NHS
Litigation Authority

NHS Litigation Authority

Risk Management Standards for Acute Trusts

Level 1 Assessment of Portsmouth Hospitals NHS Trust

28 March 2008

MANAGING RISK DNV

Contents

1: The NHS Litigation Authority

Background

The NHS Litigation Authority (NHSLA) is a Special Health Authority established in 1995 to administer the Clinical Negligence Scheme for Trusts (CNST) and thereby provide a means for NHS organisations to fund the cost of clinical negligence claims. Almost immediately the NHSLA's role expanded to cover clinical claims arising from incidents occurring before 1995. In 1999 the Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES), together known as the Risk Pooling Schemes for Trusts (RPST), were established to fund the cost of legal liabilities to third parties and property losses.

Through its schemes the NHSLA seeks to encourage and support the effective management of risk and claims. Membership of the schemes is voluntary and open to all NHS trusts and PCTs in England. Funding is on a pay-as-you-go non profit basis, and organisations receive a discount on their scheme contributions where they can demonstrate compliance with the NHSLA risk management standards.

The NHSLA introduced the CNST Clinical Risk Management Standards shortly after it was established, followed by the RPST Standard in 2000. All member organisations were required to be assessed against both sets of standards. At the end of March 2005 the RPST Standard was withdrawn (pending the development of revised standards) and in March 2006 the CNST General Standards were withdrawn and replaced by the NHSLA Risk Management Standards for Acute Trusts (including specialist hospitals).

The NHSLA has awarded a risk management contract to Det Norske Veritas (DNV). The contract includes delivery of risk assessment, standards development and maintenance, and education services to all Scheme Members.

The Assessment Process

There are currently three levels of assessment, with each level being a distinct assessment containing its own individual question sets and scored on a stand-alone basis. Lower level(s) are not reassessed as the organisation progresses.

The progression of organisations through the standards is logical and follows the development, implementation, monitoring and review of policies and procedures.

- Level 1 deals with establishing effective risk management systems and processes.
- Level 2 assesses whether the systems described at level 1 have been implemented.
- Level 3 concentrates on whether the organisation is monitoring its compliance with the systems and acting on the findings.

Assessment against the standards, in accordance with the following principles is a mandatory requirement of scheme membership. Refusal by an organisation to be assessed will result in it being deemed to be at level 0 and may lead to the NHSLA declining to provide an indemnity.

The frequency of assessment is as follows:

- Level 0 organisations must be assessed on an annual basis until such time as they achieve level 1.
- Level 1 organisations must be assessed against the standards at least once in any two-year period.
- Level 2 and 3 organisations must be assessed against the standards at least once in any three-year period.

However, if an organisation fails an assessment and, as a consequence, falls to a lower level, it will be required to be assessed at the lower level in the following financial year.

In exceptional circumstances, the NHSLA may also require organisations to be assessed outside the specified schedule.

Benefits of Assessment

The promotion of risk management and governance are integral components of the NHSLA schemes.

If organisations comply with the standards, they should benefit from the investment in risk management by having fewer claims and will pay lower scheme contributions.

The standards and assessment process are designed to:

- provide a structured framework within which to focus effective risk management activities in order to deliver quality improvements in organisational governance, patient care and the safety of patients, staff, volunteers and visitors
- increase awareness and encourage implementation of the national agenda for the NHS
- encourage and support organisations in taking a proactive approach to improvement
- reflect risk exposure and empower organisations to determine how to manage their own risks
- contribute to embedding risk management into the organisation's culture
- reduce the level of claims by reducing the number of incidents and the likelihood of recurrence
- assist in the management of adverse incidents and claims
- provide assurance to the organisation, other inspecting bodies and stakeholders, including patients

2: Executive Summary

On 28 March 2008, the NHS Litigation Authority conducted a Level 1 assessment of Portsmouth Hospitals NHS Trust.

This assessment was based on the NHSLA Risk Management Standards for Acute Trusts - April 2007.

Our key findings and recommendations are summarised below and set out in full within the body of this report.

Our key findings/recommendations

The organisation was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 1 the organisation was required to pass at least 40 of these criteria, with a minimum of five criteria being passed in each individual standard. The organisati

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The organisation was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 1 the organisation was required to pass at least 40 of these criteria, with a minimum of five criteria being passed in each individual standard. The organisation scored as follows:

Standard →	1	2	3	4	5
	Governance	Competent & Capable Workforce	Safe Environment	Clinical Care	Learning from Experience
Score	9	9	10	9	9
Compliance achieved per standard	Yes	Yes	Yes	Yes	Yes
Overall compliance achieved	Yes				

The organisation was assessed at an existing level for the first time where no formal assessment has previously been undertaken therefore in order to meet compliance overall the organisation was required to score 40 – 50, with at least five criteria being passed in each individual standard.

