The Whittington Hospital NHS
NHS Trust

ITEM: 10

MEETING: Trust Board 17th May 2006

TITLE: Clinical Governance Report

SUMMARY: This reports summarises progress against the areas of the clinical governance development plan that were considered by the March and April meetings of the Clinical Governance Steering Committee.

- Clinical Negligence Scheme for Trusts assessment (report attached-appendix 1)
- National Confidential Enquiries: CEMACH-update on diabetes report
- Clinical Governance Strategy for Maternity
- Research and Development update
- Audit and Effectiveness
- NICE guidance
- Child Protection Annual Report (attached-appendix 2)
- Complaints management

ACTION: **For Information**

REPORT FROM: **Deborah Clatworthy, Acting Assistant Director of Nursing, Clinical Governance/Risk Management**

1. Clinical Negligence Scheme for Trusts Assessment

Board members will recall that the CNST assessment against level 2 of the general risk management standards took place on 16 & 17 January 2006.

The Trust was compliant with all the required level 1 standards at the minimum of 90%, and with all the level 2 standards at the required 75%, apart from one standard (induction, training & competence), which was assessed at 71%. There were two policies considered by the assessor, which had been updated but had not been agreed by Hospital Management Board at the time of the assessment; Capability policy and Alcohol & Substance Misuse policy. Following the submission of these policies, it was confirmed in March that the Trust had been successful in achieving level 2 of the Risk Management standards.

Achievement of level 2 general will give the Trust a further reduction of approximately £78k on the annual NHSLA premium, which for 2006/7 will be £2.6m (gross premium). It will also enable the Trust to apply to be assessed against the level 3 maternity standards in 2006/7. A provisional date of January 2007 has been booked for the level 3 maternity assessment.

The attached report contains details of the assessment, including the scores achieved in each standard. It also contains action points that must be addressed prior to applying for a level 3 general assessment. Most of the action points to be addressed are from standards 5 and 6 (Induction, Training and Competence and Implementation of Risk Management). An action plan will be completed for taking the actions forward.

The Trust will be re-assessed against the general standards in January 2009, but can apply for assessment at level 3 after April 2007. The NHSLA Risk Assessment for acute Trusts will replace the CNST general standards later this year, and several trusts participating in a pilot at present.

2. National Confidential Enquiries

Recommendations from Confidential Enquiry into Maternal and Child Health (CEMACH) were reviewed in March.

The report detailed maternity care for patients with diabetes. The Trust met almost all of the standards with the exception of low availability of joint preconception clinics for diabetic patients wishing to become pregnant.
It was agreed that there needs to be agreed standards of care between GPs and the Trust, and GPs need to be included in the discussions about setting up the clinics.

Heulwen Morgan agreed to present a paper on this topic to the Primary Care Interface Group as a forum to discuss the primary care side.

3. Clinical Governance Strategy for Maternity.

The Maternity Clinical Governance Strategy for April 2006-March 2007 was presented at the April meting. The comprehensive document outlines the direction for maternity services at the Trust, and considers the implications of both local and National strategies. It includes a review of last year's action plan and the maternity risk management strategy.

The document details the Clinical Governance framework and clearly demonstrates the service commitment to both clinical governance and managing risk. The document was approved by the Committee as part of the evidence required for the Maternity CNST Assessment.

4. Research and development update

The report presented at the April meeting outlined new developments in R&D and a review of research projects from October 2005.
Most of the developmental work has been concentrated on building the clinical scientific activity and to enhance the Trust's R&D Report.

Changes in EU and UK law have led to the introduction of enhanced standards of protocol writing. Although challenging, eight new protocols have been presented for registration and ethical approval.

Developments in the organisation of research governance and administration are highlighted in the report and include:

- Development of an electronic method of administering the governance of a project
- Drafting standard written agreements between clinical sites and universities.
- Writing standard operational procedures.
- Reporting of serious adverse events from clinical trials.

The new national strategy means that there will be an advantage in working with other units to get research projects started. Celia Ingham Clark and David Sloman are meeting with Professor Vallance to discuss this issue.

5. Audit and Effectiveness

In December 2005 there was an organisational change and the Audit Department reduced the number of Audit facilitators by 1 WTE. A review of the service has been completed, and the department re-named the Clinical Governance Department to reflect the change in role. An organisational chart and details of the service was included and is available on the intranet.

The end of year progress report on audit activity and Essence of Care was presented at the April meeting. The report highlighted progress made on the Essence of Care priorities and how they have been implemented in the Trust. For the year, work focused on food and nutrition, continence and bladder and bowel care, privacy and dignity, record keeping, communication and pressure ulcer prevention.

The membership of the Essence of Care steering group is currently under review.

Multi-disciplinary audit activity remains strong, but in some areas participation is poor. Of 287 registered audits, 184 were completed (64%). The 2006-07 audit programmes have been agreed and include a minimum number of 3 NICE guidance that should be audited.

