CONFIDENTIAL – Corporate Restructure Proposals

GOVERNANCE RESTRUCTURE

Background

The Trust's Governance function supports achievement of the key Trust objective to continue to improve patient safety and the patient experience. In addition, the Chief Executive has identified that one of the top two issues for staff is to provide or support patient care that is safe and effective.

A review was undertaken of the corporate functions earlier in the year to identify whether the organisation was getting value for money from their non-clinical functions. This work was predominately around reviewing the purpose of each department (in line with corporate objectives), and analysing current processes in order to streamline where possible. The clinical governance review highlighted that services were already streamlined with very few options for removal of waste or reduction of process times. Key areas of work for the team over the next year are:

- Embed governance into the new divisional management structures.
- Support achievement of NHSLA standard level 2 in Q3 2008
- Develop electronic incident reporting
- Report incidents to NRLS

The following proposals support the Trust priorities.

Summary of proposals

1 **Develop integrated Risk and Safety team** (Patient Safety (Clinical Risk), Health and Safety, Legal Services, Information Governance Manager and Security Manager).

This would allow an integrated approach particularly to risk training and would involve moving Health and Safety from HR to Governance; and Security including admin support, from Estates to Governance. It is proposed that the Security Manager should report to the Legal Services Manager. No cost identified but non-pay budget will need to be identified. It is also proposed that the manual handling team is moved from therapies and report to the H&S Team Manager.

2 **Appoint Patient Safety Team Manager** This proposal is based on a risk analysis and follows a recommendation from the Healthcare Commission that the Trust should have a dedicated advisor for maternity. It is suggested that one patient safety post supports Division 1; one supports Women's and Children's' (the area of highest risk) and the third supports the remainder of Division 2 and Division 3. One of these posts would be the Patient Safety Team Manager **Cost approximately £45k** dependent upon outcome of banding. It is recommended that the clinical risk advisors change their title to patient safety advisors.

In addition, it is recommended that the current 0.8 wte post is increased to full time to meet the demands of the role. **Cost £8,835**

3 **Restructure clinical audit team** with loss of one band 7 post and replacement with lower banded post. There are currently two part time managers with different roles but this results in a fragmented approach. **Saving of £15,964**

4 **Create role of DATIX administrator** / data analyst to support risk and audit (band 4 post) (funded from restructure of audit team). This post would be responsible for mandatory reporting to the NPSA (currently not carried out); training in electronic incident reporting; DATIX administration; and data analysis**. Cost of £21,268 offset by above saving.**

5 **Transfer responsibility for FOI requests** from Patient Services to Information Governance which would sit under the Legal Services Manager.

6 **Transfer responsibility for patient information to Patient Services**

7 **Change job title of Head of Governance to Head of Risk and Assurance**

8 Create deputy to Head of Risk and Assurance

Background to proposals for restructuring of Governance Support

1 Current Position

The team has five components:

Head of Governance
Clinical Audit
Clinical Risk
Litigation
Information Governance

1.1 Current Composition of Teams

	2005/6				Budget 2007/8				Change
	Clinical Audit	Clinical Risk	Litigation	Head of Gov + Info Gov	Clinical Audit	Clinical Risk	Litigation	Head of Gov + Info Gov	
Band 8			1	1			1	1	
Band 7	1.55	1.8			1.55	1.8			
Band 6				1				1	
Band 5	0.66				0.66				
Band 4	2.54			0.64	1.54			0.64	**- 1**
Band 3	4.41	1.08	1		3.06	1.08**	1		**- 1.35**
Band 2	1.81*		2.8		1.81*		2.54		**- 0.26**
Total	**10.97**	**2.84**	**4.8**	**2.64**	**8.62**	**2.84**	**4.54**	**2.64**	**- 2.61**

- * includes 0.4 vacancy – currently replaced with modern apprentice
- ** 0.54 currently on maternity leave and 0.54 vacancy (w.e.f. 10 October 2007)

As can be seen, these changes have resulted in:

- A reduction in overall staffing levels
- A cost improvement in addition to the agreed CIP
- **At the end of 06/07 there was an underspend of £46,961**

1.2 Head of Governance

One wte post (band 8) supported by a 0.64 wte secretary / PA (band 4).

