figure 22: NHS Hounslow PALS contacts 2009/10

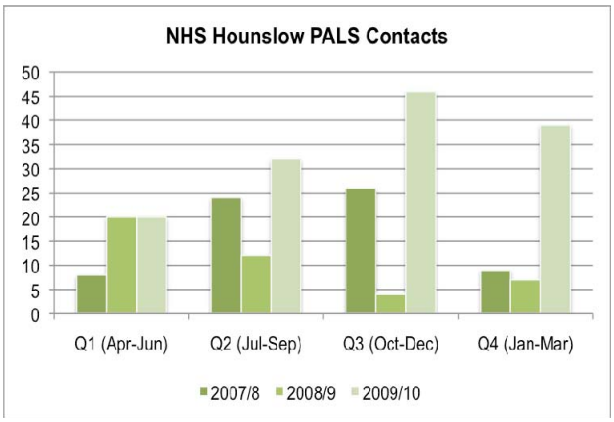
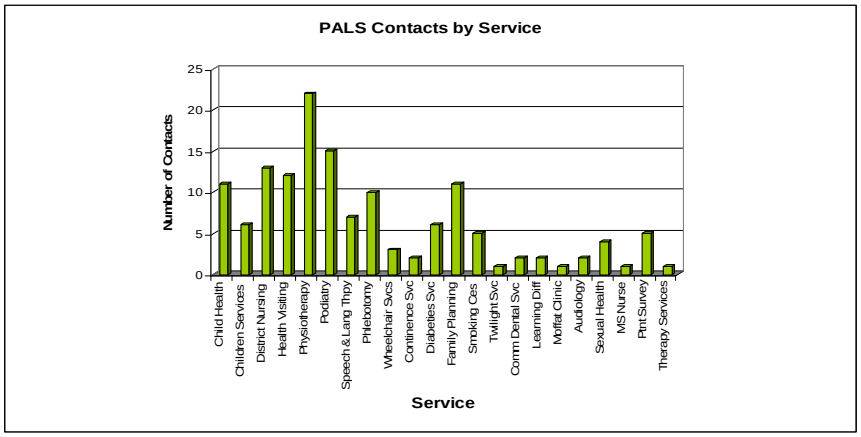


Figure 23: NHS Hounslow PALS Contacts by service 2009/10

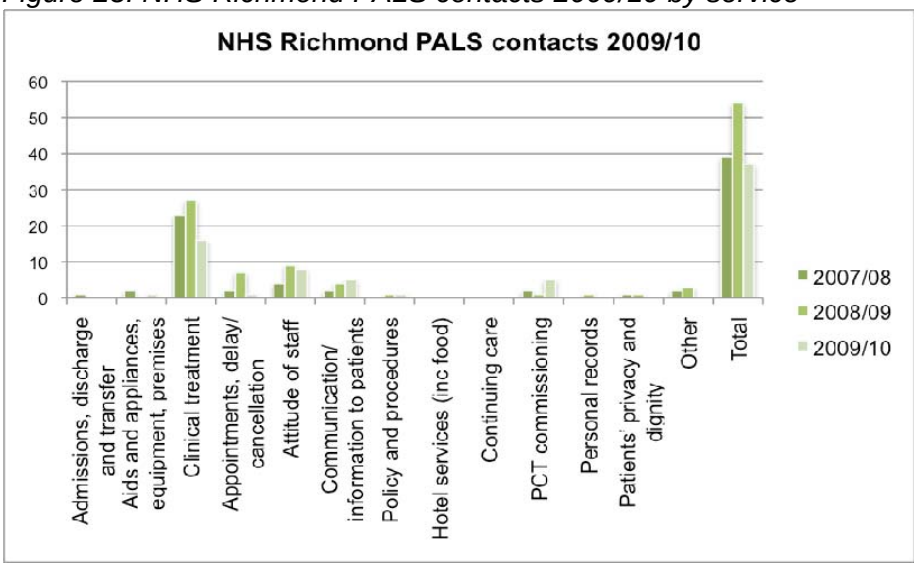


As can be seen from the graph, Physiotherapy Services have received the highest number of PALS calls (22), with Family Planning (11), Podiatry (15), and Health Visiting (12). District Nursing (13) and Child Health (11), all receiving in excess of 10 contacts.

Figure 24: NHS Richmond PALS contacts 2009/10

Main subject	2007/08	2008/09	2009/10
Admissions, discharge and transfer	1	0	0
Aids and appliances, equipment, premises	2	0	1
Clinical treatment	23	27	16
Appointments, delay/cancellation	2	7	1
Attitude of staff	4	9	8
Communication/information to patients	2	4	5
Policy and procedures	0	1	1
Hotel services (inc food)	0	0	0
Continuing care	0	0	0
PCT commissioning	2	1	5
Personal records	0	1	0
Patients' privacy and dignity	1	1	0
Other	2	3	0
Total	**39**	**54**	**37**

Figure 25: NHS Richmond PALS contacts 2009/10 by service



5.2.2 Complaints

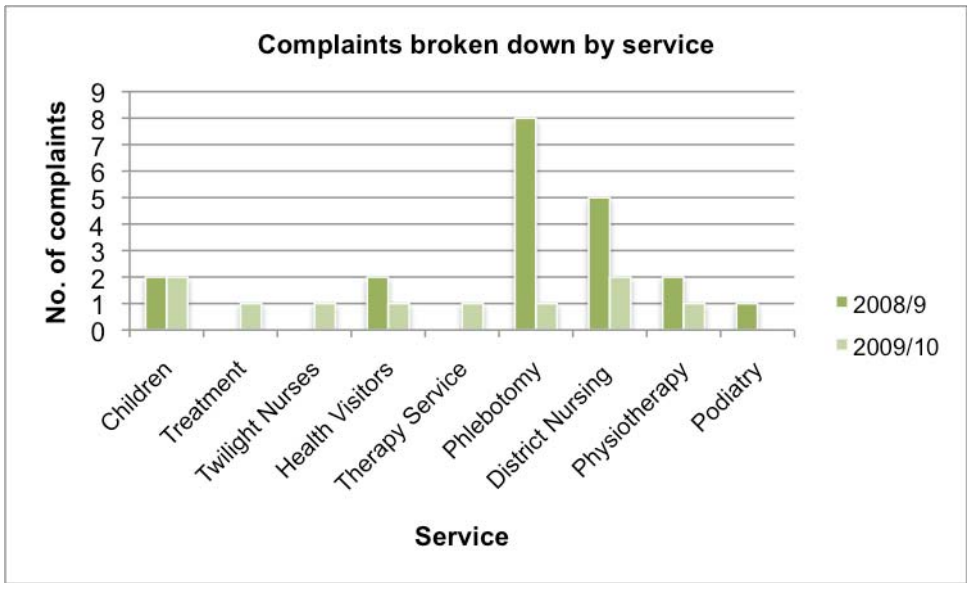
Greater emphasis is now being placed on showing that we have been listening to those who have made complaints and proving we have learned from them. It is important that action is taken and any lessons learned shared with relevant colleagues and discussed at staff meetings.