Celia Ingham Clark agreed to ask Clinical Directors to emphasise the importance of audit and to discuss the Trust's aspirations with the Director of Operations.

6. NICE guidance

The Trust uses a standardised template to elicit the response to guidance issued from the relevant clinician, and this process is managed by one of the Clinical Governance Facilitators. The responses are then reviewed by the Clinical Guidelines Committee and uploaded onto the intranet. Copies of relevant responses are also sent to Islington PCT.

The template is currently under review and there is also agreement that discussions need to take place between the Director of Clinical Audit (Dr Jennifer Worrall) and Operations in order to ensure an effective mechanism for changing clinical practice where it is recommended by NICE.

A total of 55 guidelines were published between May 2005-February 2006, of which 29% were applicable to the Trust.

7. Child Protection

The Child Protection Annual report was presented at the March meeting. A named Nurse with responsibility for Child Protection has been recruited. An additional Paediatric Consultant with a remit for child protection training has also been employed by the Trust.

The Trust's Strategic Child Protection Forum continues to meet quarterly, with a new operational group that meets monthly. No new multi-agency case reviews were undertaken last year.

Training on child protection is now included as part of Trust induction and on mandatory updates for all staff. Child protection training days take place regularly and seminars held for local GP's.

Guidelines on child protection have been revised and ratified, and an audit of case notes was undertaken in the summer of 2005. Addressing issues from the audits will be a priority for the coming year.

As part of the Annual Health check, the Improvement Review for Children's hospital services took place in January 2006. Results from this will be part of the overall Trust score, and are expected on May 15th.

8. Complaints management

The finalised complaints data for the end of Q4 is not yet available. An estimate of 84% of complaints responded to in 20 days is assumed for March, with the Q4 overall being 82%. The full year estimate will be 66%.

NHS Litigation Authority

Clinical Negligence Scheme for Trusts

Risk Management Standards
Report of Assessment

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Clinical Negligence Scheme for Trusts
Risk Management Standards
Report of Assessment at Level Two

Trust Name:	Whittington Hospital NHS Trust		
Trust Contact:	Debbie Clatworthy Acting Assistant Director of Nursing, Clinical Governance and Risk Management	**Trust No:**	T221
Assessor:	Tracy Dilger	**Date of Visit:**	16th and 17th January 2006
Outcome:	Compliance	**Date of Report:**	2nd May 2006
		Reassessment Date:	No later than January 2009

Standard	Level One	Level Two	Compliance
1. Learning from Experience	100%	100%	√
2. Response to Major Clinical Incidents	100%	100%	√
3. Advice and Consent	100%	100%	√
4. Health Records	100%	100%	√
5. Induction, Training and Competence	90%	76%	√
6. Implementation of Clinical Risk Management	N/A	86%	√
7. Clinical Care	100%	90%	√

You will receive a discount from your CNST contribution for next year and will be eligible to apply for a level three assessment after the 1 April 2007.

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Action Points
Long-term

The trust has been successful in achieving compliance with the level 2 of the Clinical Negligence Scheme for Trusts (CNST) General Clinical Risk Management Standards.
This report should be read in conjunction with the CNST General Clinical Risk Management Standards Manual (April 2005). Prior to a level 3 assessment and to be confident of achieving the required 90% compliance with level 1 and level 2, the following points should be addressed:

Standard 5: Induction, Training and Competence

5.1.2 All clinical staff attend a specific induction appropriate to the specialty in which they are working.

A partial score was awarded for this criterion. The trust was able to provide evidence of a number of completed local inductions from a variety of staff groups for example nurses, healthcare assistants, physiotherapists, speech and language, senior house officers (SHO's) and foundation year 1 students. A full score could not be awarded as the evidence relating to medical staff did not demonstrate that all grades of medical staff received or completed a local induction. The trust has a relatively new local induction checklist that will be rolled out trust-wide to all staff groups, including all grades of medical staff in all specialities in the near future. It is an expectation that the minimum requirements listed on page 108 of the CNST General Clinical Risk Management Standards (April 2005) are included in the local induction for all clinical staff.
In order to achieve a full score the trust must make certain that there is a system in place to ensure that all grades of medical staff in all specialities have a local induction. Whatever system is set up the organisation must ensure it is monitored and that evidence of the programme, attendance (where applicable) and completion of checklists are retained by the trust.

5.2.1 The Trust has a process whereby medical staff in training are assessed against identified competencies.

A partial score was awarded for this criterion. The trust was able to provide evidence of a variety of competency assessments for doctors in training from a range of specialities. A full score could not be awarded as the trust was unable to provide evidence for all grades of doctors in training in all specialities.

In order to achieve a full score the trust must be able to demonstrate that there is a system in place for competency assessments of all doctors in training that covers all specialities and includes all grades of doctor in training.

5.2.2 The Trust has an induction system covering all temporary (locum, bank or agency) clinical staff to ensure that such employees are competent to perform the duties of their post.

