



DNV's First Annual Report on the NHS Litigation Authority (NHSLA) Contract

2008/09

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DNV AND THE NHS LITIGATION AUTHORITY

Who are DNV?

Det Norske Veritas (DNV) is an independent foundation with the purpose of safeguarding life, property, and the environment.



BACKGROUND TO DNV

Our history goes back to 1864, when the foundation was established in Norway to inspect and evaluate the technical condition of Norwegian merchant vessels.

Since then, our core competence has been to identify, assess, and advise on how to manage risk. Whether we classify a ship, certify an automotive company's management system, or advise on how to best maintain an aging oil platform, our focus is to safely and responsibly improve business performance.

Whilst headquartered in Oslo, Norway, DNV has worked internationally since 1867 and has established approximately 300 offices in 100 countries.

As a knowledge-based company, our prime assets are the creativity, knowledge, and expertise of our 9,000 employees from more than 85 different nations.

NHSLA CONTRACT

In the United Kingdom the NHS Litigation Authority (NHSLA) awarded DNV a five year contract, starting from April 2007, to deliver risk assessment; standards development and maintenance; and provide education services to NHS organisations in England.

CORE OBJECTIVES

The NHSLA's core objectives include contributing to incentives for reducing the number of negligent or preventable incidents, and contributing to the improvement of the quality of patient care by providing incentives within the schemes for NHS bodies to improve cost effective clinical and non-clinical risk management.

"A strong relationship will be established between the two organisations which will facilitate the delivery of an effective, efficient and enhanced service which will make a positive contribution to the national agenda for the NHS".

Alison Bartholomew,
NHSLA Risk Management Director

This is recognised by the Department of Health in their "Safety First" document which states that the NHSLA's functions include helping to "raise standards of care in the NHS so as to reduce the number of incidents leading to claims".

These core objectives accord with DNV's mission statement which is:

Safeguarding Life, Property and the Environment

DNV VISION: GLOBAL IMPACT FOR A SAFE AND SUSTAINABLE FUTURE

Our main focus industries are:

Healthcare

Oil, gas and energy

Maritime

Food and beverage

GLOBAL SERVICES

HEALTHCARE

NIAHOSM STANDARDS
AND THE US

WORKING RELATIONSHIP

Given this close alignment of objectives, DNV views its working relationship with the NHSLA as a partnership. Since winning the contract in 2007 DNV has been committed to maintaining and enhancing a successful partnership with the NHSLA. We have identified and utilised resources that best fit with the NHSLA and its scheme members' needs.

Our key objectives in working with the NHSLA are to:

- Ensure equality and diversity
- Work in partnership with scheme members
- Support the Concordat
- Provide value for money
- Provide efficiency
- Provide a proactive service
- Seek an interface between claims and risk management
- Work flexibly

There is regular liaison and joint working at all levels between DNV and the NHSLA, which facilitates the delivery of an effective, efficient and enhanced service, and makes a positive contribution to the national agenda for the NHS.

EXPERTISE

To achieve our goals and to ensure a strong relationship with the NHSLA we have put in place a team that delivers strategic insight, operational delivery, expert support and contract oversight.

Every member of our assessment team has an NHS background and, as such, is familiar with the public sector culture. As part of our team approach all of our staff interact with the wider aspects of DNV which has helped to create a well balanced team that has a blend of both commercial and public cultures. This and our close working partnership with the NHSLA have continued to strengthen our relationship. With this history behind us we have a solid platform to work from and are uniquely placed to grow with the NHSLA.

All of our staff are aware that in addition to representing DNV they are at all times acting as ambassadors for the NHSLA. This awareness is ingrained in our staff from the moment they start work with DNV. To act as ambassadors for the NHSLA our staff need to fully understand the NHSLA's culture, objectives and aims. To facilitate this we ensure that every member of our team is aware of the NHSLA's organisational structure, accountabilities, systems and processes. All of our staff are provided with a comprehensive suite of documents including the NHSLA's framework document, risk management strategy and other publications.

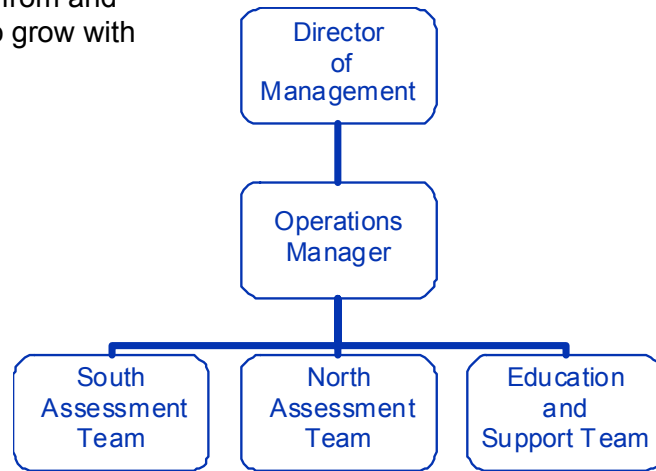


Chart 1: Team organisational structure

NIAHOSM STANDARDS

In the United States (US), DNV recently gained historic approval from the US Centres for Medicare (CMS) and Medicaid Services to deem Medicare compliance. DNV is now helping hospitals in the US transform accreditation into a strategic business advantage.

DNV's US accreditation service is based on the revolutionary National Integrated Accreditation for Healthcare Organisations (NIAHOSM) standards. NIAHOSM encourages innovation within individual hospitals whilst helping them to take advantage of system-wide best practices.

It is the first hospital accreditation program in the US that integrates the internationally recognized ISO 9001 Quality Management System with the Medicare Conditions of Participation, making it the first and only hospital accreditation program that requires continual quality improvement.

GOVERNANCE

DNV is proud to have the NHSLA as one of its most valued clients. Our aim is to continue working closely with the NHSLA and to further strengthen our relationship. For our partnership to be effective it is imperative that clear communication channels continue to function. To facilitate this we have developed a three tiered interface between the NHSLA and all levels of our organisation.

At all levels we seek to provide the NHSLA with assurance that all the threads of quality, performance and governance within our services are aligned and integrated. We also aim to assure the NHSLA that our staff, systems and processes are fit for the purpose and flexible enough to cope with changing priorities and risks.

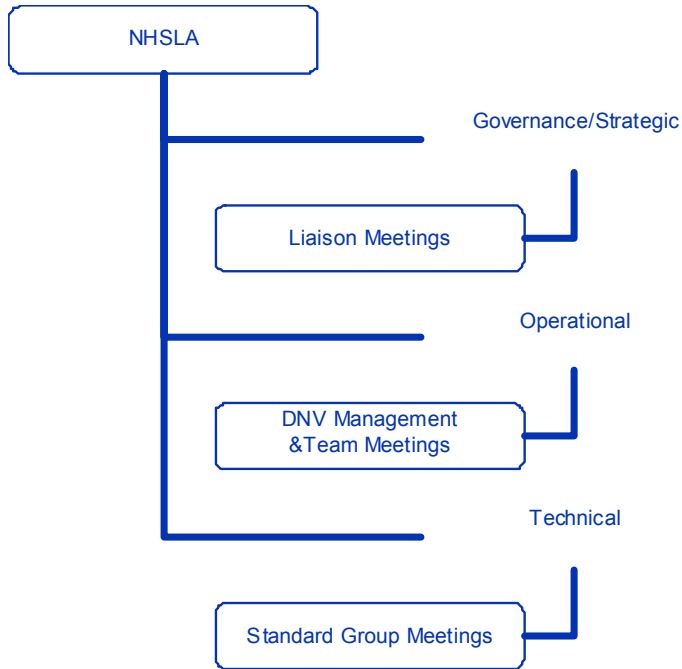


Chart 2: Governance structure

DNV'S NHSLA CONTRACT TEAM

"The NHSLA contract team transferred from Willis in April 2007. Since then the team has grown and has worked hard to integrate with DNV, whilst continuing to provide an excellent service to the NHSLA and its scheme members.

