The Whittington Hospital NHS
NHS Trust

ITEM: 12

MEETING: Trust Board 16 May 2007

TITLE: Clinical Governance Report

SUMMARY: This report summarises progress against the key aspects of clinical governance that were considered by the March and April meetings of the Clinical Governance Steering Committee:

- "Safety First" (Department of Health publication)
- National Confidential Enquiry into Patient Outcome and Deaths (NCEPOD) report
- Child Protection annual report
- Patient complaints update

Following the update at last Trust Board, the increased number of complaints since November 2006 has continued. The Trust has managed, however to maintain a response rate well over 80% since January, following the significantly lower response rate in December. The provisional overall response rate for 2006/7 is 82.7%, subject to confirmation.

ACTION: for information

REPORT FROM: Deborah Wheeler, Director of Nursing & Clinical Development

Financial details supplied/checked by: N/A

Recommendations contained within this paper have been checked for compliance with relevant statute and regulations/directions/policy as follows:

Safety First, Department of Health, December 2006

The Coroner's Autopsy: Do we deserve better? NCEPOD, October 2006

The Children Act, 1989

Healthcare Commission core standards C1, C2, C14

1. Safety First

"Safety First" was published in December 2006 by the Department of Health to reconsider the organisational arrangements currently in place to ensure that patient safety is high on the healthcare agenda. The report makes a number of key recommendations to build on he progress of embedding patient safety across the NHS.

Appendix A details each recommendation contained in the report, and benchmarks the Trust against each of these recommendations.

2. NCEPOD report 2006

The latest annual NCEPOD report was published in October 2006, looking at the quality of Coroners' autopsy reports, and processes to maintain consistency of standards and accountability.

A number of the recommendations are not relevant to the Whittington, as they are directed to Coroners' Officers. Of the remaining recommendations, the Whittington is complaint with them all, including:

- Inclusion of clinical/case history in the autopsy report
- Full record of external examination of the body
- Complete autopsy (examination of all internal organs) should be performed. Limited autopsy should be carefully considered on a case by case basis
- Autopsy reports must indicate whether tissues were retained
- Best practice is followed in the mortuary.