These scores indicate that the organisation was successful in achieving compliance at Level 1 of the standards and as such will receive a 10% discount from both CNST and RPST contributions. The discount will be applied from the beginning of the next financial quarter.

In accordance with NHSLA and Scheme requirements, the organisation will need to be reassessed against the Level 1 standards no later than the fourth quarter of 2009/10. The organisation may apply for assessment at a higher level between mandatory assessments. However, in order to ensure that systems are embedded, the organisation is advised to wait at least two years before being assessed at the next level. The organisation is asked to note that organisations which under perform at assessment will drop to a lower level and can potentially drop to Level 0.

Prior to formal assessment the organisation was encouraged to conduct a self-assessment. The organisation's self assessment results are depicted below and plotted against the actual assessment results. It will be pleasing for the organisation to note that few major discrepancies in scoring are highlighted.

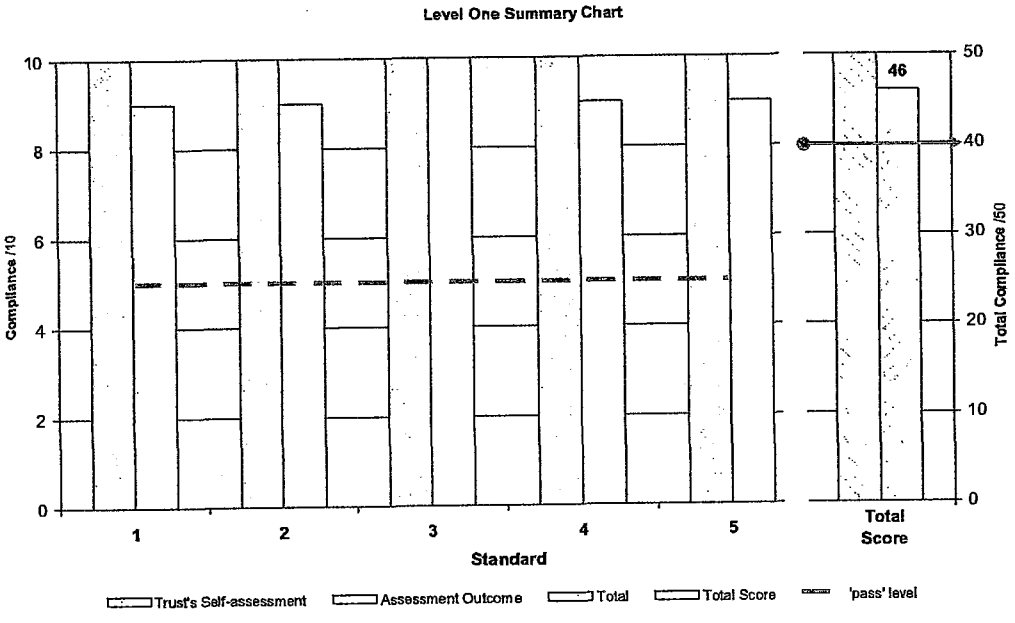

Chart 1: Comparison of the organisation's self-assessment to actual assessment outcome

Overall summary of the organisation's performance

Portsmouth Hospitals NHS Trust was successful in demonstrating compliance with the Level 1 requirements of the NHSLA Risk Management Standards for Acute Trusts, scoring 46 out of 50.

The organisation is encouraged to sustain improvements regarding positive developments and continue to embed the systems and processes outlined within the documentation seen during this assessment in order to successfully move forward to higher level assessments.

The organisation is reminded that documents seen during this assessment will require review before plans can be made to embed process into practice and prior to future assessment. Each process described in each document must reflect current practice in the trust and also satisfy the minimum requirements within these standards.

Monitoring

It became apparent during the assessment that the organisation had not addressed the minimum requirements in relation to describing the process for monitoring the effectiveness of all the minimum requirements within the approved documentation. It is recommended that the organisation reviews the documentation prior to any future assessment to ensure that this is included. Please note any document(s) with an approval date prior to 1 April 2008 should ideally contain this information. Any documents approved on or after this date must contain the information to ensure compliance. On this occasion compliance was awarded where all other minimum requirements were met.

Standard 1: Governance

A score of 9 out of 10 was achieved in the Governance Standard.

It is essential that effective functioning of the board, managerial leadership, accountability, the organisation's systems and working practices ensure that risk management, patient and staff safety are central to the activities of the Trust.

Although it was clear throughout the assessment that many processes are embedded throughout the organisation current practice was not always truly reflected within the policy documents. Therefore a number of committee terms of reference and core policies including the recruitment policy, policy on policies the risk management strategy and others will require thorough review prior to future assessment. It is expected that within its documentation the organisation is clear concerning the expectations it has with regard to committees, departments and all staff.