I would like to take the opportunity to thank the team for their ongoing contribution to the successful running of the contract".

David Salmon
Country Manager - DNV Business Assurance UK and Ireland

SERVICE DELIVERY

Performance monitoring

Performance monitoring is crucial to any contract to assure both parties that the services provided under the terms of the contract are as a minimum satisfactory. Within this section we have described and provided feedback on the various internal and external monitoring systems that were utilised in 2008/09.

KEY PERFORMANCE INDICATORS (KPIs)

Key Performance Indicators (KPIs) relating to the contract are negotiated annually and in 2008/09 numbered 34.

The KPIs are divided into four sections:

- Standards
- Assessments
- Education
- Service levels

DNV's performance against the KPIs is monitored internally on an on-going basis with exception reporting occurring on a bi-monthly basis at the NHSLA board meeting.

For 2009/10, we have produced an operational project plan to meet the expectations of the KPIs and monitor this on a weekly and monthly basis. The NHSLA receives a weekly update on our performance against the KPIs relating to assessments and we meet with the NHSLA bi-monthly to discuss performance against all other KPIs.

In the NHSLA's 2009 annual report the Risk Management Director reported that:

"In April 2007 the Authority entered into a five year contract with Det Norske Veritas Ltd (DNV) to develop and maintain the risk management standards, conduct assessments, and provide education services. DNV continued to provide a good service during the year, meeting or exceeding most of their agreed Key Performance Indicators."

NHSLA. (2009). Report and accounts 2009.

INTERNAL MONITORING

Within DNV we have introduced a number of internal monitoring mechanisms to ensure both accuracy and consistency in our processes. These monitoring mechanisms include:

- Regular management and team meetings to maintain effective communication systems
- Peer review of assessment reports
- Ongoing review of assessment data
- Accompanied assessments to ensure consistency in the assessment process
- Review and investigation of appeals and complaints

We are pleased to report that in 2008/09 we did not receive any complaints.

OUR NHS CONTACTS

FEEDBACK

POSITIVE COMMENTS RECEIVED FROM NHS ORGANISATIONS

"I would very much like to take the opportunity to thank you for all of your help and support over the last three years. You have constantly made yourself available to answer questions and I have found it a pleasure to work with you in regards to all of our assessments. Thank you for being an approachable and extremely efficient assessor".

Risk Coordinator

"On behalf of the trust, may I say how very grateful we have been for your assistance at all stages of the assessment process, and that we look forward to working with you in the future. I am aware that you have kindly offered to provide support to the trust prior to re-assessment, and I am sure this support will be invaluable".

Chief Executive

AUDIT

In 2008/09 DNV's assessment team underwent two audits. The first was an internal audit conducted by staff at DNV. The audit focused on the management of the NHSLA contract, with particular reference to the KPIs for the period 2008/09.

The audit and subsequent report determined that overall, the NHSLA contract is well managed, and is based around a detailed and comprehensive set of performance requirements defined by the NHSLA. The audit identified that there was a high level of review and monitoring from the NHSLA around all aspects of the contract. This was acknowledged to be very proactive and effective in providing key feedback to DNV in relation to key performance issues.

This high quality scrutiny is characterised in several ways including:

- Detailed review of objectives
- Regular contract performance review meetings
- A very detailed specification for reporting from DNV on KPIs
- A proactive approach to discussing and requesting further improvements to the contract and its management and content

The audit concluded that the contract was well managed.

The second audit was conducted at the request of the NHSLA, which appointed its internal auditors, Bentley Jennison, to assess the adequacy of the key controls in place to meet the KPIs and to review how DNV performance is monitored internally.

Bentley Jennison undertook sample testing and also interviewed assessors in order to test the application of controls.

Four recommendations to improve DNV's internal systems were made by Bentley Jennison, all of which have since been implemented. Bentley Jennison provided a written audit report which concluded with the following statement:

“Taking account of the issues identified, in our opinion the Board can take substantial assurance that the controls upon which the organisation relies to manage this risk as currently laid down and operated, are effective.”

Areas of good practice identified by the audit were as follows:

- ✓ Each of the Maternity pilot assessments has been arranged and is due to be completed by the end of November 2008.
- ✓ Assessment reports and completed evidence templates are currently being issued within the target of 28 calendar days.
- ✓ All mandatory informal assessments and voluntary informal assessments have been arranged or completed within target.
- ✓ The Weekly Update spreadsheet is routinely supplied to the NHSLA each week.
- ✓ Finalised assessment reports are routinely forwarded to the NHSLA within the target time period.
- ✓ The Post Assessment Questionnaire to be issued to organisations being assessed between October 2008 and March 2009 has been finalised and the Weekly Update has been adapted to prompt the sending of questionnaires to the relevant trusts.

“Although we were non-compliant in achieving Level 3 at this time, the team felt that [the assessors] guided us through the process sensitively and have fed back enough suitable information for us to feel confident that by implementing their findings we will be in a strong position to undertake a Level 3 assessment this time next year”.

Director

“Just wanted to thank you for coming to do the assessment. Although, obviously, we were disappointed with the result, I am so pleased that we did do it and we would all prefer to learn the lessons now rather than when it really matters in two years time. We were all very grateful for the opportunity”.

Maternity Risk Manager

“Your care and professionalism impressed the senior clinical and management team. We particularly found helpful the clarity of your explanations both when you found positive evidence of compliance and also where you found things we needed to improve. The lessons we have learnt will be integrated into the trust's clinical and management processes for the benefit of both patients and staff”.

Director

POST ASSESSMENT QUESTIONNAIRE

In 2008 the NHSLA and DNV introduced a Post Assessment Questionnaire (PAQ).

The PAQ, which is web based, was sent to risk management contacts at all acute trusts which underwent assessment during October 2008 to March 2009. Questions focused on the standards and assessment process and also encouraged feedback on the assessment team.

The NHSLA and DNV have valued both the positive and negative feedback received this year as it has allowed them to focus on where improvements are required.

A monthly summary PAQ report is reviewed by the management teams at both the NHSLA and DNV to ensure that all observations are investigated and remedial action is taken.

In total 50 PAQs were distributed with a response rate of 60%.

We would like to thank all those organisations which responded.

Assessment advice

- E-mail was the preferred method of contacting an assessor for 70% of respondents.
- 57% of respondents contacted their allocated assessor for advice in excess of five times in 2008/09.
- 95% of respondents found the advice given by assessors to be concise, relevant, knowledgeable, helpful, timely and understandable.
- 70% of respondents had an informal visit prior to assessment with 90% finding the visit very useful in preparing for assessment.