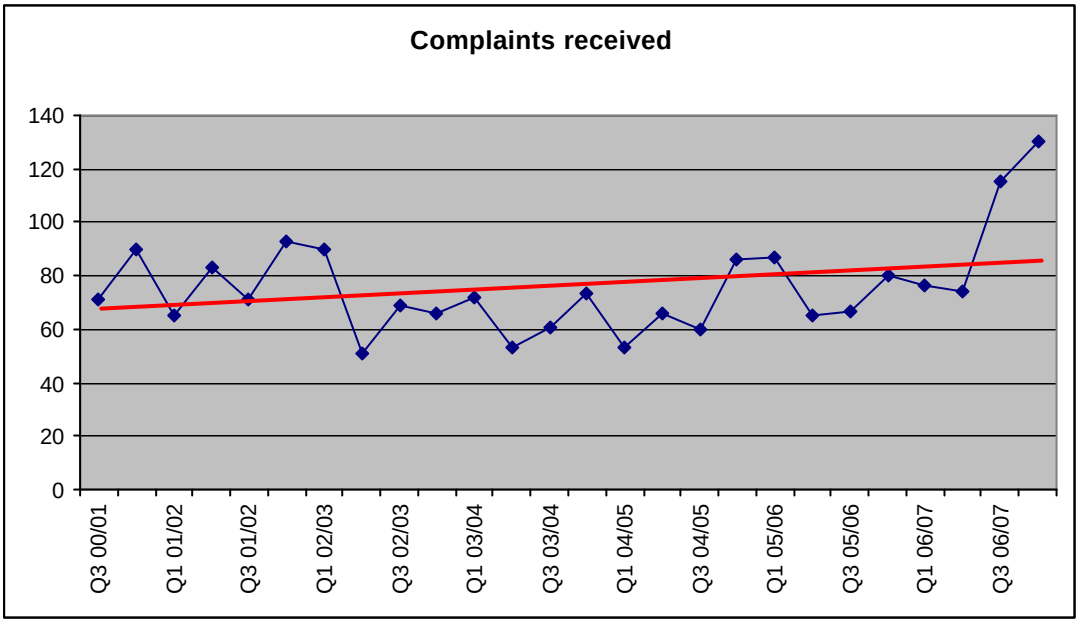
3. Child Protection annual report

Appendix B is the annual report on Safeguarding Children for 2006/7.

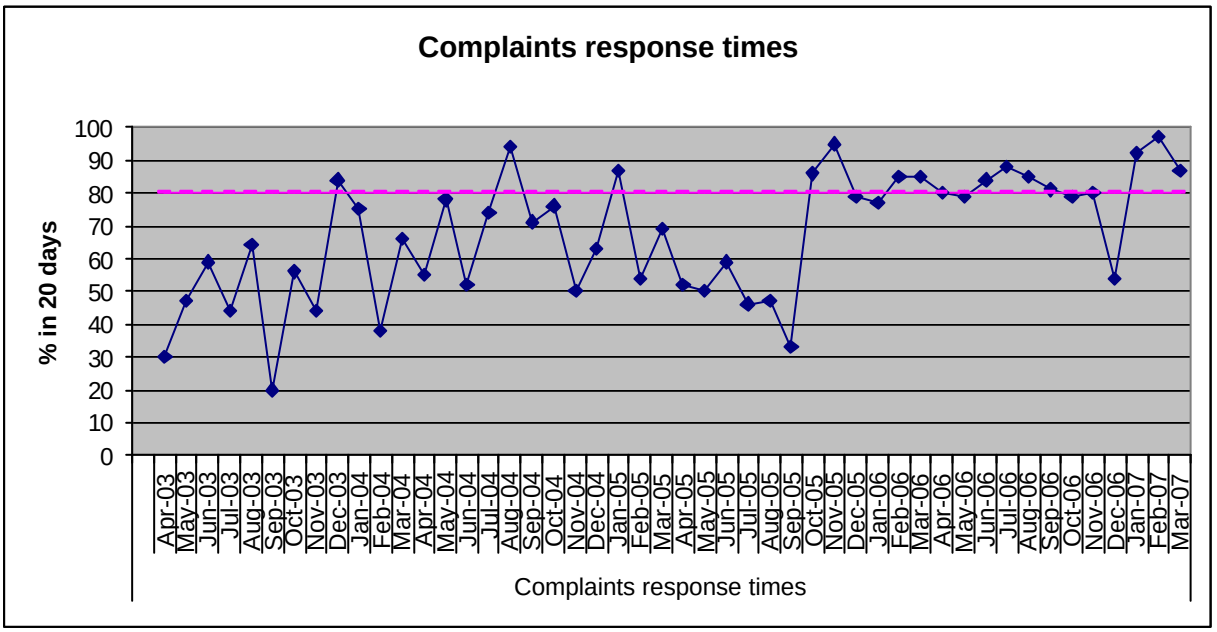
4. Patient complaints

The quarterly report for complaints received between January and March 2007 (quarter 4) is not yet available. With the longer response times for complaints (25 days), the last complaints for March was not closed until 8 May, and the report is currently being drafted. It will be available at the next Board meeting.

Initial analysis of the data shows that the number of complaints received has remained at the higher rate seen since November 2007, when the Patient Relations Office moved to the new main entrance.



Response rates have, however, been maintained through the year at over 80%, other than for December 2007, which was affected by key staff being absent. Action was, however, taken as soon as it was apparent that the December performance had deteriorated, which has been reflected in the high response rates in January, February and March.



The detailed quarterly report, which will include analysis of themes in complaints and the actions taken in response, will be presented to the next Board meeting.