Approved documentation around employment checks and professional staff registration are essential to ensure patient safety in order to prevent employment of those who should not be working within the NHS setting. The organisation must ensure that it develops documentation accurately explaining each process it has in place to ensure that only suitable persons are employed by the Trust.

Standard 2: Competent & Capable Workforce

A score of 9 out of 10 was achieved in the Competent & Capable Workforce Standard.

This standard seeks to ensure that there are documented arrangements regarding training and support with the safety of patients and staff in mind. These processes were found in some cases to be fragmented throughout the reviewed documentation. The support process for staff when being called as a witness was not seen and the policy will in future need to include this important area of support. Throughout this documentation the follow up of staff who fail to attend training has not been well addressed. Therefore the organisation is asked to review its systems in order that more robust arrangements can be developed and guidance made clear for all staff. This will require review within the body of each of the approved training documents prior to future assessment and in order to move to higher levels in this assessment process.

Standard 3: Safe Environment

A score of 10 out of 10 was achieved in the Safe Environment Standard.

This standard was well addressed however the issues highlighted in the body of the report will need to be addressed by the organisation prior to future assessment and to move to higher levels in this assessment process.

Standard 4: Clinical Care

A score of 9 out of 10 was achieved in the Clinical Care Standard.

Approved documentation describing the process for managing the risks associated with the identification of patients and infection control require thorough review in line with current best practice. Delegated consent and procedure specific training both require more robust detail within the consent policy keeping in mind the current practice across the organisation. The policy on resuscitation will require thorough review prior to future assessment in order to reflect all the minimum requirements. Issues highlighted in the detailed report below will need to be addressed by the organisation prior to future assessment and to move to higher levels in this assessment process.

Standard 5: Learning from Experience

A score of 9 out of 10 was achieved in the Learning from Experience Standard.

All NHS organisations should have in place robust systems for the reporting, management and investigation of incidents, including near misses, ill health and hazards, which will help to facilitate organisational learning. Complaints and claims should be examined in conjunction with reported incidents, and near misses to allow trends to be identified at both a local and strategic level and changes to be implemented. The Trust should consider and implement lessons learnt from appropriate external investigations such as National Confidential Enquiries to ensure a robust mechanism is in place for the Trust to operate as safely as possible.

3: Assessment Results

Standard 1: Governance

Overview

Effective functioning of the board, managerial leadership and accountability, and the organisation's systems and working practices ensure that quality assurance, quality improvement and patient safety are central to the activities of the healthcare organisation. Organisations should apply the principles of sound corporate governance. Board level responsibility for risk management should be defined clearly and there should be clear lines of individual accountability managing risk throughout the healthcare organisation leading to the board. Organisations should undertake systematic risk assessment and risk management. Risk management should be fully embedded in the organisation's management process.

A score of 9 out of 10 was awarded in this Standard.

Key Findings and Recommendations

Assurance was taken from the Audit Commission's ALE KLOE scores 4.1 for three criteria within this Standard. (Criterion number 1.1.4, 1.1.5 and 1.1.6)

1.1.1 There is an organisation-wide risk management strategy which has been approved by the board.

As a minimum, the approved documentation must include a description of the:

a. *organisational risk management structure, detailing all those committees/sub-committees/groups which have some responsibility for risk*
b. *process for board review of the organisation-wide risk register*
c. *process for the management of risk locally, which reflects the organisation-wide risk management strategy*
d. *duties of the key individual(s) for risk management activities*
e. *authority of all managers with regard to managing risk*
f. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

The process for the management of risk locally (c) was seen within the organisations guidance document, *Policy For The Management Of Adverse Events And Near Misses (Including Serious Untoword Incidents)* dated 5th March 2008. The process is well defined, however, this should be reflected in the trust wide *Risk Management Strategy* to provide clear and comprehensive guidance for all staff.

The issue highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment process.

1.1.2 The organisation has approved documentation which describes the process for developing organisation-wide procedural documents.

As a minimum, the approved documentation must include a description of the following requirements:

a. *style and format*
b. *definitions of terms used*
c. *consultation process*
d. *ratification process*
e. *review arrangements*
f. *control of documents, including archiving arrangements*
g. *associated documentation and references*
h. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

Style and format (a) was seen in the organisations guidance document *Policy for Management of Policies* dated January 2008 however the process in each case was fragmented throughout the document. When this policy is next reviewed clear instructions regarding the requirements of the organisation regarding style and format should be included.