A partial score was awarded for this criterion. The trust was able to provide evidence of an induction system for temporary locum, bank and agency clinical staff, the trust also has a Temporary Staffing Induction Handbook that is used to welcome this group of staff to the trust. A full score could not be awarded as the trust was unable to demonstrate that the system in place covered all areas.

In order to achieve a full score the trust must be able to demonstrate that the induction system in place for temporary staff applies to all staff and covers all areas where temporary staff work, or may work.

Standard 6: Implementation of Clinical Risk Management

6.2.1 All clinical risk management standards and processes are in place and operational.

A partial score was awarded for this criterion. This criterion is made up of multiple features relating to clinical risk management for example the evidence reviewed as part of the assessment, the involvement of staff in the clinical risk management system and adherence to trust-wide policies and procedures by staff. There were a few areas where it appeared the trust should consider staff compliance with some of the trust-wide training for example resuscitation, blood transfusion and local induction, including the local induction of temporary staff. The trust should also ensure that all staff receive feedback following incident reporting, although there are a variety of forums where this takes place it would appear that not all staff perceive that they receive the information, it may be that not all staff are aware of the mediums through which feedback on incidents reported are disseminated, therefore there may be a need to inform staff of the various communication channels. The trust may also wish to consider developing polices or guidelines to support practices that may already be in place to ensure they are implemented consistently throughout the trust for example the competency assessment of doctors in training and consent.
In order to achieve a full score the trust must confirm that the clinical risk management systems in place are operational; this can be performed through monitoring and auditing the policies and practices in place to ensure the desired effect, attendance and outcomes are achieved. Where

deficiencies are identified recommendations and action plans should be put in place and implementation of the same recorded where relevant.

6.2.4 A Trust-wide clinical risk assessment has been conducted.

A partial score was awarded for this criterion. The trust was able to provide evidence of a Trust-Wide Clinical Risk Assessment Report of Findings (October 2005) that covered all clinical areas. A full score could not be awarded as the risk assessment did not include the existing controls already in place for the management of the identified risks and the Trust Board had not reviewed the risk assessment although this was tabled for a forthcoming meeting.

In order to achieve a full score the trust should include the existing controls in place within the risk assessment and the risk register and ensure that the Trust Board has reviewed the trust-wide risk assessment and recorded the same in the Trust Board minutes.

Standard 7: Clinical Care

7.2.5 There is a Trust-wide annual medicines management report and programme, with clearly defined objectives and progress.

A partial score was awarded for this criterion. The trust was able to provide some of the evidence for this criterion for example the Medicines Management Annual Report (2004-2005) but the assessor was unable to see an audit of the Medicines Administration Policy that incorporated the guidance required from the level 1 criterion written on page 145 of the CNST General Clinical Risk Management Standards Manual (April 2005).

In order to achieve a full score the trust must be able to demonstrate that the Medicines Administrations Policy has been audited and that the audit performed includes the level 1 requirements listed in the guidance on page 145 of the CNST General Clinical Risk Management Standards Manual (April 2005).

Additional Information

Standard 1: Learning from Experience

1.2.6 The Trust applies the advice in the National Confidential Enquiries.

A full score was awarded for this criterion. The trust may wish to develop a flowchart to support the dissemination, review and feedback of the information from the National Confidential Enquiries (NCE's) to the Clinical Governance Steering Group or Trust Board. A table similar to the one seen within the serious untoward incident investigations may also help to ensure the coverage of the information from the NCE's is reviewed trust-wide.

Standard 3: Advice and Consent

3.1.2 The consent policy and all consent forms for investigation or treatment comply with Department of Health guidelines for design and use.

A full score was awarded for this criterion. The trust has a Policy for Consent to Examination or Treatment (September 2005) that could appear confusing to those using it. On page 11 of the policy point 3 it suggested that the trust practised delegated consent, which indicated that a clinician was permitted to obtain consent for procedures they were unable to perform themselves; but the second sentence underneath the bullet point suggested that delegated consent was not practised within the trust, as the health professional obtaining consent must be capable of performing the procedure. The consent policy was amended to state that the health care professional obtaining consent could only do so if they were capable of performing the procedure.

3.2.2 The Trust is able to demonstrate that consent for elective procedures is obtained by a health professional competent and capable of performing the procedure, or that the responsibility is delegated appropriately.

A full score was awarded for this criterion. As discussed above the consent policy was initially ambiguous and this may have affected the results of the audit; the trust was aware of this variable. The trust had completed an Audit of Informed Consent (2005) which identified that there were a range of doctors in training obtaining consent for a variety of procedures, the audit did not directly assess whether the doctors in training were able to obtain consent because they were competent to perform the procedure. The audit was overseen by the medical director who felt able to determine

the competency of the doctors in training who had obtained consent by their grade for example Specialist Registrar (SpR) and SHO. It was identified to the trust that the grade of doctor in training may not be an adequate indicator of a doctor's competency, some SHO's may be able to perform some procedures and therefore obtain consent, whilst some SpR's may have performed delegated consent in that they had sufficient information regarding the procedure to obtain informed consent but not perform the procedure. There was no evidence other than at the doctors' induction and in the Doctors Handbook (2005) of formal training programmes for consent which would be consistent with delegated consent not being practised. The audit as mentioned above did identify doctors in training obtaining consent so the trust must ensure there is a record of the doctor being competent to perform the relevant procedure(s), this information should be recorded on a speciality register that is accessible centrally and updated with each intake of doctors in training.