Standards manual

- 97% of respondents found the manual useful in their preparations for assessment.
- In addition respondents were asked to provide free text comments on the manual. The most common comment was that organisations would prefer to see the manual layout altered to have all three levels of one criterion together rather than all the Level 1 criteria followed by all the Level 2, etc. We are pleased to report that this suggestion is to be implemented in the 2010/11 standard manuals.

Evidence template

- There was mixed feedback on the evidence template with 24% of respondents reporting that they did not find it useful in their preparations for assessment.
- Many respondents reported problems with hyperlinking and insertion of additional rows. Our Education and Support Team have reviewed all comments and produced increased and enhanced guidance for users of the evidence template.

Assessment process and standard

- 90% of respondents rated the structure and length of the assessment visit as good or very good.
- 90% of respondents rated the assessors' advice, questions and feedback as good or very good.

ASSESSMENT PROCESS

FEEDBACK

COMMENDATIONS

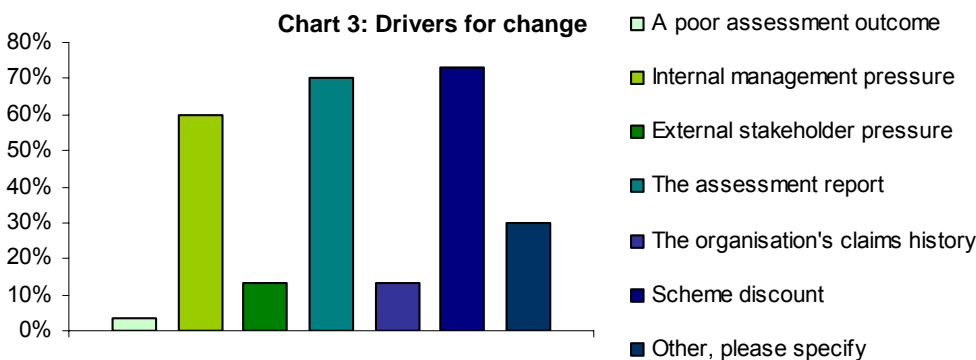
"The assessment process allows us to look at our policies in an objective manner and to challenge the content and its application against a set criteria".

"Impartiality, risk management knowledge, consistency and rigour of the assessor is key to a good assessment".

"Having an assessor who is flexible in discussions and listening to trust protocols. Also being flexible during the presentation of the information and seeing key personnel".

Ideas submitted on how the standards and assessment process could be further developed:

- ✗ Examine medication training in greater depth → This has been considered by the assessment team but is too complex an area to include at this time.
- ✓ Include fire safety → This is to be considered for inclusion within future manuals.
- ✓ Include VTE → We are working with NICE to develop a criterion for this important topic.
- ✓ Have two assessors for Level 2 assessments → This suggestion was implemented in 2009/10 with all Level 2 and 3 assessments now having two assessors.
- ✓ Allow more informal visits → This suggestion was implemented in 2009/10 with all organisations now entitled to an informal visit in the same year as formal assessment. Additionally organisations may now purchase additional support visits from DNV.
- ✓ Share good practice → Several years ago the NHSLA routinely collected and shared examples of good/notable practice with scheme members. Assessors soon found that organisations were adopting these examples of good practice as their own with little thought as to how the document would be applied and implemented within their own organisation. As a consequence the NHSLA decided to develop template documents which act as a guide for organisations to develop their own policies by ensuring that the NHSLA minimum requirements are considered. The NHSLA and DNV are committed to expanding the number of template documents and plan to introduce a further ten for use in 2009/10.
- ✓ Ensure greater integration with other standards → The NHSLA continues to work with all of its stakeholders to prevent overlap and to reduce the assessment burden on scheme members.



Respondents were additionally asked about their key drivers for change within the organisation. As can be seen from the chart the financial discount remains the key driver. Surprisingly when asked to choose other drivers, few respondents cited patient safety.

Assessment report

- Over 90% of respondents responded that they were satisfied with the current layout, quality, content and timeliness of the assessment report.
- Only 38% of respondents responded that they would publish the assessment report on their organisation's website. Whilst these are published on the NHSLA website we would encourage organisations to publish them on their own websites to ensure easy access for service users.

ASSESSMENT PROCESS

FEEDBACK

SUGGESTIONS FOR IMPROVEMENT

"I do not believe that any assessor can really fulfil their requirements for the assessment in two days".

"Breadth of assessment could be re-focused with a greater slant towards addressing clinical risks".

"As there is so much for a single assessor to work through during the assessment, the two days necessarily concentrated on documented evidence and were facilitated by the governance team. Unfortunately there was very little opportunity for the operational standard leads to "present" their standards and evidence and thereby learn directly from the assessment process".

THE ASSESSMENT PROCESS

Results from 2008/09

Performance of acute, mental health & learning disability, ambulance and primary care trusts and independent sector providers of NHS care



During 2008/09 assessments of maternity services were suspended whilst the revised CNST Maternity Clinical Risk Management Standards were piloted. This report therefore does not provide information on maternity services' performance.

SCHEME MEMBER PERFORMANCE

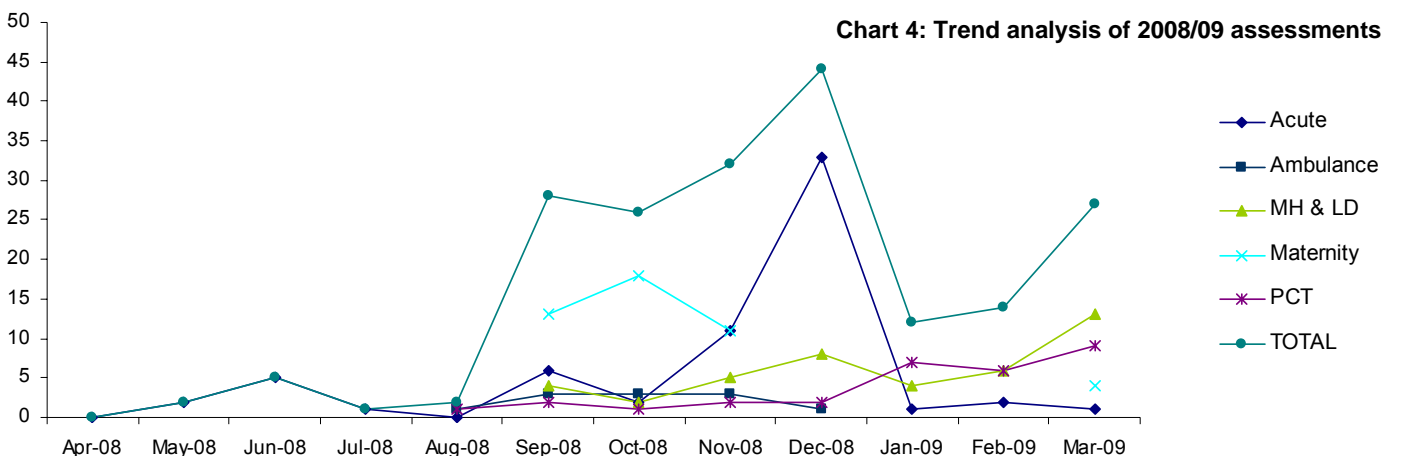
To achieve compliance at any level in the standards, organisations must pass at least 40 out of the 50 criteria with no fewer than seven passes in any single standard. Within each criterion there are a number of minimum requirements; organisations must meet all of these requirements to achieve compliance in any single criterion.