The overarching document did include definitions (b). The policy however defined these with regard to the seen document rather than giving guidance on what authors must do or consider regarding the inclusion of definitions of terms when creating a new document. On review of the *Policy for Management of Policies* more robust instructions regarding definitions should be detailed for all staff involved in the development of organisation wide procedural documents.

The overarching document did not give any guidance regarding acceptable timeframes for consultation (c) or ratification (d) of documents. Policies reviewed throughout this assessment process had in some cases taken up to 2 years from first committee to final committee approval stage. The organisation is asked to strongly consider including some detail regarding timeframes in the *Policy for Management of Policies* when it is next reviewed.

The routine review arrangement (e) for policies was documented in section 5, *Policy Control,* in the *Policy for Management of Policies.* However, no process was described there regarding when a document might require re-evaluation prior to its review date. When this policy is next reviewed the organisation should consider the inclusion of the process regarding arrangements when documents are reviewed or amended outside the agreed review dates.

Associated documentation and references (g) were found only as a heading in the approved document *Policy for Management of Policies.* They were however seen as part of a policy template document which runs concurrently with the *Policy for Management of Policies* on the Trust intranet site. The template seen was not clearly linked or appendiced to the approved document nor was the required process fully detailed in either document.
On review of the *Policy for Management of Policies* the organisation should consider that more robust guidance is detailed within for all staff to clearly follow when involved in the development of organisation wide procedural documents.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment process.

1.1.3 The organisation has approved terms of reference for the board sub-committee(s) with overarching responsibility for risk.

As a minimum, the terms of reference must include a description of the:

a. *duties*
b. *accountability, including reporting arrangements*
c. *membership, including nominated deputy where appropriate*
d. *required frequency of attendance by members*
e. *reporting arrangements into the committee(s) from sub-committees*
f. *requirements for a quorum*
g. *frequency of meetings*
h. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

The Audit Committee, the Finance Committee and *The Governance and Quality Committee* share overarching responsibility for all risk management at board sub committee level. The organisation is at present reviewing its committee structure in order to integrate all types of risk under the umbrella of one committee at sub board level (with the exception of finance). This will ensure a clear overarching picture of risks throughout the organisation which are being reported onwards to the trust board. When these committees' terms of reference are reviewed the organisation is asked to consider the inclusion of all the minimum requirements in this criterion in order to maintain compliance at future assessment.

1.1.8 The organisation has approved documentation which describes the process for managing the risks associated with clinical records in all media.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *legal obligations that apply to records, as a minimum to include Data Protection Act 1998 and Freedom of Information Act 2000*
c. *process for tracking records*
d. *process for creating records*
e. *process for retrieving records*
f. *process for retaining and disposing of records*
g. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment the *Health Records Management Policy* dated July 2007 was reviewed. Under the heading *Process for Creating a Record, Section 12* there is guidance regarding filing, temporary folders and the amalgamation of records

however this policy does not incorporate any detailed guidance to staff on the process for the routine creation (d) of the individual patient record.

The issue highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment process.

1.1.10 The organisation has approved documentation which describes the process for ensuring that all appropriate employment checks are undertaken for all staff (temporary and permanent).

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *types of check required*
c. *checking procedures*
d. *process for following up those who fail to satisfy the checking arrangements*
e. *process for monitoring/receiving assurance that checks are being carried out by all external agencies (e.g. NHS Professionals, recruitment agency etc.) used by the organisation*
f. *process for monitoring the effectiveness of all of the above.*

This criterion did not achieve compliance with the standard.

During the assessment the *Trust Policy and Protocol for Recruitment and Selection* dated February 2008 was reviewed. The duties described here were not specific to the process for those ensuring that all appropriate employment checks are undertaken for all staff (a).

The types of check required (b) were found throughout the policy however detailed guidance around these to assist those undertaking the checking must be clarified and made more robust when this policy is next reviewed in particular clearly outlining those types of identification checks that are acceptable to the organisation.

The *Trust Policy and Protocol for Recruitment and Selection* included the process for following up those who fail to satisfy the checking arrangements (d) with regard to medical health checks and Criminal Records Bureau (CRB) checks. The policy however did not include any process for following up those who fail to satisfy the checking process for any other type of check. When this policy is next reviewed the organisation must include all types of check and a process for following up those who fail to satisfy each related checking process.

The issues highlighted here will need to be addressed prior to future assessment in order to achieve a score in this criterion and move to higher levels in this assessment process.

Standard 2: Competent and Capable Workforce

Overview

The organisation has a responsibility to deliver a safe service to patients by ensuring staff are appropriately qualified and skilled professionals. To ensure that staff (temporary and permanent) and others are adequately equipped to work in the NHS environment and provide care to patients, they must receive training and support, both on initial appointment and on an ongoing basis. By ensuring effective, ongoing training and support, the organisation is promoting the delivery of high quality focused care.