In order to retain a full score at future assessments the trust must ensure that, as part of the audit, there is a list from each speciality of all the elective procedures performed and who is responsible for obtaining consent for the procedures listed, this should include nil returns as well. The trust must also address the areas of weakness identified in the consent audit performed. If the trust does have some specialities where delegated consent is practised this must be identified in the consent policy along with formalised training or competency programmes.

Standard 5: Induction, Training and Competence

5.2.4 The Trust has clear policies for addressing shortfalls in the conduct, performance and health of clinical staff, and staff are made aware of it.

A full score was awarded for this criterion. At the time of the assessment two of the relevant policies required for this criterion had not been ratified and therefore a score could not be awarded. The trust were given additional time to achieve compliance with this criterion and the relevant polices proceeded through the already planned ratification process and were then forwarded to the assessor, in a timely manner, ratified and accompanied by the relevant committee meeting minutes.

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Final Comment

The trust will be pleased to have achieved level 2 compliance with the CNST General Clinical Risk Management Standards (April 2005) at this assessment. This result is well deserved as it reflects positively on the enormous amount of work undertaken since the last assessment. The trust has undergone many changes and has worked its way steadily and surely from level 0 in March 2003 back up to level 2 in March 2006. The staff are to be commended on this achievement as it is no mean feat in these dynamic times when there are so many challenges for trusts to engage in. Risk management appeared to be viewed as a corporate issue and addressed at all levels across the trust. The involvement of senior staff throughout the assessment, suggested the importance of clinical risk management across the trust. The hard work of the all the staff n preparing for the assessment was apparent.

There were areas of good practice seen at the assessment, in particular:

- The Infection Control Report (2004-2005) which appeared extremely informative and contemporary

During 2005 work has been carried out on developing new standards for acute and specialist hospital trusts to replace the CNST General Standards. The new standards will incorporate organisational, clinical and health & safety risks. A pilot version of these standards was posted on the NHSLA website in late April 2006. During 2006/07 the formal assessment of acute and specialist hospital trusts will be suspended (and existing accreditation extended where necessary) while pilot assessments against the new standards are conducted. Information about the pilot programme will be released before the end of the current financial year.

Due to the development of the NHSLA assessment standards the trust are advised to visit the NHSLA web site www.nhsla.com regularly and to maintain contact with their risk management assessor to ensure they are kept up to date with the standards and any changes to the assessment process that may affect the trust. The trust will be assessed against these new standards at future assessments and may apply for a level 3 assessment in the financial year 2007-2008.

The trust may find it beneficial to keep the action plan up to date.

I would like to take this opportunity to wish the trust every success in its clinical risk management progress and developments.

Please do not hesitate to contact me if I can be of any further assistance.

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Action Plan for Achievement of CNST Risk Management Standards

Standard No. 3 **3.2.2 The Trust is able to demonstrate that consent for elective procedures is obtained by a health professional competent and capable of performing the procedure, or that the responsibility is delegated appropriately.**	**Weighting [H,M,L]**	**Priority**
Action Plan	**Review Date**	**Date Completed**
Person Responsible		
Standard No. 5 **5.1.2 All clinical staff attend a specific induction appropriate to the specialty in which they are working.**	**Weighting [H,M,L]**	**Priority**
Action Plan	**Review Date**	**Date Completed**
Person Responsible		
Standard No. 5 **5.2.1 The Trust has a process whereby medical staff in training are assessed against identified competencies.**	**Weighting [H,M,L]**	**Priority**
Action Plan	**Review Date**	**Date Completed**
Person Responsible		
Standard No. 5 **5.2.2 The Trust has an induction system covering all temporary (locum, bank or agency) clinical staff to ensure that such employees are competent to perform the duties of their post.**	**Weighting [H,M,L]**	**Priority**
Action Plan	**Review Date**	**Date Completed**
Person Responsible		

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Action Plan for Achievement of CNST Risk Management Standards

Standard No. 6 **6.2.1 All clinical risk management standards and processes are in place and operational.**	**Weighting [H,M,L]**	**Priority**
Action Plan	**Review Date**	**Date Completed**
Person responsible		
Standard No. 6 **6.2.4 A Trust-wide clinical risk assessment has been conducted.**	**Weighting [H,M,L]**	**Priority**
Action Plan	**Review Date**	**Date Completed**
Person Responsible		
Standard No. 7 **7.2.6 There is a Trust-wide annual medicines management report and programme, with clearly defined objectives and progress.**	**Weighting [H,M,L]**	**Priority**
Action Plan	**Review Date**	**Date Completed**
Person Responsible		