NHS trusts receive increasing discounts, ranging from 10% - 30%, on their contributions to the NHSLA risk pooling schemes as they progress from Level 1 to Level 3. The results of assessments are published on the NHSLA website (www.nhsla.com) in Factsheet 4 on a monthly basis, in addition to copies of assessment reports.

In accordance with scheme rules organisations are assigned an assessment quarter based on the date of their previous assessment, e.g. if an organisation was last assessed in October its assessment quarter is October to December. Organisations are assessed within this assigned quarter, other than when they request an assessment earlier in the financial year. Level 2 and 3 assessments are not, other than in exceptional circumstances, conducted in March.

As can be seen from the chart below the majority of assessments occur within quarters 3 and 4. The reasons for this are primarily historic in that prior to 2007/08 discounts were awarded on an annual basis (1st April of the following financial year) and therefore there was no financial incentive for organisations to be assessed earlier.

Whilst discounts are now awarded on a quarterly basis, few organisations have opted to be assessed in quarters one and two. This continuing trend has huge implications on workforce planning as work to finalise the following year's standards manuals is also undertaken during quarters three and four. Standard manuals (with the exception of the maternity standards) are to be published in December going forward from 2009. We hope this will provide organisations with more lead-in time for assessment in quarters one and two.



ACUTE TRUSTS

The new NHSLA Risk Management Standards for Acute Trusts were introduced in April 2007.

2008/09 was the second year of formal assessments against the NHSLA Acute Standards and as chart 5 indicates, a significant number of organisations chose to be assessed at a higher level.

This was a positive step forward and indicated that organisations were not only becoming more comfortable with the new standards, but that they believed that their risk management systems were improving.

This is a trend that we expect to see continuing with more organisations choosing to be assessed at higher levels. Increased contributions have acted as an additional driver with our risk management contacts reporting increased pressure from their boards to opt for assessment at a higher level. We would encourage all organisations to ensure that a full self-assessment is conducted before an assessment level is confirmed.

The consequences of poor performance at any assessment level are significant with the potential to not only lose levels but also any associated discount.

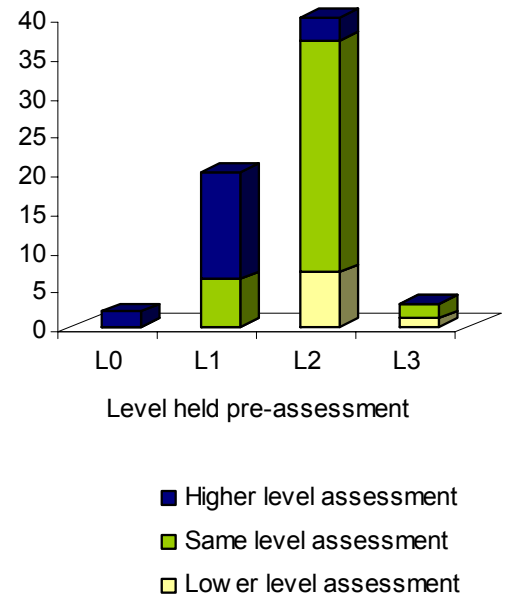
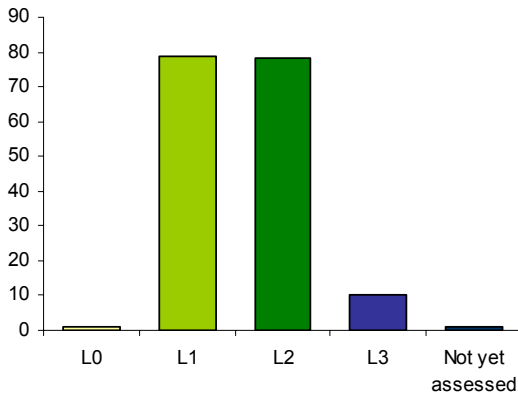


Chart 5: 2009/09 Acute levels selection

Chart 6: Acute levels - 31st March 2009

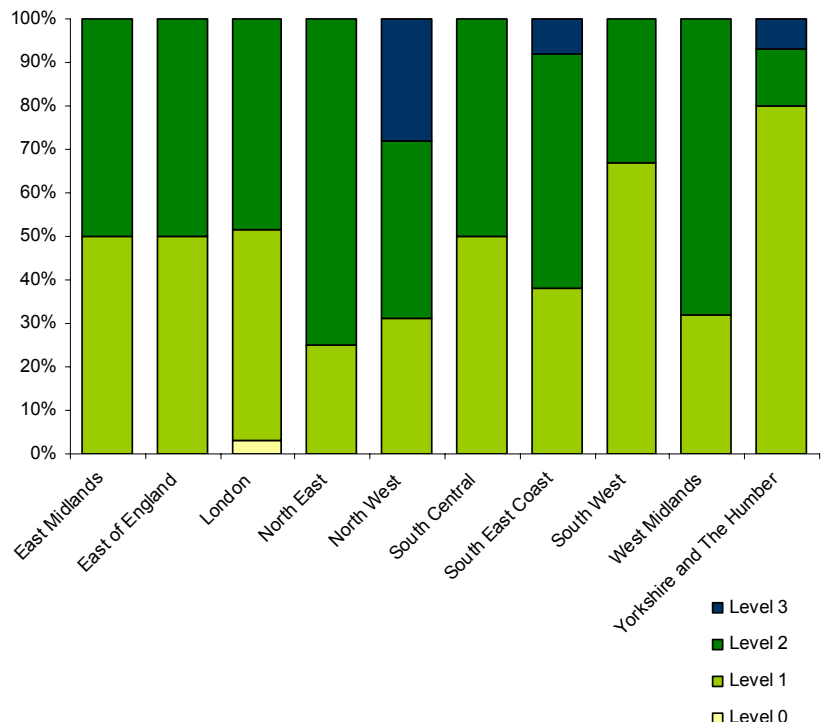


All NHS acute trusts (other than new organisations) have now been assessed against the standards and by the end of March 2009, 52% had achieved compliance at the higher levels. The results of all assessments are shown in chart 6.

Results by SHA region

The next chart indicates how acute trusts have performed by Strategic Health Authority (SHA). As can be seen a higher percentage of organisations in the North East and North West SHAs have achieved Levels 2 and 3 with the smallest percentage of Level 2 and 3 organisations being in the Yorkshire and the Humber SHA. We are keen to work with the SHAs to establish the reasons behind these regional trends and to discuss and identify potential improvement strategies.

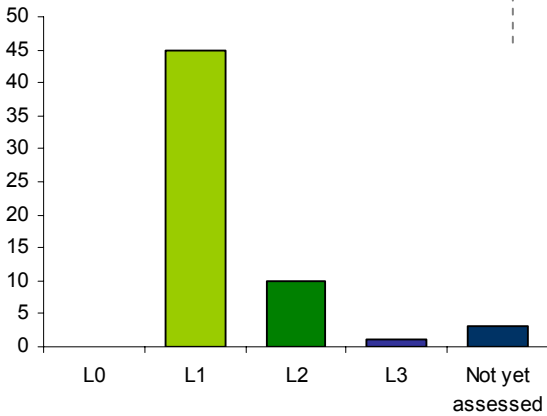
Chart 7: Acute level split - 31st March 2009



MENTAL HEALTH & LEARNING DISABILITY TRUSTS

The NHSLA Risk Management Standards for Mental Health & Learning Disability Trusts were introduced in April 2008. By the end of March 2009, most NHS mental health & learning disability trusts had been assessed against the standards.