A score of 9 out of 10 was awarded in this Standard.

Key Findings and Recommendations

1.2.1 The organisation has approved documentation which describes the corporate induction arrangements for all new permanent staff.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *minimum content of the corporate induction programme(s)*
c. *process for ensuring that all new permanent staff are booked onto corporate induction*
d. *process for enabling all new permanent staff to complete corporate induction*
e. *process for following up those who fail to attend corporate induction*
f. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment the *Trust Policy and Protocol for Induction* dated February 2008 was reviewed. A brief outline of the process for following up those who fail to attend (e) was seen in a flowchart regarding the induction process on page 22 of this document. However, the organisation should consider the fully detailed inclusion of the process within the body of this document when it is next reviewed.

The issue highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion.

1.2.2 The organisation has approved documentation which describes the local induction arrangements for all new permanent staff.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *minimum content of local induction programmes*
c. *process for enabling all new permanent staff to complete local induction*
d. *process for following up those who fail to complete local induction*
e. *process for monitoring the effectiveness of all of the above*

Compliance was awarded in this criterion.

During the assessment the *Trust Policy and Protocol for Induction* dated February 2008 was reviewed. A brief outline of the process for following up those who fail to complete local induction was seen in a flowchart regarding the induction process on page 22 of this document. However, the organisation should consider the fully detailed inclusion of the process within the body of this document when it is next reviewed.

The issue highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion.

1.2.4 Supervision of medical staff in training

Organisations which have no more than two outlying specialties in the categories contributing to the overall rating of clinical supervision as determined by the PMETB/COPMED trainee survey.

Compliance was awarded for this criterion.

A positive score has been awarded for this criterion although it has neither been assessed by the NHSLA nor assurance taken from other sources. The NHSLA, PMETB and COPMeD agree that the review of systems to ensure appropriate supervision of medical staff in training should be undertaken by PMETB and COPMeD and direct assurance taken from these bodies by the NHSLA within its assessment process. Unfortunately, the arrangements necessary to enable this approach to be implemented were not in place at the time of the assessment.

1.2.5 The organisation has approved documentation which describes the process for ensuring a systematic approach to risk management training for all permanent staff.

As a minimum, the approved document must include a description of the process for:

a. *identifying the training needs of all permanent staff*
b. *creating an action plan(s) for the delivery of the identified training*
c. *developing a training prospectus*
d. *enabling all permanent staff to complete the relevant training programmes*
e. *following up those who fail to attend relevant training programmes*
f. *co-ordinating training records*
g. *monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment *The Trust Policy and Protocol for Learning and Development* dated February 2008 was reviewed. The process for following up those who fail to attend relevant training programmes (e) should be made more explicit within the body of this document as it is also fragmented throughout other training documents seen as part of this assessment process. When a clear process has been created and included within the overarching document the organisation should consider either reflecting this or linking it to all other relevant training documents.
The issue highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion.

1.2.8 *The organisation has approved documentation which describes the process for ensuring the delivery of effective hand hygiene training for all relevant permanent staff groups.*

As a minimum, the approved documentation must include a description of the:

a. *duties*

b. *process for enabling all relevant permanent staff groups, as identified in the training needs analysis, to complete hand hygiene training*

c. *process for following up those who fail to attend hand hygiene training*

d. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

Duties (a) were referred to briefly within the hand hygiene policy however the terminology used is in regard to infection control and is not specific to hand hygiene. When the policy is next reviewed the wording should fully reflect the special detail around hand hygiene training and not just the broader aspects of infection control.

The policy mentions hand hygiene link advisors and trainers. These roles should be expanded within the policy in order to fully clarify the duties (a) of those individuals with responsibility for hand hygiene training when this policy is next reviewed.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion.

1.2.9 *The organisation has approved documentation which describes the process for ensuring the delivery of effective moving and handling training to all permanent staff.*

As a minimum, the approved documentation must include a description of the:

a. *duties*

b. *process for enabling all permanent staff, as identified in the training needs analysis, to complete relevant moving and handling training*

c. *process for following up those who fail to attend relevant moving and handling training*

d. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment the Trust *People Moving and Handling Policy* dated March 2008 was reviewed. Moving and handling trainers were mentioned in the policy however they were not included in duties (a).

When this policy is next reviewed the organisation should ensure that duties for staff delivering moving and handling training are clearly included in the overarching policy.

The issue highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion.