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CNST Risk Assessment Summary - Core Doc Ref Apr 2005

Trust Name :	Whittington Hospital NhS Trust
Trust No.	T221
Date:	16th + 17th Janaury 2006
Assessor:	Tracy Dilger
Level:	2
Chief Executive:	David Sloman
Trust Contact:	Debbie Clatworthy Acting ADN (Clinical Governance and Risk Management)
Type:	General

	Learning from Experience	Response to Major Clinical Incidents	Advice and Consent	Health Records	Induction, Training and Competence	Implementation of Clinical Risk Management
	1	**2**	**3**	**4**	**5**	**6**
Level 1	**100%**	**100%**	**100%**	**100%**	**90%**	**N/A**
Level 2	**100%**	**100%**	**100%**	**100%**	**76%**	**86%**
Level 3	**0%**	**N/A**	**0%**	**0%**	**0%**	**0%**

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1 Learning from Experience							
The Trust proactively uses internal and external information to improve clinical care.		Max Score	Compliance			Actual Score	Comments
			F	P	N		
1.1.1	Patient adverse incidents and near misses are reported in 50% of all specialties.	20				20	
1.1.2	Summarised patient incident reports are provided regularly to relevant bodies for review and action.	20				20	
1.2.1	Clinically related events are reported as they occur and before claims are made.	10				10	
1.2.2	There is evidence of management action arising from patient adverse incident reporting.	20				20	
1.2.3	Patient adverse incidents and near misses are reported by all professionals in 100% of all specialties.	20				20	
1.2.4	In the interests of patient safety, openness and constructive criticism of clinical care is actively encouraged.	10				10	
1.2.5	Examples of two changes which reduce risk as a consequence of complaints can be demonstrated.	10				10	
1.2.6	The Trust applies the advice in the National Confidential Enquiries.	30				30	
1.3.1	All clinical staff receive training in patient adverse incident reporting.	10					
1.3.2	Examples of five changes which reduce risk as a consequence of complaints can be demonstrated.	10					
	LEVEL 1	40				40	100%
	LEVEL 2	100				100	100%
	LEVEL 3	20				0	0%

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2	Response to Major Clinical Incidents						
There is a policy for the rapid follow-up of major clinical incidents.		Max Score	Compliance F	Compliance P	Compliance N	Actual Score	Comments
2.1.1	The policy identifies the responsible person for overall management of the incident (in hours and out of hours).	10				10	
2.1.2	The policy explicitly states who has responsibility for informing the patient(s) and/or relative(s).	30				30	
2.1.3	The policy covers record keeping about the incident.	5				5	
2.1.4	The policy is explicit about which individuals in the Trust must be informed.	5				5	
2.1.5	The policy details which other interested parties need to be informed of the event.	5				5	
2.1.6	The policy makes it explicit that the patient must be informed before the media.	5				5	
2.1.7	The policy covers media relations and who will be responsible for them.	5				5	
2.1.8	The policy includes the strategy for the management of multiple enquires.	10				10	
2.2.1	There is in place a process for the detailed investigation of major clinical incidents.	10				10	
	LEVEL 1	**75**				**85**	**100%**
	LEVEL 2	**10**				**10**	**100%**
	LEVEL 3	**N/A**				**N/A**	**N/A**

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3 Advice and Consent							
Appropriate information is provided to patients on the risks and benefits of the proposed treatment or investigation, and the alternatives available, before a signature on a consent form is sought. There is a process of seeking consent, which involves providing information, discussion and decision making.		Max Score	Compliance F	Compliance P	Compliance N	Actual Score	Comments
3.1.1	There is patient information available that is dated and includes a reference to the risks, benefits and alternatives of twenty elective treatments common to the organisation.	50				50	
3.1.2	The consent policy and all consent forms for investigation or treatment comply with Department of Health guidelines for design and use.	50				50	
3.2.1	There is a system for reviewing and monitoring patient information, which is overseen by a nominated group.	25				25	
3.2.2	The Trust is able to demonstrate that consent for elective procedures is obtained by a health professional competent and capable of performing the procedure, or that the responsibility is delegated appropriately.	25				25	
3.2.3	The Trust is able to demonstrate that there is a process for providing information to patients and a discussion regarding the proposed treatment, and that there is a confirmation stage to ensure that the patient still wants to proceed.	25				25	
3.2.4	There is a clear mechanism for patients to obtain additional information about their condition.	25				25	
3.3.1	The consent policy is audited for compliance.	100					
	LEVEL 1	100				100	100%
	LEVEL 2	100				100	100%
	LEVEL 3	100				0	0%