The Head of Governance is responsible for managing the above areas and coordinates the Corporate Risk Register, Board Assurance Framework, NHSLA standards, SUI reporting, policy development, and patient survey reporting. Reports to Clinical Governance Executive include risk management, CNST, NHSLA, Confidential Enquiries

Currently there is little support available from the team as all are overstretched.

The secretary supports the Clinical Governance Executive, Risk Group, including medical devices (from Aug) and the Trust Patient Information Group.

1.3 Clinical Risk

There are currently 2 clinical risk advisors (1.8 wte) for the Trust.

The team currently has:
1.8 wte x Band 7

- One risk advisor covers women's, paediatrics and surgery (0.8wte)
- One risk advisor covers medicine, radiology, pathology and all other support services

1.08 wte x Band 3 (one 0.54 wte currently on maternity leave)

1.4 Litigation

The Trust developed a litigation department several years ago to save solicitors costs. Previously no preliminary analysis of claims or photocopying for litigation was carried out in house. Legal costs for the two separate Trusts were in excess of £180k pa previously for medical negligence work. These have been reduced to under £70k pa. The Trust also employed 1 A&C Band 5, and 4 A&C Band 3s so significant savings have already been made in this area. It is important to note that the Litigation Manager also handles Employers and Occupiers' Litigation

	2005/06	**2007/08**	**Change**
Band 8	1.0	1.0	
Band 3	1.0	1.0	
Band 2	2.8	2.54	**-0.26**
	4.8	**4.54**	**-0.26**

1.5 Information Governance (IG)

This is one wte post (band 6) responsible for all IG related policies and the IG action plan and return. This post is required to monitor data protection and Caldicott compliance and to handle Trust issues in this area.

1.6. Clinical Audit

The numbers of clinical audit staff have shown a steady decrease over the past five years, but clinical audit remains an essential element of sound clinical governance and clinical risk management processes.

The team currently has:
1.55 wte x Band 7

- one leads on NICE, guidelines, national audits, and confidential enquiries Speciality support for medicine, radiology, pathology and all other support services (0.8wte)
- one leads on staff supervision and training, Speciality support for women's, and surgery, CNST and NHSLA audit requirements, patient surveys and income generation.

0.66 x Band 5 – 0.66 wte clinical audit coordinator for Women's

1.54 x Band 4 – 1 wte clinical audit coordinator for surgical specialities
- 0.54 wte clinical audit coordinator for medicine, pathology,

3.06 x Band 3 1 wte general support
1 wte national patient survey coordinator (the Trust currently carries out the patient surveys under contract to T&W PCT.)
0.65 wte general support
0. 41 wte – intranet support – guidelines and audit database

1.55 x Band 2 0.40 wte vacancy
1 wte – medical records clerk (RSH) and DATIX inputting
0.41 - medical records clerk (PRH)

1.7 Modern Apprentice

A modern apprentice is currently employed between audit/risk to cover the work of the band 2 vacancy in audit and the clinical risk support currently on maternity leave.

2 Future Considerations

2.1 Patient Safety (Clinical Risk) Team

There are 1.8 wte Patient Safety (clinical risk) advisors in the team with 1.08 of admin support (but 0.54 admin on maternity leave and one 0.54 vacancy)

Current Issues

- Healthcare Commission recommended that the Trust should consider appointing a patient safety advisor for obstetrics
- Increasing numbers of SUI's and high risk cases being investigated including coroner's cases, HCAIs and police investigations.
- Increasing risk of facing prosecution by HSE and/or charge of Corporate Manslaughter in line with national trends (Corporate Manslaughter Bill was passed 26 July 2007 and becomes law in April 2008
- More wide ranging and rigorous risk management standards from the NHSLA – due for reassessment in Autumn of 2008. Need to maintain level 2 in this assessment
- New maternity risk management standards due to be piloted next year
- Current team cannot meet demands of statutory training or other risk management training.