1.2.10 *The organisation has approved documentation which describes the process for ensuring that all staff involved in traumatic/stressful incidents, complaints or claims are adequately supported.*

As a minimum, the approved documentation must include a description of the:

a. *duties*

b. *immediate support offered to staff (internally and, if necessary, externally)*

c. *ongoing support offered to staff (internally and, if necessary, externally)*

d. *advice available to staff in the event of their being called as a witness (internally and, if necessary, externally)*

e. *action for managers or individuals to take if the staff member is experiencing difficulties associated with the event*

f. *process for monitoring the effectiveness of all of the above.*

This criterion did not achieve compliance with the standard.

The minimum requirements for this criterion were presented in a number of separate documents. The required information appeared very fragmented. When these documents are next reviewed the organisation should consider bringing together all the elements in this criterion for clear instruction to ensure all staff involved in stressful situations are adequately supported.

Although a number of hyperlinks were reviewed during the assessment including large sections of detail in the documents there was nothing relevant seen for advice available to staff in the event of their being called as a witness (internally and, if necessary, externally) (d) and therefore compliance could not be awarded in this criterion.

The issue highlighted here will need to be addressed prior to future assessment in order to achieve a score in this criterion and move to higher levels in this assessment.

Standard 3: Safe Environment

Overview

A safe environment is essential to the provision of healthcare to ensure that staff, patients and their visitors are protected from accidents, injury and disease and to provide a safe place in which high quality clinical care can be provided. During visits to an organisation, patients and staff have a right to have their needs assessed and action taken so they are protected from harm. When adverse events (incidents) occur, appropriate responses should be taken to support individuals.

Full Compliance was awarded in this Standard.

Key Findings and Recommendations

1.3.2 The organisation has approved documentation which describes the process for managing the risks associated with child protection.

As a minimum, the approved documentation must include the:

a. *duties*

b. *local arrangements for addressing child protection*

c. *organisation's expectations in relation to staff training, as identified in the training needs analysis*

d. *process for supporting staff involved in child protection*

e. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this standard.

During the assessment the procedure for *Safeguarding and Promoting the Welfare of Children and Young People: Multiprofessional Guidelines* dated February 2008 was reviewed. The process for supporting staff involved in child protection (d) was fragmented throughout the document and appeared incomplete. The organisation is asked to consider the clear inclusion of a robust process for supporting staff involved in child protection when the overarching document is reviewed.

The issue highlighted here will need to be addressed prior to future assessment in order to achieve a score in this criterion and move to higher levels in this assessment.

1.3.4 The organisation has approved documentation which describes the process for managing the risks associated with moving and handling.

As a minimum, the approved documentation must include the:

a. *duties*

b. *agreed techniques for the moving and handling of patients and objects, including the use of appropriate equipment*

c. *arrangements for access to appropriate specialist advice*

d. *requirement to undertake appropriate risk assessments for the moving and handling of patients and objects*

e. *process for the development and review of an organisational action plan following risk assessment*

f. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment a number of policies were reviewed with regard to moving and handling of patients and objects. A booklet containing techniques was hyperlinked on the intranet to the trust wide *People Moving and Handling Manual Handling Operations* document dated March 2008. However these are not available together in hard copy. Also this document was labelled as a nursing and midwifery policy which appeared to indicate it was not applicable to other grades of staff within the organisation. The organisation is asked to consider bringing these policies together for clarity and incorporating the booklet on techniques so that they can be available together in hard copy and that they are made applicable to all staff within the Trust.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

1.3.5 The organisation has approved documentation which describes the process for managing the risks associated with slips, trips and falls involving patients, staff and others.

As a minimum, the approved documentation must include the:

a. *duties*

b. *requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients*

c. *requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving staff and others*

d. *organisation's expectations in relation to staff training, as identified in the training needs analysis*

e. *process for raising awareness about preventing and reducing the number of slips, trips and falls involving patients, staff and others*

f. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment a large number of hyperlinks were made available to the *Clinical Policy & Associated Guideline for the Assessment, Prevention and Management of Adult In Patients at Risk of Falling or Who Have Already Fallen* dated

March 2008. The requirement for undertaking appropriate risk assessments for the management of slips, trips and falls involving patients (b) was however not overly clear within the document. The undertaking of a risk assessment must be made explicit within the body of the overarching document when it is next reviewed.

The process for raising awareness about preventing and reducing the number of slips, trips and falls involving patients, staff and others (e) was not fully explained within this document. This process must be clearly detailed when this policy is next reviewed.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

Standard 4: Clinical Care

Overview

The clinical care provided within the NHS environment should be of the highest quality. To support this, robust policies and procedures should be in place for all clinical care processes. Some of the higher volume and higher risk processes have been selected for assessment by the NHSLA, namely: blood transfusion, medication management and resuscitation. Care should be provided in such a way as to minimise the risk of hospital associated infection. To underpin these care processes, systematic approaches must be in place to ensure effective communication between staff and with patients.