During the year a 'complaint action review form' was introduced for completion by the Patient Experience Team. This information is then captured on the complaints database. Where it is felt there could be organisation-wide learning, service leads are encouraged to publish details in the Staff Bulletin that is shared with all staff fortnightly. In NHS Richmond an audit of complaint action plans was undertaken to monitor the completion of action plans. Of the 22 (100%) returned audit questions, 19 (86%) indicated that action plans had been followed through, and 3 (14%) indicated partial follow through of action plans. 22 (100%) responses gave details of how action plans have been followed through (partially in some cases). 9 (41%) responses included documentary evidence. It is planned to repeat this audit across the Alliance for 2010-11

As a result of complaints received during 2009/10, a number of actions were taken and changes made to improve services. Some of these improvements have come about as a result of the Alliance's and NHS Richmond's ongoing service improvements, to which issues arising from complaints have added weight:

- Consent policy used by podiatry to be reviewed, and more information about treatment options provided to clients
- A GP practice developed an action plan to improve frontline customer care, which included the use of actors to help train staff using role play, and implementation of a CCTV system in reception.
- Staff on the Inpatient Unit reminded to place call bells within easy reach.
- Quality feedback newsletters were sent to GP practices and dental practices to highlight changes in the NHS complaints procedure.
- New complaints leaflet produced
- The PALS and complaint team continue to provide a training session at induction for all new PCT staff, and to GP practice staff.
- In line with the Health Service Ombudsman's guidance, the complaints team has an independent review/conciliation as an additional tool in resolving complaints by local resolution
- NHS Richmond produces the second audit of complaint action plans to assess the follow through of actions arising from complaints about CHSE was carried out. 86% of action plans had been followed through in full, and 14% had been partially followed through
- Ongoing evaluation of complaint handling satisfaction. We send out 20 complaint handling evaluation forms, five were returned and of those, three were satisfied or very satisfied that their complaint had been handled. Two were dissatisfied and very dissatisfied.

Figure 26: NHS Hounslow Complaints by service: April 2009 – March 2010

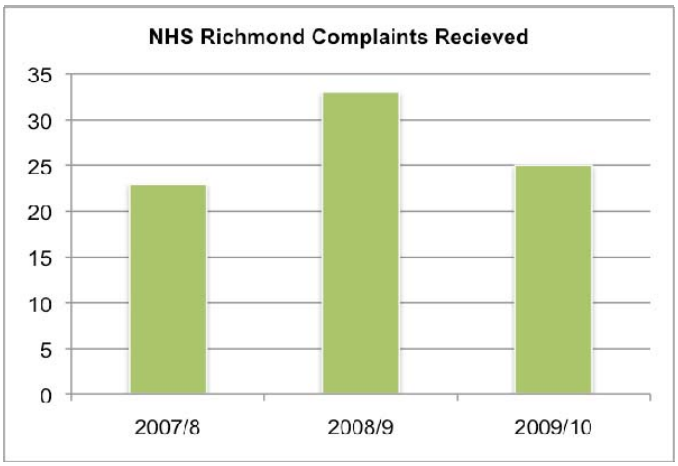


NHS Richmond complaints

Of the 25 complaints received in 2009-10, the breakdown was as follows:

- Aids, appliances and equipment (1)
- Appointments (outpatient) (1)
- Attitude of staff (6)
- Aspects of clinical treatment (11)
- Communication to patients (3)
- Waiting lists (3)

Figure 27: NHS Richmond Complaints



5.2.3 Compliments

Staff regularly receive compliments both verbally and written. The number each month is reported as a performance metric by NHS London.

5.2.4 Patient Satisfaction Surveys

Two patient postal surveys have been undertaken over the last year initially in April 2009 on 2,000 known patients identified by RiO (the electronic patient record system) in Richmond and led by an external firm: Clinical Audit Support Centre Limited. An identical survey was undertaken by Hounslow provider services in December 2009 - January 2010 with the final report being published in April 2010. The response rate was 496 (24.8%) in Richmond and 387 (19.4%) in Hounslow. Comments received on both sides were largely complementary for all services however similar themes can be identified where issues were raised:

- Lack of recognition of who or what provider services are
- Access including clinic times
- Facilities
- Advice and communication

- Hand hygiene
- How to contact services with complaints or compliments?

The results of the survey were used to develop an action plan that is now in place and will address the issues raised.

Generic paper based questionnaires for both clinic and home-based care were developed in Hounslow under the auspices of the Clinical Audit Facilitator, which have been completed by 14 services over the year. Also two services run by the physiotherapy services have commenced using Patient Related Outcome Measurements (PROMs). The tools used are nationally developed disability questionnaires to identify pain levels pre and post intervention and activities of daily living post knee surgery.

The use of patient experience tracker machines to gain public feedback on clinic-based services in Hounslow has commenced. These machines gather information on five generic questions focussed on access, the environment, privacy and dignity, communication, and staff attitude. These machines offer an effective mechanism for us to monitor the patient experience in specific services. Weekly reports will become available during the first quarter of 2010-2011.

Looking to the future

The board has agreed not to renew the two SLAs in place with the PCTs for the PALS and complaints service for 2010-11. Following staff consultation on the Corporate Structures of the Alliance in February - March 2010 the Joint Provider Board has agreed to develop its own Patient Experience Team under the auspices of the Director of Quality and Clinical Excellence. This team has the remit for facilitating the investigation and responses to complaints and PALS, leading on patient satisfaction surveys, working jointly with the Communications Team to facilitate focus groups identifying service users and marketing of services and liaison with partner agencies such as social care, LINkS, and voluntary agencies. A formal policy and procedure will be ratified for the Alliance that will encompass Department of Health (DoH) Guidance.

In the coming year we will develop a PALS and Communications group with terms of reference to include robust feedback of learning outcomes to frontline staff.

It is an objective of the Patient Experience Team to review the Patient Experience Strategy by September 2010

Historical data collection on Ethic Minority Groups by the PALS and Complaints service has not been robust enough to compare the demographic profile of complaints with that of the local population. This means there is currently no clarity in respect of equal access. Work is underway within the newly formed the Alliance patient experience team to rectify this, through the introduction of the Datix database system that will enable better data recording.

5.3 Clinical Effectiveness

Introduction

The aims of the Clinical Audit Department are to encourage reflective practice and help clinicians bring about continual improvements to patient care, while supporting the governance agenda for the organisation as a whole. Clinical audit is well recognised as the component of clinical governance that offers the greatest potential to assess the quality of care. It is the key element of clinical governance and is an important process for assuring the quality of patient care and safety.

This report highlights the challenges faced by the organisation with regard to clinical audit and the plans to improve clinical audit activity in the organisation.

Despite the challenges, the team has strived for reinvigoration of clinical audit to enable the organisation to reach its full potential. It provides a rich source of information regarding patient outcomes and service improvement. Within the Alliance the work of clinical audit is being given a higher priority.