Chart 8: MH&LD levels - 31st March 2009



AMBULANCE TRUSTS

All NHS ambulance trusts have been assessed against the NHSLA Risk Management Standards for Ambulance Trusts which were introduced in April 2008 and 91% (10) had attained Level 1 by the end of March 2009.

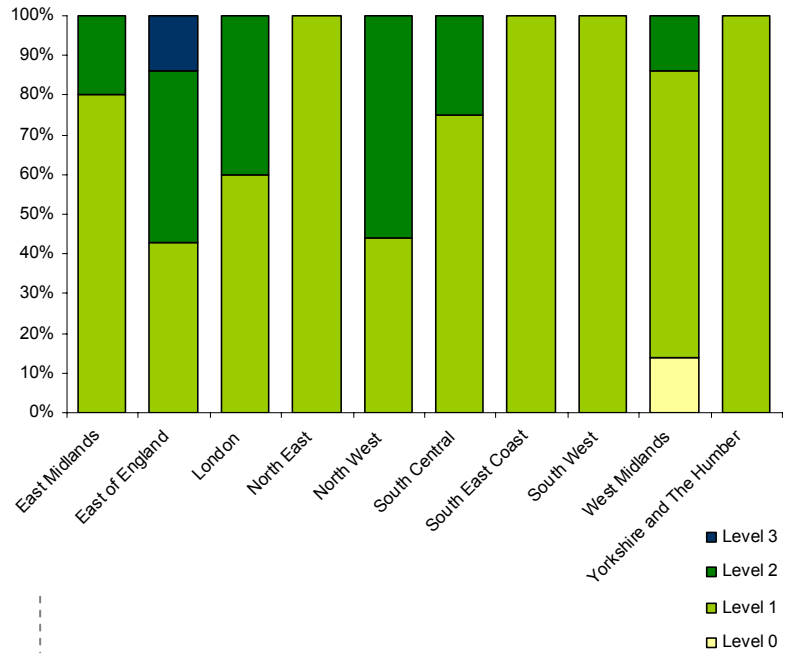


Chart 9: MH & LD levels split - 31st March 2009

Results by SHA region

The above chart indicates how mental health & learning disability trusts have performed by Strategic Health Authority (SHA). A higher percentage of organisations in the North West and East of England SHAs have achieved Levels 2 and 3. Five SHAs are yet to include organisations at Level 2 or Level 3. We expect to see this situation improve in 2009/10 as 16 organisations have opted for assessment at one of the higher levels.

THE ASSESSMENT PROCESS

Analysis of 2008/09 results

The results achieved across the different levels illustrate the progression of organisations through the standards, and highlight the challenges faced at each stage of assessment.



Key findings and recommendations - Level 1:

Level 1

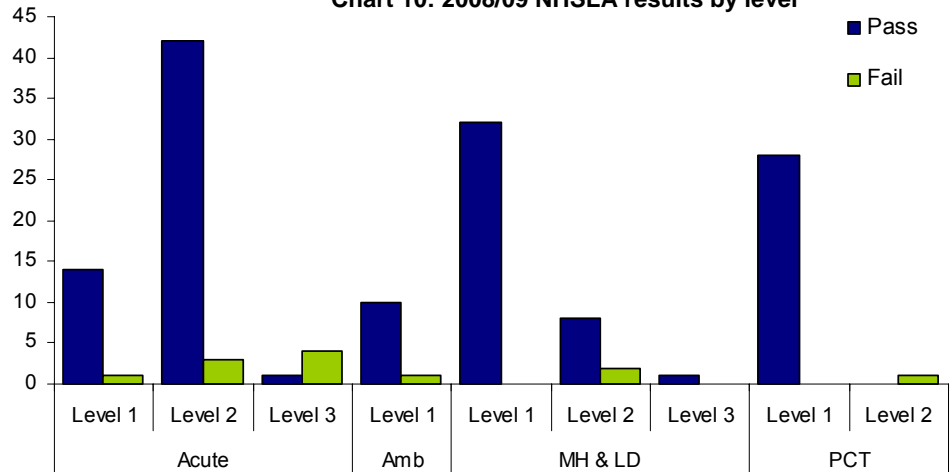
In 2008/09 organisations mostly performed well against the Level 1 standards. Stumbling blocks arose when organisations presented draft documentation. This is not admissible at any assessment level and cannot be scored. Additionally if documentation does not meet all of the minimum requirements within the criterion compliance cannot be awarded.

Assessors reported that for Level 1 assessments they were often asked what makes a good policy. In short it is one that works for the organisation and reflects actual practice. Ideally it should be as simple as possible, user friendly and accessible by all.

Too often the assessment team views policies that have been developed by organisations which sit on shelves and are then not implemented. The sections on monitoring need to describe the systems actually in use within the organisation. Importantly the monitoring sections need to be measurable, realistic and achievable. Organisations continue to use words such as ‘regular’ to describe their monitoring programme; such a word is not measurable and it will therefore be difficult for an organisation to demonstrate compliance at Level 3.

Organisations are advised to define the frequency and detail of the measurement, monitoring and evaluation processes.

Chart 10: 2008/09 NHSLA results by level



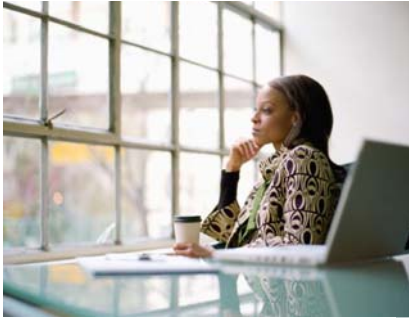
ASSESSMENT RESULTS

RESULTS BY LEVEL

FINDINGS AND RECOMMENDATIONS

The chart above indicates how acute, mental health & learning disability, ambulance and primary care trusts performed by level in 2008/09. As is evidenced from the chart the majority of non-compliance was at the higher levels of assessment.

We have explained on these pages the main reasons for non-compliance and have included some recommendations on how organisations can prepare better for the higher levels of assessment.



Key findings and recommendations - Level 2:

Level 2

In 2008/09 organisations performed well against the Level 2 standards. Organisations that failed to achieve compliance with the standards did so for two key reasons - firstly a failure to show practice that matched policy and secondly a failure to show implementation across the organisation.

At Level 2 assessors expect to see evidence provided for all relevant areas of the organisation (i.e. clinical and non-clinical areas) and all relevant staff groups. In some cases evidence was only provided for one staff group and a small percentage of wards and departments - such a small sample size does not provide the assessors with adequate assurance that processes are being implemented across the organisation.

In preparing for a Level 2 assessments organisations are advised to provide evidence in accordance with the following:

- ✓ Illustrate implementation across the whole of the organisation
- ✓ Cross-site
- ✓ Cross-service
- ✓ High and low risk areas
- ✓ Across all staff groups
- ✓ Clinical and non-clinical

Key findings and recommendations - Level 3:

Level 3

The main issue to arise at Level 3 was that organisations had failed to adequately describe within their Level 1 documentation how practice would be monitored. In some instances monitoring statements would exist but they were very generic and failed to describe in detail how monitoring would happen in practice. For example a policy would say something loose like "this policy will be reviewed annually by the XYZ committee".