A score of 8 out of 10 was awarded in this Standard.

Key Findings and Recommendations

1.4.1 The organisation has approved documentation which describes the process for managing the risks associated with the identification of all patients.

As a minimum, the approved documentation must include a description of the:

a. *process for identifying all patients*

b. *process for ongoing checks throughout the patient care episode*

c. *procedure to be followed in cases where patient misidentification occurs*

d. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment the *Patient Identification Policy* dated February 2008 was reviewed. The process for outpatients was somewhat limited and will require the inclusion of a process for identification of all patients (a) when this policy is next reviewed. The detail regarding how each patient's identity is checked prior to applying a wristband and identification of those without a wristband should be made more robust and less fragmented within the policy.

The procedure to be followed in cases of misidentification (c) is fragmented and seems incomplete. A full and explicit procedure will need to be included for guidance when this policy is next reviewed.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

1.4.3 The organisation has approved documentation which describes the process for managing the risks associated with consent.

As a minimum, the approved documentation must include a description of the:

a. *process for obtaining consent*

b. *process for recording consent*

c. *staff who are not capable of performing the procedure but are authorised to obtain consent*

d. *generic training on the consent process*

e. *procedure-specific training on consent for staff to whom the consent process is delegated and who are not capable of performing the procedure*

f. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment the *Consent to Examination or Treatment Policy* dated February 2008 was reviewed. The detail regarding those grades of staff not capable of performing a procedure but who are authorised to obtain consent (c) was not included in the policy. When this policy is next reviewed this detail should be made explicit.

Procedure-specific training on consent for staff to whom the consent process is delegated and who are not capable of performing the procedure (e) will require review within the policy as the detail regarding procedure specific training must be included when this policy is next reviewed.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

1.4.5 The organisation has approved documentation which describes the process for managing risks associated with the transfer of patients.

As a minimum, the approved documentation must include a description of the:

a. *duties*

b. *transfer requirements which are specific to each patient group*

c. *documentation to accompany the patient when being transferred*

d. *process for transfer out of hours*

e. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment the *Transfer of Patients Policy* dated March 2008 was reviewed. Whilst escorts were mentioned within the policy, their duties (a) were not fully explored. When this policy is next reviewed the duties of all grades of staff or others involved in escort duties must be outlined clearly within the body of the document.

The policy also appeared limited as it does not sufficiently identify all groups (b) of patients in the context of the clinical services provided by the organisation nor does it relate to all their specific requirements.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

1.4.8 The organisation has approved documentation which describes the process for managing the risks associated with resuscitation.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *early warning systems in place for the recognition of patients at risk of cardio-respiratory arrest*
c. *post-resuscitation care*
d. *do not attempt resuscitation orders (DNAR)*
e. *process for ensuring the continual availability of resuscitation equipment*
f. *training requirements for all staff, as identified in the training needs analysis*
g. *process for monitoring the effectiveness of all of the above.*

This criterion did not achieve compliance with the standard.

During the assessment the *Combined NHS Trusts Cardiopulmonary Resuscitation Policy* dated January 2008 was reviewed. Although the duties (a) of the training department were seen in *Section 8* of this document, the duties of those personnel delivering training did not appear to be included. This should be detailed within the policy when it is next reviewed.

There is a scoring system and algorithm available on the wards to demonstrate an early warning system (b). However, neither document was seen to form part or be appendiced to the approved overarching document. Also there appeared to be no clear guidance explaining how these scores should be used in practice. Detailed explanation and guidance should be included when this policy is next reviewed.

Post resuscitation care (c) requires additional detail and guidance for staff. This should be detailed within when this policy is next reviewed.

A process for ensuring the continual availability of equipment (e) did not appear to be included within this policy. This should be detailed within the policy when it is next reviewed.

The training requirements for all grades of staff (f) did not appear to be outlined in the policy, although basic life support was reflected in the organisations *Essential Training Matrix 2008.* Other types of resuscitation training such as paediatric, neonatal and advanced were not found to be sufficiently outlined within the policy nor seen in the matrix.

Overall this policy requires thorough review in order to reflect the missing detail highlighted above.

The issues highlighted here will need to be addressed prior to future assessment in order to achieve a score in this criterion and move to higher levels in this assessment.