What we achieved in 2009-10

Amongst other things the following have now been implemented:

- Clinical audit forward planners from all departments have now been submitted and 81 clinical audits have been identified across services
- A robust and continual monitoring of clinical audit activity is in place across the organisation
- Clinical audit training at all levels has been identified as a priority. Clinical audit training has been delivered at induction for new staff members since December 2009. It is now mandatory for all clinical staff to take the training once
- Support is given to staff engaging in clinical audit by the Audit Facilitator
- The Clinical Audit Strategy was ratified by Joint Integrated Governance Committee in March 2010.
- A Clinical Audit and Effectiveness Committee (CAEC) has been created

Looking to the future

It is intended that there will be a successful implementation of the refreshed clinical audit strategy and that there will be increased participation by all services in audits. Rolling clinical audit half days will be introduced and there will be improved and robust monitoring of clinical audit activity by the Board. Audit data will be published. Evidence will be provided of service improvement, as a result of clinical audit activity as will any evidence of the improvement in the quality of patient care and outcomes. Patient involvement will be considered in all elements of clinical audit, including priority setting.

We will benchmark the organisation against the Robert Francis Inquiry into Mid Staffordshire NHS Trust. Clinical audit was found to be poorly developed at the Trust.

Across the Alliance, we will establish a programme of improving participation in clinical audit by all departments, ensuring our processes are constantly reviewed and outcomes monitored.

We are encouraging clinical staff to use clinical audit as a tool for demonstrating and improving quality of care.

Figure 28 & 29 - Audit activity 1 April 2009- 31 March 2010

Richmond Audit Activity

Area	Number of registered audits	Number of completed audits- with evidence	Number of audits reported to be completed - no evidence	Number of audits actioned - work in progress	Number audits deferred	Number of audits with Status unknown	Number of audits registered but withdrawn	Audit replaced
Hospital Services	20	2	18	0	0	0	0	0

Adults and older people	35	6- Including PEAT audit	13	4	5	4	1	2
Children's services	22	2	8	6	0	4	0	2
Clinical Governance & Risk - All services	2	0	0	2-analysis complete. MD audit in draft	0	0	0	0
Infection Control	1	1	0	0	0	0	0	0
External Audits	1	1	0	0	0	0	0	0
Total	81	12	39	12	5	8	1	4

Hounslow Audit Activity

Number of audits planned	72	(Trust wide RK audits counted once only)
Project forms	19	
Number of audits completed	25	
Number of audits ongoing	32	
Number of audits deferred	2	
Number of audits abandoned	7	
Number of reports	24	
Number of full reports	12	
Number of action plans	8	+ 2 possibles
Number of short reports	10	
Number of audits PowerPoint presentation only of results	3	
Patient Satisfaction	14	*Physio (CRS, Acupuncture, Palliative care), Continence, DN (Treatment room), MS, S&L, Sexual Health (KISS), Diabetes Intermediate Service, 0-16 teams, Specialist Children's Services, Paediatric physiotherapy, Podiatry, Trust wide*
PROMS (patient reported outcome measures)	2	*Physiotherapy*
National Audits	4	*Continence, Tissue Viability, Multiple Sclerosis*

Input from audit facilitator	35	*Little involvement through to very involved*

PGDs (patient group	10	

directions)		
NICE Guidance	1	*Multiple Sclerosis*

No of audit workshops held	4	*Run jointly with WMUH*
Number of attendees	40	
Number of HPCT attendees	26	
Number of WMUH attendees	12	
Number of Richmond attendees	2	*Only last workshop open to Richmond staff*

Conclusion

Having uncovered areas for improvement we are striving to reinvigorate the clinical audit programme. It is essential for the organisation to agree criteria for the prioritisation of clinical audits, balancing national and local interests with the need to address specific local risks, strategic interests and concerns.

6. Your Local Services

6.1 Services Provided

The Alliance provided community services in a variety of settings across the boroughs of Hounslow and Richmond as well at to some parts of Ealing and also provides some therapy and nursing services for the West Middlesex University Hospital.

Alliance services were designed to be convenient and accessible for service users and are delivered in clinics and health centres, children's centres, Teddington Memorial Hospital, nursing and residential homes, leisure centres, local hospitals and patients' own homes.

Services were borough focussed in that they are commissioned by two separate organisations (NHS Hounslow and NHS Richmond) and each commissioner sets out their own specific requirements for how services in their borough will be delivered. Although in 2009-10 services continued to be managed separately we are now considering the joint management of services where there are advantages to be gained in terms of scale and cross learning. We will be carrying out these exercises in the coming year.

The below will give you a brief overview of our services and shows what have been the main achievements in 2009-10, as well as identifying objectives for the coming year and recognising the challenges faced by each individual service.

6.1.1 Services offered in Hounslow

6.1.1.1 Hounslow Urgent and Unscheduled Care Services

Overview
The Urgent and Unscheduled Care Services include District Nursing, Community Matrons and Nurse Assessors, Residential Homes Nursing, Continuing Care, Community Rehabilitation, Neuro-Rehabilitation, Tissue Viability and the Continence service. Services are provided across the community in people's homes, clinics, health centres and also into West Middlesex Hospital.

Achievements
Nurses, therapists and specialists in the services have worked closely together and with partner organisations to improve pathways to support people with long-term conditions living in the community, prevent admissions and facilitate discharges from hospital. Some specific achievements include:

- **District Nursing -** the service has launched a new weekend treatment room at Heart of Hounslow and has performed over and above its contracted activity dealing with severe winter conditions, the flu virus and working with highly dependent patients.
- **Community Matrons and Nurse Assessors -** the service has prevented significant numbers of admissions (over 60/month in Oct-Dec09) and developed a care pathway for prevention of admission together with the London Ambulance Service. It has also overseen the development of the practice development nurse (PDN) role.
- **Continuing Care and Residential Homes Service -** the service has successfully merged the community and West Middlesex Hospital continuing care teams into a single integrated service.
- **Community Rehabilitation Service -** the service has implemented mobility clinics in Hounslow and Chiswick, a balance group and developed a falls-prevention booklet.

- **Neuro-Rehabilitation Service -** the service has implemented a Parkinson's nursing service and completed a thorough review of multiple sclerosis services in partnership with the MS Society.
- **Tissue Viability Service -** a review led to an increase in the number of leg ulcer clinics available and increased capacity in the Moffat complex wound clinic led to reduced amputation rates in patients accessing the diabetic foot clinic.
- **Continence Service -** the service introduced a monthly joint physiotherapy consultant clinic and increased the referral rate for patients following extensive prostrate surgery.

Challenges
The main challenges for the service are to manage the increasing numbers of referrals, increasing complexity of conditions in the community setting and related budget pressures in all service areas.

Objectives
Further integration of pathways are planned to provide more responsive care, especially to prevent admissions and facilitate discharges. The services also aim to increase user involvement. Specific aims include:

- **District Nursing -** The service aims to enhance its 24/7 service, increase referrals from the London Ambulance Service and to deliver improved palliative and end-of-life care.
- **Community Rehabilitation Service -** the service aims to align its locality base working and rapid response service with community nursing for a more integrated service provision.
- **Neuro-Rehabilitation Service -** working with commissioners, the service will develop the service capacity to ensure delivery of stroke rehabilitation to the standards set out in *Healthcare for London*
- **Tissue Viability Service -** the service aims to develop an education plan, implement improved monitoring of standards of care in leg ulcer clinics and reduce pressure ulcer incidence in hospital.