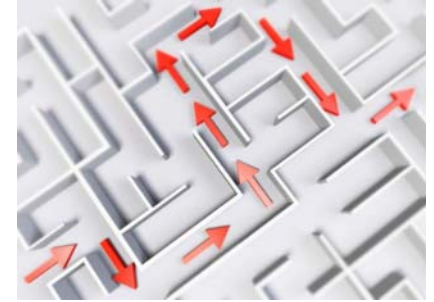
This statement alone does not outline a process which determines how the organisation will gain assurance that each of the individual minimum requirements is being implemented in the manner determined by the policy. It fails to describe where or by whom results of any monitoring will be reviewed and how the organisation will address shortfalls in practice through action plans.

To achieve compliance at Level 3 organisations should describe how they intend to measure, monitor and evaluate compliance with the minimum requirements within the standards. This could include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

THE ASSESSMENT PROCESS

Key recommendations

Each year an increasing amount of work is undertaken on analysing the results of assessments and considering how organisations can be supported in improving their compliance.



Standard 1 - Governance:

Criterion 1.3 - The organisation has approved terms of reference for the high level committee(s) with overarching responsibility for risk.

Organisational structures remain an area of weakness with some organisations failing to draft detailed terms of reference for those committees charged with responsibility for risk management. It is crucial that terms of reference adequately describe accountability and reporting arrangements to assist with the correct functioning of the organisational structure. Failing to action this can lead to organisations having fragmented and poorly functioning committee structures.

Organisations that failed to describe reporting structures struggled to demonstrate implementation at Level 2.

Organisations that failed to comply with this criterion predominately had documentation in place but it failed to adequately describe the checking processes for all professional registrations. For example many would describe the processes for checking medical, nursing and midwifery registration but did not describe the process for checking allied health professional registrations.

A failure to adequately describe processes at Level 1 had an impact on organisations' ability to demonstrate implementation at Level 2. Notably implementation of checking processes for medical staff registration was the weakest area. This could in part be due to the fact that responsibility for this is often devolved from human resources to medical staffing with the result being that processes are distinctly different and are managed differently. This led in some cases to implementation evidence failing to match Level 1 documentation.

Criterion 1.9 - The organisation has approved documentation which describes the process for ensuring that all clinical staff (temporary and permanent) are registered with the appropriate professional body.

ASSESSMENT RESULTS

RESULTS BY STANDARD

FINDINGS AND RECOMMENDATIONS

As can be seen from chart 11 there was a high level of compliance across the five standards both by acute and mental health & learning disability organisations. It is pleasing to note that there is consistency across the standards and that organisations are not finding a particular standard more difficult than the others.

An analysis of individual criteria within the standards has indicated that organisations have encountered problems with the criteria highlighted within this report. These represent the lowest scoring criteria across the acute, mental health & learning disability and ambulance standards.

Criterion 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).

Again this was an area of weakness for organisations with assessors reporting that Level 2 evidence of implementation failed to match Level 1 documentation. Prior to submitting for assessment at higher levels organisations are encouraged to conduct a full review of their processes and a full self-assessment. The review and self-assessment need to consider all employment checks and it is vital that checks of temporary staff are not forgotten, particularly where these may be undertaken by a third party.

Standard 2 - Competence and capable workforce

This criterion was reasonably well addressed at Level 1 but at Level 2 organisations struggled to demonstrate implementation of processes. Whilst assessors were assured that local induction occurred, a lack of records resulted in non-compliance being awarded. This was particularly true for locum medical staff.

Criterion 2.3 - The organisation has approved documentation which describes the local induction arrangements for all temporary staff.

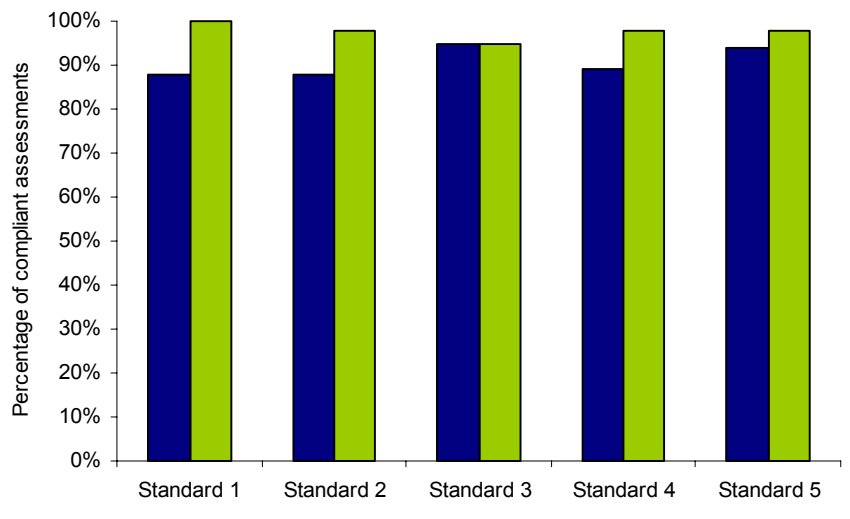
We would suggest that a time limit should be imposed for the completion of local induction. Ideally the local induction should be straightforward and practical for local delivery. Organisations have introduced very complicated checklists which have been impossible to complete in the allotted timescales. It is for individual organisations to determine the penalties for non-completion of the local induction. A monitoring system should be put in place to ensure completion and return of local induction checklists.

Criterion 2.5 - The organisation has approved documentation which describes the process for ensuring a systematic approach to risk management training for all permanent staff.

Whilst many organisations could demonstrate that they had conducted a training needs analysis their process for doing this was not documented and as a result some struggled at Level 1. The process needs to be documented to ensure that it is followed consistently by all departments and that national guidance, legislation, standards, etc. are considered in the process.

Additionally, assessors found that the training needs analyses provided by organisations did not match the minimum data set provided by the NHSLA.

Chart 11: 2008/09 standard assessment results



ASSESSMENT RESULTS

RESULTS BY STANDARD

ACUTE AND MH&LD TRUSTS

■ Acute
■ MH&LD

Criterion 2.7 - The organisation has approved documentation which describes the process for ensuring that all permanent staff are trained to safely use diagnostic and therapeutic equipment appropriate to their role.

Due to the amount and nature of medical equipment used within the NHS, this is a criterion that organisations continue to struggle with. Organisations that have devolved the management of training to local wards and departments have in particular experienced difficulty due to an uncoordinated approach to the delivery and administration of training. Whilst it is important that local training is delivered, organisations must implement suitable systems to capture administrative details such as who delivered the training, who received the training and when.

Standard 3 - Safe Environment

The most common failing encountered with this criterion was a lack of documentation on the manual handling of patients and loads. Most organisations could demonstrate at Level 1 that they had suitable manual handling documentation for patients but this was not always the case for loads. Organisations are reminded that assessors will look for evidence of both, not only at Level 1 but also at higher levels of assessment.

Criterion 3.4 - The organisation has approved documentation which describes the process for managing the risks associated with moving and handling.