1.4.9 The organisation has approved documentation which describes the process for managing the risks associated with infection prevention and control.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *infection control assurance framework*
c. *details of, or cross reference to, all 12 core clinical care protocols*
d. *information available to patients and the public about the organisation's general processes and arrangements for preventing and controlling health care acquired infections*
e. *training requirements for all staff, as identified in the training needs analysis*
f. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment the *Infection Control Policy* dated March 2008 was reviewed. In addition *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections Evidence Log* document was made available. This document outlines what the Trust Board should receive assurance on (b) regarding relevant aspects of infection control however, audit of the core protocols (c) was not included. The audit of core protocols should be incorporated into this log (infection control assurance framework) in order to ensure that the organisation is fully informed regarding all aspects of infection control and to demonstrate a clear process for managing the associated risks.

The current process in use within the organisation regarding the infection control framework (*The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections Evidence Log*) is not reflected within the approved *Infection Control Policy*. The description of the infection control assurance framework should be made explicit in the approved *Infection Control Policy* when it is next reviewed.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

1.4.10 The organisation has approved documentation which describes the process for managing the risks associated with the discharge of patients.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *discharge requirements which are specific to each patient group*
c. *documentation to accompany the patient when being discharged*
d. *information to be given to the patient*
e. *process for discharge out of hours*
f. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this criterion.

During the assessment the *Discharge Planning Policy* dated March 2008 was reviewed. The policy although mainly robust in nature does not sufficiently identify all groups (b) of patients in the context of the clinical services provided by the organisation nor does it relate to all their specific requirements.

The issue highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

Standard 5: Learning from Experience

Overview

All NHS organisations should have in place robust systems for the reporting, management and investigation of incidents, including near misses, ill health and hazards, which will help to facilitate organisational learning. Complaints and claims, when examined in conjunction with reported incidents, and near misses, allow trends to be identified at both a local and strategic level and changes to be implemented. This can lead to the prevention or recurrence of incidents, claims and complaints. The sharing of lessons learnt from one service to other areas of the organisation helps ensure that any system failures discovered during investigations are adopted by the organisation as a whole and pockets of good practice are not isolated. Organisations should consider and implement appropriate external guidance to ensure the organisation is operating as safely as possible.

A score of 9 out of 10 was awarded in this Standard.

Key Findings and Recommendations

1.5.2 The organisation has approved documentation which describes the process for ensuring that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to raise concerns informally.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *process for raising concerns (informal complaints/PALS)*
c. *process for ensuring that patients, relatives and their carers are not treated differently as a result of raising a concern*
d. *process by which the organisation aims to make changes as a result of concerns being raised*
e. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this requirement.

During the assessment the *Patient Advice and Liaison Service* policy dated March 2008 was reviewed. The process by which the organisation aims to make changes as a result of concerns being raised (d) although mentioned in the document the detail was insufficient. When this policy is next reviewed the organisation should consider more explicit detail and guidance regarding this process in the overarching document.

The issue highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

1.5.5 The organisation has approved documentation which describes the process for investigating all incidents, complaints and claims.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *organisation's expectations in relation to staff training, as identified in the training needs analysis*
c. *different levels of investigation appropriate to the severity of event*
d. *process for involving and communicating with internal and external stakeholders to share safety lessons*
e. *process for following up relevant action plans*
f. *process for monitoring the effectiveness of all of the above.*

Compliance was awarded in this requirement.

Three policies were reviewed during the assessment in this criterion. All three policies did not fully describe duties with regard to investigations (a). When these policies are next reviewed duties should be explained and detailed within each of these documents.

The organisations expectations with regard to training (b) should be made more explicit within the claims policy when it is next reviewed and fully reflected within the training matrix.

The issues highlighted here will need to be addressed prior to future assessment in order to maintain a score in this criterion and move to higher levels in this assessment.

1.5.8 The organisation has approved documentation which describes the process for ensuring that agreed best practice as defined in NICE clinical guidelines, national confidential enquiries and other nationally agreed guidance is taken into account in the context of the clinical services provided by the organisation.

As a minimum, the approved documentation must include a description of the:

a. *duties*
b. *process for identifying relevant documents*
c. *process for disseminating relevant documents*
d. *process for conducting an organisational gap analysis*
e. *process for ensuring that lessons learnt are acted upon throughout the organisation*
f. *process for monitoring the effectiveness of all of the above.*

This criterion did not achieve compliance with the standard.

During the assessment the *Policy for the Assurance of Implementation of NICE Guidance* dated May 2007 was reviewed. The process for disseminating documents regarding NICE (c) and conducting an organisational gap analysis for (d) CEMACH were not fully detailed within the documentation seen nor was the process for

ensuring that lessons learnt are acted upon throughout the organisation (e). When this document is next reviewed these elements should be detailed within the policy.

The issues highlighted here will need to be addressed prior to future assessment in order to achieve a score in this criterion and move to higher levels in this assessment.

4: Contacts

Assessment/Report Enquiries

This report was prepared by DNV on behalf of the NHS Litigation Authority. Any queries regarding this report should be directed to:

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