6.1.1.2 West Middlesex Hospital Primary Care Stream in A&E

Overview
This service navigates all walk-in attendances to A&E at West Middlesex University Hospital (WMUH). Senior nurses signpost patients to the appropriate areas in A&E where they need to be seen dependent on their clinical presentation. Part of the focus for the Primary Care Stream is to facilitate appointments (where available and appropriate) for sign-posting patients back to their own GPs. It also supports the registration of non-registered patients. A multidisciplinary team of GPs, physiotherapy practitioners, nurses and administrative staff run the Primary Care Stream.

Achievements
- For 09-10 the Primary Care Stream assessed and had intervention with 19,087 patients (an average of 52 patients per day). This amounts to approximately 22% of all A&E attendances.
- Patient feedback has been very positive that patients are both seen and treated and given appropriate access to healthcare with a minimal wait.

This service is now going to be passed to WMUH in the summer of 2010 to be managed as part of their Urgent Care Centre development.

6.1.1.3 Hounslow Planned and Clinic Based Services

Overview

Planned and Clinic Based Services for Hounslow comprise of cardiac rehabilitation, community and intermediate care diabetes, health promotion, healthy lifestyles service, musculoskeletal services including physiotherapy, podiatry and hand therapy, nutrition and dietetics, phlebotomy, podiatry, single point of access (SPA), adult speech and language therapy, a stop smoking service and the wheelchair service. These services are provided across the community including in clinics, health centres, leisure centres and people's homes. Services are also provided to West Middlesex Hospital, West London Mental Health Trust, Teddington Memorial Hospital and Feltham Young Offenders Institute.

Achievements

Planned and Clinic Based services span a wide range of different services, from therapy and diagnostics to specialist care for people with long term conditions and health and wellbeing. All of these have delivered significant changes and improvements in the care they offer, including improved partnerships across services, organisations and with patients and significantly the development of self-care and patient empowerment. Some specific achievements include:

- **Stop smoking service -** the service has worked with West Middlesex Hospital to launch a project to increase the numbers of people who quit smoking whilst attending the hospital.
- **Physiotherapy -** the service has kept its waiting times down, despite increased numbers of referrals, and has started making direct referrals to the West Middlesex Hospital imaging service, including for X-rays and MRI (magnetic resonance imaging) scanning, to speed up and simplify access for patients
- **Diabetes -** the service has started a diabetic specialist nurse/dietician clinic at Feltham Centre for Health, and restarted a South Asian X-Pert Patient Education Course.
- **Wheelchairs -** the service secured new contracts for local provision of the specialist-seating contract, and for electric powered indoor/outdoor chairs. This service was won as part of a competitive tendering process.
- **Equipment -** Hounslow began the introduction of the national initiative for transforming community equipment services (TCES) across NHS services. This will allow people to use funded 'prescriptions' to purchase from specific outlets small items of equipment for themselves.
- **Podiatry -** the service has developed and implemented a best practice diabetic foot clinical pathway, and has published a nail surgery research project in the National Journal of Foot and Ankle Surgery
- **Health Promotion -** 404 people were seen in the year by the Healthy Lifestyles Road Show since June 2009 when we began. 294 people were screened for vascular risk, and we successfully targeted higher risk groups of people. Our Weigh to Lose weight-loss programme is targeting our most deprived area.
- **Dietetics -** a service has been set up in the community to support people at home (or in community care) with feeding difficulties who are on sip feeds and supplements; we have increased the number of programmes helping people who are overweight (including Weigh to Lose) and we have set up a new clinic for people with Coeliac Disease.
- **Vascular risk assessment -** This screening service has been successfully launched in Hounslow, and we have provided a range of intervention services, including fitness and lifestyle programmes, following assessment, to help people to improve their health. The Department of Health has used our NHS health check passport as an example of good practice.
- **Healthy Lifestyles -** the service rolled out provision of sessions to more leisure centre locations across Hounslow.
- **Cardiac rehabilitation -** the service successfully piloted a patient questionnaire to secure views about how to improve the service.
- **Phlebotomy -** new clinics have been set up in the community, including specialist clinics for children.

Challenges
These include increased demand on the podiatry service with increasing foot health needs, the delivery of a challenging stop smoking service quitters target, setting up Choose & Book for our community out patient services, and meeting the 18 week waits monitoring targets. Along with other services there will be budget pressures related to increases in activity.

Objectives

- **Podiatry -** the service aims to put in place a central co-ordination of podiatry appointments bookings and also to develop a Single Point of Access referral centre.
- **Stop Smoking service -** further improvements are planned to ensure that the stop smoking service hits it `Quit Smoking' target including the use of health trainers. Increased training and support will also be provided to GP practices and pharmacists to help more people to give up smoking.
- **Dietetics and diabetes -** it is intended to secure funding from the MacMillan Fund to support a Dietician for Oncology for Hounslow. Other proposed improvements within the diabetes service include the development of an expanded community and primary care service. This will increasing the frequency and locations of X-Pert patient education programmes, training and educating GPs so that patients are looked after in the community where appropriate and possible, reducing the waiting times in community outpatient clinics and supporting and increasing the effectiveness of the service through input from a community diabetic consultant and additional diabetic specialist nursing. The service also aims to ensure that a fully recruited workforce is in place, reducing dependency on bank and agency staff.

6.1.1.4 Hounslow Children's Services

Overview
The Children and Family service provision in Hounslow currently includes:

- The 0 – 16 Service - health visiting and school nursing services delivered across nine 0 – 16 skill mix teams.
- Healthy weight team
- Immunisation team
- Children's therapies
- Sexual health and family planning
- Child development services
- Specialist nursing services
- Continuing care service for Children
- Audiology and the Newborn Hearing Screening Service.

Achievements
Despite the demands on the service the retention of staff remains high and we have had many achievements to be proud of. The dedication and commitment of staff are shown in the achievements that have been made. Some of these are:

- Securing pathfinder status for the implementation of the Bercow Report aimed at improving Children's Speech and Language development.
- Joint CQC and Ofsted inspection that rated our services as 'good'.
- The continued development of the "KISS" clinics to support young people's sexual health needs which contributes towards a reduction in teenage pregnancy.

- A reduction in 18 week waits across audiology services.
- Implementation of the staff nurse pilot across the 0 – 16 service to support the early new birth contact with families from 0 – 14 days.
- Continued recruitment of community staff nurses into the 0 – 16 services promoting long term recruitment of health visitors into the workforce.
- Expansion of Clinical Practice Teachers (CPT) across the 0 – 16 service to promote health visiting recruitment.
- Investment by the Local Authority in partnership with health to support the recruitment of health visitors by the creation of three new posts to support local Children's Centres
- Successful data cleansing project across our Child Health Information Team that has resulted in us achieving key performance targets for primary immunisation coverage.