Criterion 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 with manual handling assessors found that most organisations had good documentation in place for the management of slips, trips and falls involving patients. Documentation regarding staff and others was less robust and in particular organisations in some cases negated to produce documentation of falls from heights. This is an important area not only for patients but for staff and assessors will expect so see evidence relating to this.

Standard 4 - Clinical Care

Criterion 4.4 - The organisation has approved documentation which describes the process for managing the risks associated with the quality of clinical records in all media.

Most organisations performed well against this criterion, but those that failed to comply had not addressed all minimum requirements in their documentation at Level 1. Organisations are reminded of the need to undertake an accurate self-assessment and review their documentation against all the minimum requirements.

This criterion was reasonably well addressed at Level 1 but at Level 2 organisations struggled to demonstrate implementation of processes. Whilst assessors were assured that transfer was taking place in accordance with policy, evidence did not always support this. Additionally, organisations in some cases failed to demonstrate transfer for all patient groups and clinical areas. This is crucial to provide the assessor and wider organisation with assurance that systems are being implemented.

Criterion 4.5 - The organisation has approved documentation which describes the process for managing the risks associated with the transfer of patients.

MH&LD Criterion 4.2 - The organisation has approved documentation which describes the process for developing service user information associated with care, treatments and procedures.

This criterion was not well addressed at Level 1 as in many cases the documentation provided did not meet all of the minimum requirements. At Level 2 organisations failed to evidence implementation across the full range of services and clinical areas.

Ambulance Criterion 4.10 - The organisation has approved documentation which describes the process for managing the risks associated with obstetric care.

Ambulance Criterion 4.8 - The organisation has approved documentation which describes the process for managing the risks associated with resuscitation.

For both these criteria ambulance services places a strong emphasis on the use of Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. Whilst services should refer to this guidance they still need to produce guidance which reflects local practice. This was the main failing at Level 1 and if not appropriately actioned ambulance services will struggle to demonstrate implementation at Level 2 as local practice will not reflect policy.

Standard 5 - Learning from Experience

Criterion 5.6 - The organisation has approved documentation which describes the process for ensuring a systematic approach to the aggregation of incidents, complaints and claims on an ongoing basis.

This criterion continues to be poorly addressed as many organisations fail to understand how to aggregate incidents, complaints and claims.

Organisations that choose to use separate aggregated data reports for incidents, complaints and claims should clearly document how coordinated discussion and correlation of risk issues take place and will require clear documentation of discussions within the relevant committee/group minutes. The organisation should also highlight how local structures will provide a forum for the discussions arising from the aggregated analysis reports. A template document has been created for this criterion to provide a framework within which to develop a policy, procedure, etc. to support best practice and to assist organisations in complying with the criterion, but its use is entirely optional.

THE STANDARDS

Structure and review

An annual review is undertaken of the standards based on feedback from assessments, developments in healthcare and input from stakeholders.



The NHSLA Risk Management Standards:

The NHSLA Risk Management Standards incorporate:

- Organisational risks
- Clinical risks
- Health and safety risks

These apply to:

- Acute trusts
- Mental health & learning disability trusts
- Ambulance trusts
- Primary care trusts
- Independent sector providers of NHS care

Each set of standards contains five individual standard areas:

- Governance
- Competent & Capable Workforce
- Safe Environment
- Clinical Care
- Learning from Experience

Within each standard, there are ten equally weighted criteria or risk areas

Each risk area is addressed through an ongoing programme of assessment at three distinct, progressive levels:

- Level 1 - Documentation (policy)
- Level 2 - Implementation (practice)
- Level 3 - Monitoring and improvement (performance)

The CNST Maternity Clinical Risk Management Standards:

The CNST Maternity Clinical Risk Management Standards cover five individual standard areas:

- Organisation
- Clinical Care
- High Risk Conditions
- Communication
- Postnatal and Newborn Care

In addition there are separate clinical risk management standards for maternity services

The standards review process:

PROJECT GROUPS

Within DNV two project groups have been established to coordinate and oversee the maintenance of these existing standards and, where necessary, the development of new standards. One group leads the maternity standards with the second leading all others. Clear terms of reference have been developed for each group detailing accountability and reporting arrangements, roles and responsibilities.

Each group is made up of assessors who have either a clinical background or interest in the specialist area. Individual standard leads have been appointed to each group, and they are responsible for advising on the technical aspects of the relevant standard.

STANDARDS REVIEW

For each set of standards a project plan covering their ongoing maintenance has been produced. These plans detail objectives, timescales and responsibilities and they are reviewed on a monthly basis by the management team to ensure that each group is on track with achieving its objectives.

Each set of standards is reviewed annually to ensure that they continue to meet their key objectives as described within section 3 of the relevant standards manual. The review process is continuous with a key aim being to ensure that the standards are published on time, which allows scheme members to prepare for assessment in a timely manner.

Throughout the year our project groups and standard leads review national guidance, consult with stakeholders and review feedback on the standards and assessment process. Feedback from scheme members and the assessment team has the most significant impact on the standard review process. In addition we review assessment data to identify trends. The information generated by these various systems is analysed to provide information such as:

- Common stumbling blocks
- Scores by standard and/or criterion
- Levels attained
- Comparison of self-assessment and formal assessment results

Members of the NHSLA Risk Management Team sit on each of the project groups and are fully involved in the standards review process.

OUR STAKEHOLDERS

A wide range of stakeholders have been involved in the development and on-going review of the standards. Both the NHSLA and DNV gratefully acknowledge the support of these organisations and their valuable input.

For each set of standards a key stakeholder list has been produced and agreed with the NHSLA. To date over 50 stakeholder organisations have been involved in the development of the standards. These stakeholders include national bodies, royal colleges, charities, etc. Some examples of our stakeholders are included below.

Our liaison with the NHSLA's stakeholders is crucial and to facilitate this process we have developed communication logs. These record all of our contacts and communications and provide the NHSLA with assurance that stakeholder liaison is occurring in practice.

National Bodies

- Department of Health
- Care Quality Commission
- National Institute for Health and Clinical Excellence
- National Patient Safety Agency
- Health and Safety Executive
- NHS Security Management Service

Royal Colleges

- Royal College of Midwives
- Royal College of Obstetricians and Gynaecologists
- Royal College of Physicians
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health

Others

- National Confidential Enquiries
- Kings Fund
- Baby Lifeline

EDUCATION PROGRAMME

Events and learning

Analysis of assessment results, and feedback from the assessment process are used to develop the education programme and to ensure it focuses on supporting organisations achieve compliance.

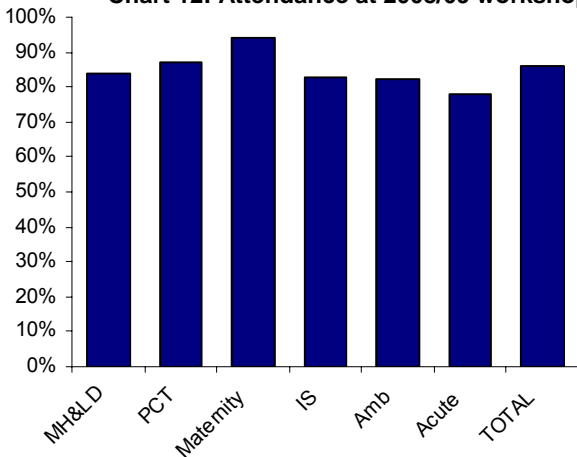


EDUCATION PROGRAMME

Education events are provided to support the assessment of organisations against the NHSLA and CNST Risk Management Standards and are targeted towards risk management representatives of scheme member organisations. The objective of the events is to assist organisations in preparing for assessment and achieving compliance against the standards.