2.2 Risk Analysis by Division

The Clinical Negligence Scheme for Trusts handles all clinical negligence claims against the Trust where the incident in question took place on or after 1 April 1995. When a claim is made against a member of CNST, the NHS body remains the legal defendant. However, the NHSLA takes over full responsibility for handling the claim and meeting the associated costs.

The costs of the scheme are met by membership contributions. The projected claim costs are assessed in advance each year by professional actuaries. Contributions are then calculated to meet the total forecast expenditure for that year. Individual member contribution levels are influenced by a range of factors, including the type of trust, the specialties it provides and the number of "whole time equivalent" clinical staff it employs.

Analysis of the relative contribution to the scheme by speciality results in the following divisional breakdown (since 2004):

Division 1 13%
Division 2 85% (of which Women's and Children's comprise 73%)
Division 3 2%
Corporate n/a

Moderate to high risk incident reports, (ie those requiring support from the clinical risk advisors) give the following divisional breakdown (since 2004):

Division 1 34%
Division 2 62% (of which Women's and Children's comprise 32%)
Division 3 4%
Corporate 0.1%

See attachment 1 for detailed breakdown.

These figures support the need for a dedicated advisor for Women's and Paediatric SDU. (It is prudent to include children's due to the close links between obstetrics and neonatology.)

2.3 Proposal: create new post of patient safety team manager

Based on this risk analysis, there should be a patient safety post to support Division 1, one patient safety post for Women's and Paediatrics and one patient safety post to support the remainder of Division 2 and Division 3. Many of the clinical risks from Division 3 will be linked to other areas of the Trust eg errors reported by Pharmacy or pathology often originate from the wards. These issues can be picked up by the relevant divisional patient safety advisor.

This would require an additional post – Patient Safety Team Manager, banding to be confirmed at a cost of approximately £40K - £50k. This post would be responsible for the two patient safety advisors and the admin support and report direct to the Head of Risk and Assurance (Head of Governance).

Each patient safety post would be linked to the divisions and provide ongoing advice and support, but should be outside the divisional structure to enable constructive challenge. It is also expected that the advisors will coordinate work on specific issues across the Trust working across the divisions on major issues to ensure consistency.

Eg Specified NHSLA standards (general risk management standards)
NHSLA maternity standards (Clinical)
Infection Control
Training
Consent
NPSA guidance
Confidential Enquiries (currently linked to Head of Governance & Audit Department but overseen nationally by NPSA)

In addition, it is recommended that the 0.8 wte post is increased to full time. This would cost £8,835

It is recommended that the team name be changed from clinical risk to patient safety.

2.4 Proposal: Integrated Risk and Safety Team

The effectiveness of risk management would be further enhanced by the development of an integrated risk and safety team. The team would comprise of patient safety, health and safety, legal services, information governance, and security management. This is the approach developed at Southampton after they were prosecuted under Health and Safety Laws relating to clinical issues. Other Trusts also use this model.

This would have the following advantages:

- Closer working links for incident and police investigations
- Divisions would be able to have dedicated risk management support to provide defined support including advice on risk assessment, risk mitigation, incident investigation etc
- Training in risk management could organised more easily as there would be a larger pool of staff to provide the training
- Sharing of admin support
- Coordination of work on NHSLA standards

Admin support would be shared – with the current admin support at PRH providing support to H&S and Security and the admin support at RSH providing support to patient safety. The current support for clinical risk is inadequate but if, as suggested, the responsibility for patient information leaflets is transferred to Patient Services, the 1.08 budgeted support should be sufficient for the 3 patient safety advisors.

It is expected that the advisors will coordinate work on specific issues across the Trust.