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4	Health Records						
A comprehensive system for the completion, use, storage and retrieval of health records is in place. Record keeping standards are monitored through the clinical audit process.			Compliance			Actual Score	Comments
			F	P	N		
4.1.1	There is a unified health record which all specialties use.	20				20	
4.1.2	Records are bound so that loss of documents and traces are minimised for in-patients and out-patients.	10				10	
4.1.3	There are clear instructions in the health record regarding the filing of documents.	5				5	
4.1.4	Operation notes, care pathways and other key procedures are readily identifiable.	10				10	
4.1.5	Machine produced recordings are securely stored using a method that will minimise deterioration.	5				5	
4.1.6	The storage arrangements allow retrieval on a 24 hour/7 day basis.	5				5	
4.1.7	There is clear evidence of multi-professionals clinical audits of record keeping standards for all professional groups, in at least 25% of services, including any high risk services, within the twelve months prior to the assessment.	20				20	
4.1.8	There is a mechanism for retaining certain records which must not be destroyed.	5				5	
4.1.9	The health record contains a designated place for the recording of hyper-sensitivity reactions, and other information relevant to all healthcare professionals.	10				10	
4.2.1	Accident and Emergency records are contained within the main record for patients who are subsequently admitted.	5				5	
4.2.2	There is a system for ensuring that the General Practitioner is sent a copy of the Accident and Emergency record.	5				5	
4.2.3	Nursing, medical and other records (e.g. physiotherapy notes, obstetric notes) are filed together, or referenced when the patient is discharged.	10				10	
4.2.4	There is a system for measuring efficiency in the recovery of records for in-patients and out-patients.	5				5	

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4	**HEALTH RECORDS CONTINUED**						
4.2.5	There is clear evidence of multi-professional clinical audits of record keeping standards for all professional groups, in at least 50% of the services, within the twelve months prior to the assessment.	**20**				**20**	
4.3.1	An author of an entry in a health record is clearly and easily identifiable.	**20**					
4.3.2	There is clear evidence of multi-professional clinical audits of record keeping standards for all professional groups, in all of the services, within the twelve months prior to the assessment.	**20**					
	LEVEL 1	**90**				**90**	**100%**
	LEVEL 2	**45**				**45**	**100%**
	LEVEL 3	**40**				**0**	**0%**

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5	Induction, Training and Competence						
There are management systems in place to ensure the competence and appropriate training of all clinical staff.		Max Score	Compliance			Actual Score	Comments
			F	P	N		
5.1.1	All clinical staff (including all grades of medical staff) attend a mandatory general induction course on joining the Trust.	20				20	
5.1.2	All clinical staff attend a specific induction appropriate to the specialty in which they are working.	20				10	
5.1.3	The Trust has a written policy which requires relevant clinical staff to be competent to perform basic life support whenever called upon to do so, and can demonstrate that there is a system in place to fulfil the policy and that training records are maintained.	10				10	
5.1.4	There is a procedure to verify the registration and ongoing monitoring of clinical staff.	10				10	
5.1.5	There is a system which identifies any therapeutic and diagnostic equipment for which the operator is required to have specialist training.	20				20	
5.1.6	The Trust's policy on hand hygiene and hand care is clear, and the Trust is actively promoting specific initiatives and education programmes on hand hygiene.	20				20	
5.2.1	The Trust has a process whereby medical staff in training are assessed against identified competencies.	20				10	
5.2.2	The Trust has an induction system covering all temporary (locum, bank or agency) clinical staff to ensure that such employees are competent to perform the duties of their post.	20				10	
5.2.3	Clinical risk management is included in the general induction arrangements for all healthcare staff.	10				10	
5.2.4	The Trust has clear policies for addressing shortfalls in the conduct, performance and health of clinical staff, and staff are made aware of it.	5				5	

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5	**Induction, Training and Competence continued**						
5.2.5	The Trust has a clear policy requiring a consultant to have attended a relevant training programme before embarking upon techniques which are new to him or her and which are not part of an Ethical Committee approved research programme.	**10**				**10**	
5.2.6	Training programmes are in place to ensure that staff operating diagnostic or therapeutic equipment can do so in a safe and effective manner.	**10**				**10**	
5.2.7	All staff have an understanding of infection control practice.	**10**				**10**	
5.3.1	90% of eligible staff have attended basic life support training in the last 12 months.	**10**					
5.3.2	There is a section on clinical risk management in the staff handbook, incorporating key policies and procedures.	**10**					
5.3.3	Staff who operate diagnostic or therapeutic equipment are systematically trained to do so safely and effectively.	**10**					
	LEVEL 1	**100**				**90**	**90%**
	LEVEL 2	**85**				**65**	**76%**
	LEVEL 3	**30**				**0**	**0%**