Organisation type	Number of organisations	Events provided	Date
Mental Health & Learning Disability Trusts	58	4 workshops	March 2008
Primary Care Trusts	152	9 workshops	June/August 2008
Maternity Services	152	9 workshops	May 2008
		3 seminars	March 2009
Independent Sector Providers of NHS Care	18	1 workshop	July 2008
Ambulance Trusts	11	1 workshop	July 2008
Acute Trusts	171	8 workshops	September/October 2008

Chart 12: Attendance at 2008/09 workshops



Events are defined as follows:

- Workshop - small interactive sessions for 25-35 delegates
- Seminar - larger with formal presentations for 50-150 delegates
- National conference - very large formal events for 300+ delegates

We are pleased to report that 86% of all organisations attended the events. This was extremely encouraging and represented an increased attendance rate on previous years.

EDUCATION EVENTS

FEEDBACK

WORKSHOP DELEGATE COMMENTS

“Good interactive sessions, driven by assessors and delegates, showed what is needed, now all we have to do is achieve it!!”

“The knowledge, understanding and experience of the NHSLA and DNV staff are much appreciated. Their guidance in steering organisations in the right direction is invaluable”.

“This was an excellent day, the workshop environment was very useful for practical discussion and information exchange with colleagues and the NHSLA Team were very helpful in focusing us on key areas to address and to try to avoid pitfalls experienced by others during the pilots. Thank you”.

Feedback on the education programme for 2008/09:

Delegates that attended events in 2008/09 were asked to provide feedback on the content and usefulness of the events.

These charts show the comments grouped by those that refer to:

- Usefulness of the content of the sessions
- Delivery, including:
 - Delivery method or style
 - Facilitation
 - Organisation
 - Amount/depth of information provided
 - Timings of sessions
- Networking opportunities
- Other/general

At least 90% delegates from maternity services, mental health & learning disability and primary care trusts, and nearly 80% of acute trusts, gave a positive rating that they would use the information gained at an event and recommend a similar event to a colleague.

Chart 13: Number of positive and negative comments by category

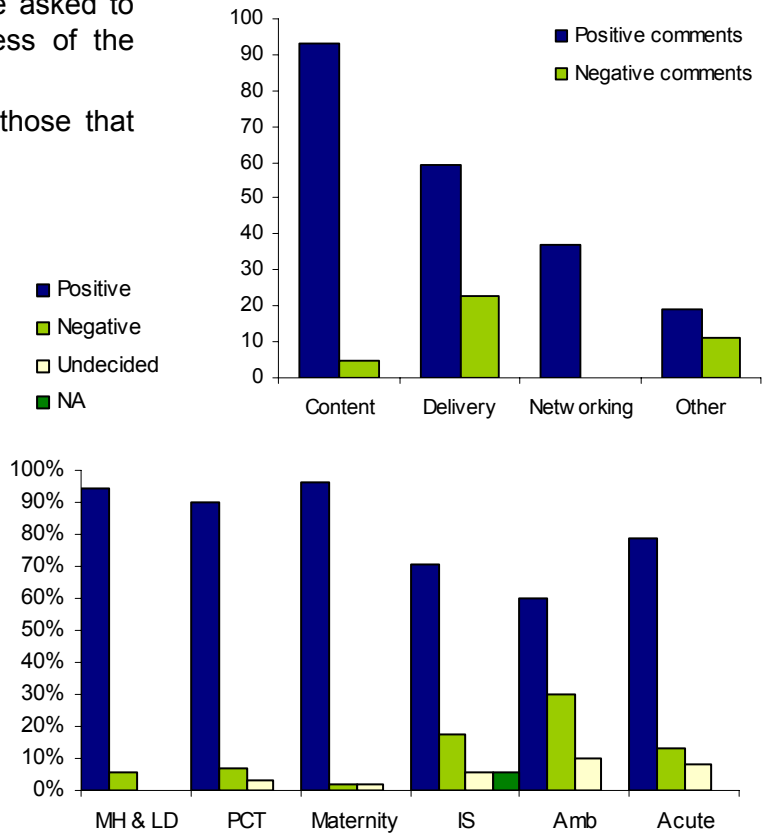


Chart 14: Responses as to whether a delegate would use the information gained at the workshop

Education programme for 2009/10:

The programme of education for 2009/10 saw the trial of a new format for education events; providing small, localised workshops for training, networking and discussion. These have been organised by strategic health authority areas and have incorporated delegates from across different organisations.

In order to provide education tailored to the needs of individual organisations, 2009/10 has seen the launch of additional support visits. The visits are delivered by the assessment team to provide extra guidance beyond the current scope offered as standard within the scheme.

“I found all of the workshops very useful - especially being able to ask questions of the assessors who were all very helpful. Difficult to know how you could be more helpful to organisations. As the healthcare standards programme manager, I find that the NHSLA standards provides useful supporting/complementary criteria”.

“Extremely useful and answered many questions. Also made me believe that the NHSLA is a responsive and insightful organisation”.

“One of the best NHSLA events that I have attended over the past 10 years mainly due to small workshops and focused itinerary”.

“I would like to thank all the staff for maintaining the continued excellence with the delivery of these days and support they afford... even when I think my question might sound a little daft!”

“I left feeling supported as well as directed. Thank you”.

Training needs analysis for 2008/09:

As part of the 2008/09 education programme, it was agreed to undertake a training needs analysis (TNA) of delegates attending NHSLA events and other organisation risk management contacts. The results of the TNA were used to inform the events programme for 2009/10.

Data was gathered from delegate feedback on the 2008/09 education programme and from delegate and risk management contact opinions on the preferred focus and delivery of future events and training.

The question set aimed to identify:

- The response to the 2008/09 education programme
- Trends in the level of experience of risk management contacts
- Trends in previous attendance at NHSLA events
- The preferred type and focus of events
- Whether risk management contacts would be interested in accreditation being sought for events
- Whether risk management contacts would be interested in, and able to access, podcasts/vodcasts



Chart 15: The length of time delegates have worked in risk management

Key findings of the TNA:

- Between 20% and 35% of delegates were attending for the first time
- Over 25% of all risk management contacts had less than two years experience in governance or risk management
- Around 70% of contacts marked a preference for workshop style events
- An interest in accreditation by relevant bodies was expressed by between 40% and 65% of contacts
- An interest in podcasts was expressed by around 50% of contacts, but up to 80% did not know if they would be able to access this type of resource

EDUCATION EVENTS

FEEDBACK

MATERNITY SEMINAR DELEGATE COMMENTS

“Very useful introduction to the standards and extremely well organised. The presence of senior people from NHSLA, RCM and RCOG lends gravitas and weight to the whole process and shows an encouraging collaborative and ‘joined-up’ approach”.

“A very useful and informative day - time well spent. Thank you”.

“I thought it was excellent, particularly the tone and atmosphere which were perfectly pitched, offset by an ideal venue”.

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