Challenges
Recruitment and retention of staff remains a key challenge across our services but particularly around Health Visiting and Children with Complex Health Needs. There is ongoing pressure to achieve key performance targets within limited resources. We look to securing existing business and seeking new opportunities whilst continuing to deliver high quality services. We strive to attain the continued delivery of high quality services with a context of organisation change, and managing the potential threats of the increasingly open provider market.

Objectives
These include:
- Looking at creative ways of securing recruitment of new staff and retaining the existing workforce.
- Focussing on the achievement of key performance targets.
- Applying learning techniques as appropriate.
- Continuing to look at innovative ways of delivering services which maximise existing resources.
- To develop new business opportunities and secure investment into the service.
- Progressing the integration and partnership working with the Local Authority with the Children's Trust arrangements.
- Continuing to explore joint funding initiatives with the Local Authority.
- Completing and most importantly progressing the integration of Children's Services across Richmond and Hounslow.

6.1.1.5 Hounslow Learning Disability Services

Overview
The Learning Disability Service in Hounslow is an integrated service with the Local Authority. It aims to provide specialist assessment and treatment to residents of the London Borough of Hounslow. The team is multidisciplinary in nature and is co-located with care managers that enable the delivery of a seamless service.

Achievements
The Learning Disability Service can be pleased with its achievements to date in being able to deliver in partnership, with the Local Authority, community-based, person-centred care. Some key achievements this year include:
- Relocation of the service to New Heston Road with improved facilities including meeting and conference rooms in addition to a changing places facility
- The roll out of the newly commissioned Local Enhanced Service (LES) for people with Learning Disabilities.
- The 'Big Health Check Up Day', attended by over 130 service users, carers and local health service providers.

- Improved partnership working with West Middlesex University Hospital that enabled the rollout of the Patient Passport that promotes the Safeguarding of vulnerable patients whilst in hospital.
- Secured funding for an Autism Project Worker which will enable the service to scope the number of people locally that have autism and will assist in the development of a local autism strategy to ensure Hounslow is compliant with the Autism Act.

Challenges
We are working to improve cross border working with Richmond to ensure that appropriate, eligible people with learning disabilities receive the correct level of support. Some existing pathways will need to be redesigned to ensure maximum value for money whilst maintaining and improving quality along with other services working within the financial envelope and delivering the cost improvement programme.

Objectives
In collaboration with NHS Hounslow the service will review the prison health programme. It will work with both NHS Hounslow and the London Borough of Hounslow to consider how the services will work together to ensure that those out of Borough service users in high cost health placements are moved to appropriate placed, local community provision.

6.1.2 Services offered in Richmond

6.1.2.1 Richmond Adult and Older People's Services

Overview
Richmond Adults and Older People's Services provide a full range of community services at several locations in the borough. These are detailed below.

Achievements

Inpatient Unit - Teddington Memorial Hospital
The Inpatient Unit is a 50-bed facility comprising two wards: the Grace Anderson Ward that has 21 beds and the Pamela Bryant Ward that has 29 beds. A total of 43 beds provide rehabilitation, sub acute, palliative and provision for seven continuing care cases within Teddington Memorial Hospital. The aim of the Unit is to enable adults to maximise their health and wellbeing. It operates within a multidisciplinary team framework, ensuring that agreed outcomes are set and the patient's potential is maximised.

Respiratory Care Services (RCT)
The Respiratory Care Team (RCT) provides respiratory specialist assessment and management to patients with long-term respiratory conditions in the community. The caseload has grown to almost 1100 patients who are encouraged to self manage with advice and support from a multi-disciplinary respiratory team.

There has been successful liaison with the DoH and engaging with National Strategy to ensure NHS Richmond patients are managed within best practice guidelines. The RCT has also commenced utilising the British Lung Foundation Self Management Plan. The team moved from Teddington Memorial Hospital (TMH) to Centre House at the end of January 2010 that resulted in increased referrals of new patients, particularly from the Richmond-Barnes locality.

Intermediate Care Service (ICS)
ICS provides a rapid response service aimed at people who are at risk of a hospital admission or to support a timely hospital discharge to enable rehabilitation to continue at home thus allowing earlier discharge from acute care. The primary aim is to support people in their own home setting by delivering and tailoring the support they need around their home environment. If it is not possible to deliver the care in the home setting immediately, access to Intermediate Care beds will be made available with the goal of resettling the person at home as soon as possible.

Community Nursing Service
The Community Adult Health and Social Care teams are made up of several disciplines including District Nursing services, social workers and occupational therapists working within an integrated management structure incorporating both the main day and night nursing teams and community matrons. In January 2010, the Twickenham and Whitton nursing teams co-located with their Social Services colleagues in offices at Regal House. The Teddington & Hampton nursing teams co-located with their social services colleagues at the newly built Teddington Health & Social Care Centre.

Podiatry
The service assesses and treats a variety of conditions affecting the foot and lower limb in adults and children. This includes preventative, palliative and corrective care in order to maintain tissue viability and improve foot health and mobility. The service provides generalist community foot care for conditions such as management of fungal nail infections, dressings, specialist diagnostic and treatment services, gait analysis, orthotics and management of the Diabetic Foot. Care is delivered via a range of podiatry clinics, outreach visits and, in the case of Diabetes, as part of a multidisciplinary clinic with a consultant diabetologist, clinical nurse specialist and dietician. Services transferred from Whitton and Hampton to Teddington Memorial Hospital and St John's Health Centre.

Community Neuro-Rehabilitation and Community Physiotherapy Team
The team provides a community based multi-disciplinary neuro-rehabilitation service for all patients with a newly acquired condition e.g. stroke, head injury, spinal injury; or for those with a long-term neurological condition e.g. Parkinson's Disease, Multiple Sclerosis (MS), Motor Neurone Disease, cerebella ataxia. Patients can be seen in their own homes or as outpatients at Richmond Rehabilitation Unit. The team provides goal-orientated, evidence-based rehabilitation to residents in the Borough of Richmond.

The Community Physiotherapy Service is primarily delivered in the patient's own home but patients can also be seen in alternative locations within the borough. The service provides open access to case manage patients whose ongoing condition may require rehabilitation. The service also provides Phase 2 and 3 Cardiac Rehabilitation.

Musculoskeletal Physiotherapy Service
The service is delivered at various locations including Centre House Sheen, Teddington Memorial Hospital, GP practices and the hydrotherapy pool at Teddington. The service provides assessment, treatment and/or management of all musculoskeletal conditions including orthopaedics, rheumatology and sports or soft tissue injuries. Treatment/management options include patient education, coping strategies, exercise therapy, acupuncture as an adjunct to their management, manual therapy and hydrotherapy. The emphasis is on promoting a positive attitude to self-management of musculoskeletal health.

Falls Service
The service aims to reduce the number of falls, without reducing activity/mobility. The service consists of a senior physiotherapist specialising in falls prevention and the management of fallers and a physiotherapist. The core team has the addition of a community matron and the health

development team leader. The core team delivers services in Teddington Memorial Hospital or in people's own homes.