Appendix One

6	Implementation of Clinical Risk Management						
A clinical risk management system is in place.		Max Score	Compliance			Actual Score	Comments
			F	P	N		
6.2.1	All clinical risk management standards and processes are in place and operational.	50				38	
6.2.2	Risk management policy is implemented through the general management arrangements of the Trust.	15				15	
6.2.3	A formal risk management forum exists in which clinical risk related issues are discussed.	20				20	
6.2.4	A Trust-wide clinical risk assessment has been conducted.	60				52	
6.3.1	There is evidence of progression and achievement of action points based on recommendations made in the risk assessment.	60					
	LEVEL 1	**N/A**				**N/A**	**N/A**
	LEVEL 2	**145**				**125**	**86%**
	LEVEL 3	**60**				**0**	**0%**

Appendix One

7 Clinical Care							
There are clear procedures for the management of general clinical care.		Max Score	Compliance			Actual Score	Comments
			F	P	N		
7.1.1	All specialties have in place an integrated policy that identifies and addresses the needs of the patient prior to, and in preparation for, discharge from the hospital.	10				10	
7.1.2	There are appropriate systems in place for the request, safe storage, collection and administration of human blood and blood products.	10				10	
7.1.3	There is an appropriately constituted and functioning Infection Control Team.	10				10	
7.1.4	The Infection Control Team produces a Trust-wide annual infection control programme, with clearly defined objectives.	10				10	
7.1.5	Timely and effective specialist microbiological support is provided for the infection control service.	10				10	
7.1.6	There is a Trust-wide medicines management policy for the storage, prescription and administration of medicines.	10				10	
7.2.1	Clinical areas admitting emergencies are appropriately staffed at all times.	20				20	
7.2.2	There are clear lines of accountability and responsibility for staff working in another organisation's facility.	5				5	
7.2.3	The Trust's policy(ies) on procedures for the discharge of patients is subject to ongoing monitoring.	5				5	
7.2.4	There is a system in place to ensure that a programme of targeted infection surveillance is carried out.	10				10	
7.2.5	There is a Trust-wide annual medicines management report and programme, with clearly defined objectives and progress.	10				5	
7.3.1	Emergency surgery out of hours is reduced to a minimum.	20					
7.3.2	There is a system for the co-ordination, ratification and review of specific clinical procedures, pathways or guidelines for each specialty.	20					
	LEVEL 1	60				60	100%
	LEVEL 2	50				45	90%
	LEVEL 3	40				0	0%

Appendix One

Date 2nd May 2006

Howard House
Queens Avenue
Bristol BS8 1SN

Direct Tel: 0208 364 3666
Email:dilgert@willis.com

Mr. D. Sloman
Chief Executive
Whittington Hospital
Highgate Hill
London
N19 5NF

Our reference T221

Dear Mr Sloman

CNST General Assessment

Please find enclosed your report following my visit on the 16th and 17th January 2006 which confirms that the trust has been successful in achieving level 2 of the CNST Risk Management standards.

The summary score sheet indicates the score awarded in each of the standards. In order to meet compliance at level 2 the trust must achieve a minimum of 90% in each standard at level 1 and a minimum of 75% against each of the standards at level 2.

An action plan is attached at the end of the report, which summarises the areas which will need to be addressed to increase the level 2 score to 90% in order to go forwards for a level 3 assessment.

The action plan should be completed and include realistic timescales and designated responsibilities for taking the actions forward. After completion you may want to confirm the actions with your assessor as this will be used by CNST at subsequent assessments and may well be requested by other organisations such as the Healthcare Commission and Internal Audit for their reviews. The action plan should therefore be up to date and readily available.

In accordance with NHSLA and CNST requirements, the trust will need to be re-assessed against the level 2 standards no later than January 2009. The trust is able to request a visit earlier if it is ready to be assessed at level 3, this should be discussed with your assessor in more detail.

Following a request under the Freedom of Information Act, and in line with the ethos of providing more information for patients and public, the NHSLA now publishes on its website the reports which are produced following a risk management assessment. This approach is also consistent with the principles of the *Concordat between bodies inspecting, regulating and auditing healthcare* to which the NHSLA is a signatory.

If you wish to raise any concerns you may have as to the wording of the report please contact your assessor within four weeks of the date of this letter.

Should you have any queries please contact me at dilgert@willis.com or via the office number above.

Yours sincerely

Tracy Dilger
Risk Management Assessor (East Team) – NHSLA Schemes

C.c. Deborah Wheeler, Director of Nursing and Clinical Governance
Debbie Clatworthy, Acting Assistant Director of Nursing (Clinical Governance and Risk Management

Appendix 2

Child Protection Annual Report 2005/2006

1. Child protection staffing

Trust staff with specific responsibilities for child protection are:

Named Doctor:	Dr Heather Mackinnon
Named Nurse:	Post has been covered by temporary arrangements. Post has now been recruited to.
Named midwife:	Jacqueline Davidson
Trust Board lead:	Deborah Wheeler
Divisional manager for women and children's services	Anne Gibbs

The child protection team within the hospital has been depleted over the past two years, following the departure of the previous named nurse. The trust was unable to recruit a substantive replacement, and has covered the post through acting arrangements. The Paediatric Liaison Health Visitor has covered key aspects of the post.