Eg NHSLA standards (general risk management standards)
NHSLA maternity standards (Clinical)
H&S policies
Infection Control
Training
Consent
Confidential Enquiries (currently linked to Audit Department but overseen nationally by NPSA)

This team would also include manual handling trainers who would report to the Health and Safety Team leader. The Manual Handling team provide training and advice. It is further recommended that the Fire Trainer reports to the H&S Team Manager for the training part of the role.

2.5 Proposal: Create post of DATIX administrator / data analyst

DATIX is an integrated risk management systemwhich the Trusts uses to manage complaints, litigation, all types of incidents (clinical, non-clinical, falls, security, H&S) and PALS.

Current issues

- No facility for regular reporting to National Reporting and Learning System (NRLS) operated by the NPSA. This is a time consuming task which should be carried out regularly. Most Trusts report on a daily or weekly basis. Non-compliance with this reporting requirement is reported centrally
- Backlog of clinical incidents awaiting inputting onto system
- Introduction of electronic reporting
  - This needs further support and training to staff throughout the Trust
  - In time the need for input clerks will decrease, but it experience in other Trusts show that there will always be some incidents which are not reported electronically.
- No dedicated support for DATIX risk management system – system needs maintenance, recoding, administration. Currently this is carried out by one of the Clinical Risk Advisors
- System currently not used to full capability which could be developed with more dedicated support.

It is proposed that a new role is developed to oversee the DATIX system. This would free up some time from the current risk & H&S advisors and allow them to use their time more effectively.

It is anticipated that this role could be combined with data analysis to support corporate projects / audit work. Looking at comparable roles in other Trusts would suggest a band 4 post.

Currently the Trust is not providing regular reports to the NPSA reporting scheme (NRLS) as this is time consuming and requires technical expertise. Sporadic reporting is carried out by the Head of Governance and a clinical risk advisor. However, this would be within the capabilities of a band 4 post.

2.6 Litigation / Legal Services

The Litigation Manager's job has only recently been banded following completion of JAQ. It is proposed that the Security Manager and the Information Governance Managers report to the Litigation Manager. The title of this post would change to Legal Services Manager. There may be some changes to the admin structure within the department to enable more flexibility. The Legal Services Manager would be the nominated deputy to the Head of Risk and Assurance.

2.7 Proposal: Security Manager

It is proposed that the security manager also form part of an integrated risk and safety team. There are already close working links between this post and the litigation manager – particularly in respect of police investigations. This post should report to the Legal Services Manager

2.8 Proposal: Patient Information leaflets

It is proposed that the responsibility for coordinating patient information leaflets move from the risk team to patient services. This responsibility could usefully be combined with the administrator role in the Member's Office, making this post full time. This would allow the existing admin establishment to provide support to the 3 patient safety advisors.

One of the admin posts (0.54) was carrying out this role but is currently on maternity leave. The role involves coordinating the development of leaflets which are compliant with Trust policy and uploading onto the intranet database.

2.9 Proposal: Information Governance

It is proposed that the role of the Information Governance manager should be expanded to include Freedom of Information and report to the Head of Legal Services. This function currently sits with Patient Services. It is proposed that this role be accountable to the Director of Corporate Affairs because of the governance implications.

2.10 Clinical Audit - Trust wide changes needed to support restructure

It is recommended that a clinical audit lead (senior clinician) be nominated to lead the agenda centrally. This would seem to fit with the duties of the existing R&D Director who is also linked to effectiveness work through the guideline programme. Indications are that the R&D Director would be prepared to lead on clinical audit.