Intermediate Diabetes Service
The diabetes services provides expert advice and support to community and primary care teams on the development and delivery of diabetes care promoting high quality, culturally sensitive access to services for patients in a range of settings closer to home. It provides quality and appropriate care that is based on a comprehensive assessment, examination, investigation and providing a patient centred treatment plan for each patient. Thus enabling patients to stay active and reduce the impact on quality of life and reducing the incidence of admission and re-admission. Support is also provided through health education sessions and groups.

Continence Service
The Continence Service leads the bowel and bladder dysfunction care across all community teams. Continence Services are embedded in a number of generic teams and a core of specialist nursing and physiotherapy roles. The network as a whole aims to diagnose, assess and treat a range of bladder and bowel problems such as all types of urinary incontinence, faecal incontinence, chronic constipation. Interventions are designed to restore normal function or reduce the impact of bladder and/or bowel problems on quality of life and independence. For those in need of long term support, services also support appropriate and effective prescribing of incontinence pads and other incontinence products.

Continuing Care
The service supports users and families in their applications for NHS Continuing Care and Funded Nursing Care within care homes and to support health and social care professionals to ensure that service user health needs are accurately reflected within assessments and recommendations. The NHS Continuing Care team service users are kept under regular review and enable patients to receive nursing care in the most appropriate environment, and coordinate the procurement of care packages with other agencies such as social care services. The service continues to make improvements in efficiency, quality and patient experience.

Tissue Viability
This service commenced in October 2009 with the Tissue Viability Nurse Specialist coming into post to provide expert advice and support to community and primary care teams on the development and delivery of Tissue Viability care. The Nurse Specialist is responsible for managing a complex caseload autonomously in the community setting and providing leadership and expert clinical support for the leg ulcer clinics, pressure ulcer prevention and lymphoedema care across the borough, establishing and agreeing clinical outcomes and monitoring progress against agreed targets.

Objectives
- The Intermediate Care service intends to successfully implement the alternative pathway, developed with the London Ambulance Service, to prevent unnecessary hospital admission. It will be a major partner in the implementation of the Single Point of Access (SPA) and the 24-hour Rapid Response (RR) Service

6.1.2.2 Teddington Walk-In Centre (WIC)

Overview
The Teddington WIC is a Nurse led unit based at Teddington Memorial Hospital comprising of 15.39 whole time equivalent staff. The WIC provides a range of NHS services including health information, advice and treatment for a range of minor illnesses (coughs, colds, infections) and minor injuries (strains, sprains, cuts). The Walk-In Centre sees approximately 48,000 patients per year of which roughly half are illnesses and the other half are injuries.

Achievements

- 100% of patients being treated and discharged within four hours and 90% of patients treated and discharged within two hours. 76% of patients were assessed within 15 minutes of arrival.
- Protocols and pathways have been developed with the London Ambulance Service (LAS) to increase attendance at the centre and decrease attendances at A&E and the service remained within its budget.
- The Wick has successfully integrated with the GP-Led Health Centre (GPLHC) since its inception on 1 March 2010.

Challenges

The main challenge will be to continue to maintain a good quality service that is highly regarded by the public, and continue to achieve financial balance within the financial climate.

Objectives

The service objectives include the following:

- To develop standardised clinical pathways for treatments with the new GPLHC;
- To continue to work with the LAS to increase the number of attendances at the WIC;
- To improve the quality and definition of x-ray images in the WIC through installation of PACs (Picture Archiving Computer system) monitors.

The service will also increase the number of patients assessed within 15 minutes to 85% by streamlining the triage process in line with the nationally accepted Manchester Triage system and increase the number of Category C ambulance attendances to one per day by 2011.

6.1.2.3 TMH Outpatients

Overview

The main aim of this service is to provide a one-stop clinic where diagnostics, clinical opinion and management plans are delivered in one visit. The service is for adults over the age of 18 presenting with symptoms such as palpitations, non-acute chest pain, uncontrollable blood pressure, heart failure and shortness of breath. Overall the outpatient department provides nursing and support services to around 12000 patients per year.

Achievements

Working with commissioning colleagues, the service was involved in designing, operationally managing and providing nursing support for the One Stop Cardiology Non–Invasive Diagnostic Clinic Service. This service commenced at Teddington Memorial Hospital on the 20 August 2009.

Teddington Memorial Hospital Outpatients

The outpatient department provides nursing and support services to around 12000 patients per year. A broad range of clinics are delivered including podiatry, continence, gynaecology, urology, orthopaedics, ophthalmology, retinal screening, audiology, ENT, cardiology, rheumatology and gastroenterology.

Teddington Memorial Hospital X-ray Service

The X-ray service delivers around 12500 - 13000 x-ray examinations per year providing a ‘same day’ appointment system for Orthopaedic Outpatient clinics, GP and Walk-in Centre referrals. The team also provide support for the growing ultrasound and cardiology service.

Housekeeping

The housekeeping service within the hospital continues to achieve high standards. In the most recent PEAT survey, the hospital scored excellent for environment, food, and privacy and dignity.

Volunteers
The Volunteer Service consists of 85 active members. The volunteers are involved in a range of services including meeting and greeting, hospital chaplaincy, the rehabilitation clinic, speech and language therapy, befriending, hydrotherapy, PatDog visiting, administration and clerical work. They are also involved in Red Cross therapeutic care, the League of Friends shop and trolley rounds and assist in patient surveys and feedback. A new service developed this year has been for a volunteer pianist to provide music entertainment fortnightly to the Inpatient Unit.

Chaplaincy Service
An invaluable chaplaincy service, commissioned through the Bishop of Kensington, is provided to the inpatient unit at Teddington Memorial Hospital. The Chaplain is supported by a team of volunteers who ensure that a service, for all faiths and none, is available at times of need. In addition regular communion and Sunday services are held in the Hospital Chapel. The services are accessible to patients, visitors, staff and members of the public.

Challenges
- To maintain the service despite financial pressures

Objectives
- To retain and increase the number of volunteers.

6.1.2.4 Richmond Children and Family Services

Overview
Services within this portfolio (with responsibility of caring for children aged between 0-18) include universal services such as health visiting and school nursing, specialist health visiting for children with special needs, community children's nursing, paediatric medical staff, audiology, newborn Hearing Screening, family planning and sexual health and paediatric therapies as well as school based weight monitoring and immunisation programmes.

Achievements
- Re-organisation of universal services in year to replicate the 'Quindrat' Local Authority boundaries for alignment of services with partner organisations working locally
- Targeted programme of immunisation on the traveller's site has resulted in optimal uptake of immunisation and access to services provided by Local Authority in relation to early learning and adult learning.
- Delivery of the National Weight measurement programme is undertaken each academic year in reception year, 1970 and year 6, 1780 children of which 93% participated
- Vision screening is offered and undertaken for all year 1 children
- Human Papilloma Virus (HPV) was delivered in both secondary and independent schools and 85% girls have been immunised for the academic year 2008/09. The current academic year programme is completed in August 2010
- SRE sessions are delivered in to both Year 9 and Year 10 students in secondary school on contraception, STIs, and Healthy Lifestyles and well being.
- Increased number of Specialist Practice Teachers from 2 to 4

Challenges

These relate to the difficulties in recruiting appropriate numbers of health visitors to deliver services, introducing further skill mix to support delivery of services including the development of the community staff nurse.