A named nurse has now been recruited and will take up the post in March 2006.

The named doctor is currently working over 10 PAs per week. The Trust has recruited additional consultant paediatricians one of whom has a special interest in medical education and has a particular remit for child protection training in her job description. This will reduce the named doctor's workload, and in due course enable a reduction to 10 PAs, including sessions for child protection.

2. Child protection structures

The Trust has a Strategic Child Protection Forum, where representatives from all areas within the hospital that care for children meet, to ensure common practice and to discuss key issues and priorities. It is chaired by the Director of Nursing & Clinical Development, and has representatives from local primary care trusts and social services. This Forum meets quarterly. In addition a new operational group has been formed which is intended to meet monthly. This is a smaller group chaired by The Divisional Manager of Women and Children's services.

Work is being undertaken to create a safeguarding children team, which will mean that the named nurse post no longer works as a single function, and will provide better cover during periods of leave. This is in line with national recommendations.

3. Child protection training

Specific training on child protection is now included as part of The Trust Induction and also on mandatory updates for all staff.
Child protection training days have taken place most months within the hospital.

In addition, all new Paediatric and Emergency Department Senior House Officers have specific child protection training.

In October 2005, Dr Mackinnon, Named Doctor, and Annie Souter, Paediatric Social Worker, presented “Thinking the Unthinkable – Deliberate Harm to Children in Hospital”, a presentation of cases where children may have been non-accidentally injured in hospital, on the trust-wide audit and training afternoon.

In February 2006. Dr Mackinnon, Dr Fertleman, Consultant Paediatrician, Annie Souter and Jo Carroll gave an afternoon seminar to local GP’s on Children at risk – babies and adolescents.

One of the priorities for the new named nurse is to develop a Trust training strategy for child protection.

4. Whittington Child Protection Guidelines

These have been substantially revised this year and ratified by the Trust Board. They are currently being formatted by CEAD and will then be available on the intranet.

5. Audit

An audit of 24 case notes of children admitted to The Whittington between July 2004 and July 2005 and referred to the hospital’s Children and Families Social Work team was conducted by a Paediatric SpR and SHO, supervised by Dr Mackinnon. This demonstrated “room for improvement” in a number of areas.

An audit of the use of the forms used by ward staff to make referrals to the hospital social workers was conducted by Sue King, social worker. Twenty forms were audited. The audit demonstrated that referral forms were frequently inadequately filled in by ward staff before being faxed to the social work department and were often not filed in the patients case notes when faxed back to the ward by the social workers.

It is anticipated that the named nurse will prospectively monitor all documentation in future.

6. Healthcare Commission

Improvement Review

In January 2006 The Healthcare Commission requested information on the training of doctors in Child Protection in the Trust.

Definitions of Child Protection training were:-
Level1 – A basic talk eg: at induction
Level 2 – More specialised eg: 1 day general training
Level 3 – Very specialised eg: for those that will train others

In collecting this information we identified that a large number of children are seen at The Whittington outside of the Paediatric department. Staff in those areas generally have had

very little Child Protection training. There is also room for improvement in the training of paediatric doctors.

These issues will be addressed by the named nurse in developing the Trusts training strategy for Child Protection.

Core standard 2

The Trust has had difficulty in fully meeting the child protection standards. It is hoped that this will be easier to achieve once the named nurse is in post.

7. Serious Case Reviews

There have been no new multi-agency serious case reviews in the last year.

A recent incident where a three year old child (AT) who was on police protection was removed from the hospital by her mother and was missing for 24 hours is currently being investigated internally. Anne Gibbs is leading on this.

One case (Y) was described in last years Child Protection annual report. Following a Part 8 review, four recommendations pertaining to the Whittington Trust were made and ratified by the ACPC. The Quality Assurance sub-group of the ACPC are tasked with monitoring the Trust's response to and implementation of the recommendations. A meeting between the Quality Assurance sub-group and the Whittington's named doctor and nurse was held on the 6th of March 2006. It was agreed that a lot of progress had been made and that this was backed up by written evidence (eg: the audits described above).

8. Conclusion

It has been another challenging year for the people leading on child protection within the hospital, due to ongoing difficulties in recruiting a substantive named nurse.

Despite this we have managed to revise the Trust's Child Protection guidelines, increase the amount of training occurring in the hospital and to conduct an important case notes audit.

A number of areas for improvement have been identified through the case notes audit, the SW referral forms audit, the Heathcare Commission Annual Healthcheck and the serious case review (Y). Addressing these will be a priority for the new named nurse.

Other priorities for 2006/7 include finalising the guidelines, developing a training strategy, improving electronic access to all child protection guidelines and other documents and working towards meeting the Healthcare commission's core standards for child protection.

We hope to recruit another nurse to support the named nurse and doctor in developing the Whittington safeguarding children team.

HSM
8.3.06