It is proposed that the model adopted by obstetrics for the successful achievement of CNST level 3 should provide the template for the way in which audit is carried out within the Trust. Divisions should draw up an annual audit plan in conjunction with the Directors to enable the Board to be provided with assurances on clinical quality. This forward plan should be linked to the Board Assurance Framework taking account of national and local priorities eg NICE guidance, CNST / NHSLA requirements / clinical guidelines and areas of identified risk. Audits should be carried out in line with a pre-specified format, and facilitated by audit staff. If junior doctors are carrying out these audits on behalf of the division, they will need training and supervision in order that audits are carried out to the required standard. It is proposed that junior doctors should not be able to use the resources of the audit department to carry out audits which are not on the agreed forward plan; however, this suggestion may not be a popular one. However limited NHS resources are currently being wasted on clinical audits that are ill-conceived or never completed.

It is essential that flexibility is retained in the audit team to allow a timely response to serious incidents or similar urgent matters. (eg the audit team provide background investigation in some serious incidents eg investigation of work of Dr El-Khadem who was charged with manslaughter following a forceps delivery).

Comparison with other Trusts indicate that most audit departments work with members of the team within a matrix structure to provide multidisciplinary clinical staff with advice and information to effectively implement clinical governance and audit across the Trust.

2.11 PROPOSAL: Clinical Audit Staffing

It is proposed that there is one audit manager responsible for co-ordinating the work of the team. (Currently 1 x 0.81 wte and 1 x 0.74 wte). Ideally, this post would be full time. This would result in the disestablishment of one band 7 post to be replaced by a lower banded post.

The clinical audit facilitators will be allocated to support each division. These posts will remain within a central team and be accountable centrally. They will continue to facilitate the design of audit tools and audit plans and provide audit training. However, it is anticipated that staff will work with members of the team within a matrix structure across the Trust. Again, because of the high workload from Women's (due to the CNST standards), there would be four audit facilitators. (not necessarily full time)

No changes are proposed to the audit clerks who obtain records for audit as these posts will continue to be required on each site.

One part time post in clinical audit is responsible for maintaining the document library (guidelines and policies) and the audit database – it is essential that this continues.

It is essential that the division's clinical governance leads (Lead Nurses and CDs) link into the corporate roles. It is expected that implementation of NICE guidance and NSFs' will be led by the Divisional management teams.

2.12 Non pay budget for Health and Safety, Security and Clinical Risk

A non-pay budget will need to be agreed for these services.

3 Head of Governance

3.1 Proposal: Head of Governance job title

It is proposed that the job title for this post change from Head of Governance to Head of Risk and Assurance if the proposals in this paper are implemented.

3.2 Proposal: Creation of Deputy Post

It is proposed that a deputy be nominated to the Head of Risk and Assurance to provide cover for the Head of Governance during times of annual leave / sickness. It is recommended that this is the Legal Services Manager.

Attachment 1: **Risk Analysis by Division.**

All incidents / claims / litigation from April 04 to June 07.

Since April 2004	Division 1	Division 2	Division 2 excluding W&C	W&C	Division 3	Corporate
All Patient Safety Incidents (PSI)	9082	6664	3056	3608	632	62
Percentage of total	*57.45*	*42.16*	*19.33*	*22.82*	*4.00*	*0.39*
Of which Falls	5102	723	590	133	70	25
Percentage of total	*86.18*	*12.21*	*19.33*	*2.25*	*1.18*	*0.42*
PSI excluding falls	3980	5941	2466	3475	562	37
Percentage of total	*24.18*	*36.09*	*14.98*	*21.11*	*3.41*	*0.22*
Moderate & High Risk incidents	773	1387	663	724	80	3
Percentage of total	*34.46*	*61.84*	*29.56*	*32.28*	*3.57*	*0.13*
Non-clinical incidents	1025	588	331	257	427	467
Percentage of total	*33.12*	*19.00*	*10.69*	*8.30*	*13.80*	*15.09*
Total claims	77	106	45	61	9	19
Employee liability	8	5	3	2	4	12
Public liability	0	0	0	1	0	7
Med neg claims	69	102	42	60	5	0
Percentage of total	*24.82*	*36.69*	*15.11*	*21.58*	*1.80*	*0.00*
% of CNST contribution	13	85	12	73	2	0
Complaints since April 2004	536	514	358	156	214	0