Objectives

- To further increase skill mix within the team by the employment of more staff nurses.
- To improve recruitment and retention by working with NHS London on alternative direct entry routes into health visiting.
- Improving the percentage of new birth visits by health visitors to improve the percentage of new births undertaken within 10 to 14 days.
- To achieve 95% by using electronic transfer of information to the Child Health department and prioritisation of workload.
- To develop and implement Patient Related Outcome Measures (PROM) for Universal Services by 31st March 2010.

6.1.2.5 Richmond Paediatric Medical Service

Overview

The service aims to review the medical needs of children with complex neurological needs, developmental delay and co-ordination difficulties, Autism and Aspergers syndrome, child protection and safeguarding concerns, Attention Deficit Disorder up to primary school age and adoption and fostering. There are strong links with a local acute trust paediatric services and tertiary centres within London especially St. George's Hospital and Great Ormond Street Hospital.

The service is based at Richmond Royal but delivers clinic based sessions across the borough at the Croft Centre, special schools and clinic bases as appropriate to the location of the child and family. The medical staff form part of the multidisciplinary team for children with disabilities and learning difficulties and will undertake joint assessments.

Achievements

- Activity levels have been maintained despite a decrease in staffing.
- There has also been scheduling and participation in adoption and fostering panels and attendance at rapid response meetings following child deaths.
- There has been increased flexibility to meet the needs of children and their families.

Challenges

- Maintaining services with increasing demands and reducing costs.
- Funding issues for adoption and fostering work.

Objectives

- Identifying time allocation and funding for specific work. It is intended to report increased activity.
- Linking services together with Hounslow medical staffing to ensure more robust structures are put in place.

6.1.2.6 Richmond Paediatric Audiology Services

Overview

Paediatric audiology clinics are delivered at Teddington Memorial Hospital and Centre House in Sheen. The service receives referrals from the Newborn Hearing Screening Team, GPs, health visitors and education and will also undertake the school hearing screening programme. The audiology service assesses children for hearing loss and refers on to more specialist services at

Hounslow or other tertiary centre for hearing aid fitting or possibly cochlear implant. Children are then followed up after hearing aid fitting within local services. The audiology service works with other neighbouring services and peer review for the quality of tests undertaken is part of the service so that quality standards are met.

Achievements
The service has ensured that all children are seen for diagnostic testing within 6 weeks. The service undertook extra clinic sessions in year to support the Croydon Audiology Service and continued to deliver services within timescales from June 2010.

Challenges
These include working without a specific audiology database and the management of capacity whilst vacancies exist within the service.

Objectives
Staff will be developed within the service to undertake a wider remit. There will be improved links with Hounslow with regard to fitting of hearing aids on a more local basis.

6.1.2.7 South West London Newborn Hearing Screening Services

Overview
The Newborn Hearing Screening Programme aims to test the hearing of babies within 24 hours of birth at the place of birth or within four weeks of birth at community based clinics to enable hearing loss to be detected and remedial action taken by provision of hearing aids or onward referral if complex underlying medical conditions exist. NHS Richmond has commissioned the local service to lead the programme for the whole of South West London with the exception of Croydon – this covers four PCTs, three maternity hospitals and four diagnostic services.
Of the total number of babies screened approximately 2,900 are from Richmond with the remaining 16,500 spread across the area. The service aims to complete the screening of babies within four weeks. The Medical Research Council reviewed the service in September 2009 and many improvements were noted when compared to the previous review in March 2008.

Achievements
- Completion of screening processes within 4 weeks of birth.
- The development of a senior screener role to support local delivery sites
- Links have been developed with audiology departments to ensure improvements to the appointments system.

Challenges
- Managing a large disparate staff group across several sites and ensuring that staff training remains up to date.
- Managing vacancies
- Meeting the target of 95% of all screens completed within four weeks.
- Ensuring that there is sufficient capacity in screeners to meet the expected increase in birth rates across the southwest London sector.

Objectives
- These include meeting the target for 95% of screens for new babies completed within four weeks.
- Leadership roles within the Newborn Hearing Screening Programme will be filled to ensure that the service can maintain national standards

6.1.2.8 Richmond Family Planning, Sexual Health and Teenage Pregnancy

Overview
The Family Planning Service is run by trained family planning nurses and a sexual health consultant is available at specific sessions for more complex cases. Services include:

- The young people's sexual health worker aims to provide sexual health advice to young people in a variety of youth and leisure settings ensuring access to contraception – the service links closely with the local authority at Heatham House, KISS and Off the Record.
- Teenage pregnancy services based at St John's Health Centre in Twickenham, supporting all young women who are pregnant and also working with them to prevent further unplanned pregnancies.

Achievements

- Maintenance of family planning services when part of the service relocated to the new Teddington Health and Social Care Centre.
- The service was accessible to and supported all teenagers who suspected they were pregnant and

Challenges

- The change to the service base and access for specific geographically located clientele
- Maintaining services in the light of political and economic challenges and reducing costs.
- Training and expertise will be required in the newer methods of contraceptives such as Implanon. We also need to meet the disparate needs of pregnant teenagers across Richmond.

Objectives

- The service will need to ensure funding to support the changes to the delivery of contraceptives such as Implanon and IUDS
- Ensure that young people's sexual health workers are based alongside other services that best meet this need

6.1.2.9 Richmond Paediatric Therapy Service

Overview
The Richmond Paediatric Therapy Service is made up of three different teams delivering care to children in a range of settings including mainstream schools, special schools and nurseries. They work together to form a multidisciplinary "Team Around the Child".

Speech and Language Therapy aims to maximise communication potential for children in the early years in primary school. The Local Authority also funds posts within the service as required to meet specific complex needs that cannot be met through group or generic Speech and Language Therapy services. The service has focussed on one of the least advantaged areas to enrich the language environment of all children on entry into full time education in order to allow them to reach their educational potential in line with Every Child Matters outcomes.

The Physiotherapy Team sees children with a variety of difficulties including complex neurological needs, developmental delay, balance and co-ordination difficulties, musculo-skeletal or orthopaedic conditions. The service forms part of the 18 week pathway for referral to treatment and aims to see, assess and commence treatment for children within this timescale. The service provides advice to schools and parents with regard to individual children.

Occupational Therapy aims to develop or maintain a child's ability to perform functional activities independently or to the best of their ability. These activities may include self help tasks such as eating, dressing and washing or other daily activities such as play. Occupational therapists can help to maximise a child's sensory processing, fine motor skills and co-ordination, play concepts and visual perceptual skills. They suggest strategies or activities to further a child's development or may adapt equipment, the environment or activities to meet a child's needs.

Achievements

- A speech and language telephone advice line is in use for service users and health professionals to enable appropriate referrals to be made to the service.
- There has also been speech and language involvement in the local authority's 'Every Child A Talker' pilot in the Early Years. This involved 20 pilot nurseries with a speech and language therapist to improve working practices in nurseries for all children as a result of the Bercow report.
- The service also delivered the Primary Language Programme into all schools in the borough in order to teach education staff strategies and techniques to support children with speech, language and communication needs in their schools.
- Occupational therapy and physiotherapy maintained waits below 16 weeks
- Activity targets as set by commissioners for physiotherapy services have been achieved and rates of non attendance at musculoskeletal clinic have decreased markedly as a result of implementing clear guidelines for booking appointments and the access policy.
- Reporting templates have been redesigned and this has resulted in increased efficiency of the service.

Challenges

- Maintaining services funded by the Borough in light of political and economic changes whilst also reducing costs,
- Managing capacity to provide in schools for children without statements in mainstream schools in an equitable manner.
- Funding arrangements for local projects are under threat.
- Within occupational therapy there is a high staff turnover.

Objectives

- The service aims to embed working with mainstream schools on the Primary Language Programme to up skill education staff to embed language into the curriculum involving planning curriculum with teachers. It will also ensure funding streams are identified and support provided for submitting bids within timescales.
- An Early Years clinic will be established to encourage appropriate referrals for Occupational Therapy.

6.2 Performance

One of our objectives is to "ensure our processes are sufficiently robust to deliver high quality (safe, effective and patient focused) services; maintain and improve our service delivery to meet existing and new targets". In order to demonstrate that we provide high quality and clinically effective service provision, we are constantly monitoring our performance against nationally and locally agreed targets and reporting on action taken where there are variances.
Within the Alliance we have a culture of monitoring our performance and this is reported through our Provider Executive Team, Provider and PCT Boards, to our Commissioners and external bodies, such as NHS London. This is to ensure that we are meeting national priorities in healthcare, such as waiting times and Vital Signs, and also locally defined targets.

The table below shows the significant performance indicators that we reported on to the NHS London community provider regime for 2009/10 (quarter 4 figures given):

Key Performance Indicator	Hounslow	Richmond	Commentary on quarter 4 performance
18 week wait (for consultant-led services)	93%	100%	Reporting takes place on any breaches of 18 week waits for consultant-led services. Prioritised action has been taken and significant improvements are being seen
A&E wait	N/A	100%	Waiting time in Teddington Memorial Hospital Walk-in Centre remained consistently below 4 hours
District Nurse response times	100%	100%	All urgent referrals to DNs seen within 4 hours and routine within 24 hours
New Birth Visits	12.44%	62.22%	Performance is below target for the number of visits carried out within 10-14 days of birth due to capacity and process issues. However a considerable amount of work is being carried out in this area and improvements will be seen in 2010/11
Children's height & weight measurement	94.8%	92.99%	Annual figure (08/09) for H&W measured at reception & year 6
Childhood Obesity	12.1% 23.5%	N/A	Annual data (08/09) for obesity recorded at reception and year 6 children
Breastfeeding recording	91.37%	N/A	Breastfeeding status recorded as reported by the PCT
Smoking cessation	1384 quitters	N/A	We are working with pharmacies & GPs and have implemented a number of new initiatives within service to meet identified need
Chlamydia screening	91.5%	N/A	Community services carry out CaSH clinics as part of PCT wide campaign
HPV vaccination	N/A	85.26%	Annual figure (08/09) showing uptake of HPV vaccine which is offered to all year 8 girls in schools, with catch-up sessions arranged.
Complaints (responses)	100%	100%	All complaints in Q4 responded to within 25 working day target
Infection control	3/5	3/5	3 out of 5 specified standards are currently being met, with plans in place to increase attendance on Infection Control training and complete Essential Steps audit
Data quality checks	60%	90%	Assessment of processes in place to produce & validate regular monitoring reports

Note: Performance targets for 2009/10 separated into Hounslow and Richmond and not all indicators applicable to both, according to which services have been commissioned by PCT.

6.3 Standards for Better Health/CQC Declarations

6.3.1 Standards for Better Health

In 2009-10 PCTs as providers were required to make a December mid year declaration against the Care Quality Commission's (CQC's) core standards for better health.

In March 2009 both Hounslow and Richmond PCT Boards had previously declared compliance in respect of all standards. Following these declarations, both Hounslow Community Healthcare (HCH) and Richmond Community Health Services (RCHS) became Autonomous Provider Organisations and the interim Director of Quality and Integrated Governance/Clinical Director introduced a new system of assurance around the process of declaration. This led to the existing

evidence being reviewed in depth and a new process of assurance in respect of the declaration was introduced.

Following the introduction of the new assurance processes, both HCH and RCHS assessed themselves against the core standards and agreed the following declarations.

Richmond Community Health Services declared *Not Met* against the following standards;
C4b - Safe Use of Medical Devices; C4e – Waste Management and C5d Clinical Audit and Review. In respect of C2 Safeguarding Children – it was agreed to declare *Insufficient Assurance.* In respect of all the other standards, RCHS declared that it had met the standards.

Hounslow Community Healthcare declared *Not Met* in respect of standard C4b: Safe Use of Medical Devices. In respect of all the other standards, HCH declared that it had met the standards.

These declarations were approved by the respective PCT boards and submitted to the CQC. Where there was a declaration of non compliance or insufficient assurance, action plans were prepared to achieve compliance and submitted with the declaration. The action plans have been continuously monitored by the JIGC and progress against them was reported to the Joint Provider Board.

6.3.2 Care Quality Commission Registration – January 2010

Following the introduction of the Health and Social Care Act in 2009, Standards for Better Health were replaced by the CQC's *Essential Standards of Quality and Safety.* The introduction of the act also meant that from 1 April 2010 all regulated health and social care providers were required to be registered with the CQC. To enable both Hounslow and Richmond PCTs as providers to be registered with the CQC, they were required to show that they were meeting with the *Essential Standards of Quality and Safety.*

In January 2010, both HCH and RCHS declared that they were compliant with all 16 *Essential Standards* and this declaration was ratified by their respective PCT boards. Following the application for registration, both Hounslow and Richmond PCTs as providers were successfully registered without condition by the CQC

7. Looking forward to 2010-11

Hounslow and Richmond Community Healthcare Alliance was launched on 1st April 2010 with a new chairman and board of directors. 2010 is and will continue to be an exciting year. We face the challenge of creating a new organisation whilst building on the excellent quality of our existing services.

In the midst of this, and following the results of the general election, there will undoubtedly be more external change, the challenging nature of public sector finances and further decisions about our eventual end state. In August 2010 we were pleased that the Boards of NHS Richmond and NHS Hounslow agreed that HRCH had a strong case to become a standalone organisation. A full business case was being prepared at the time of writing.

I am confident that if we remain focused on the needs of the patient and the delivery of high quality services we will be in strong position to deal with whatever external changes may emerge.

Steve Swords
Chairman