NHS Litigation Authority

Risk Management Standards
for
Acute Trusts

Level 3 Assessment
of
Guy’s and St Thomas’ NHS Foundation Trust

28th and 29th June 2010
The comments and findings of the assessment recorded in this report reflect the opinions of the assessor(s) based on the evidence provided by the organisation in relation to the requirements contained in the relevant standards manual. They should not be read as approval or comment in any other context.
**1: Executive Summary**

On Monday 28th and Tuesday 29th June 2010, Det Norske Veritas (DNV) on behalf of the NHS Litigation Authority (NHSLA) conducted a Level 3 assessment of Guy’s and St Thomas’ NHS Foundation Trust.

This assessment was based on the **NHSLA Risk Management Standards for Acute Trusts 2010/11**. The key findings and recommendations are summarised in this report.

The organisation was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 3 the organisation was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The organisation scored as follows:

<table>
<thead>
<tr>
<th>Standard</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>10/10</td>
<td>9/10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
</tr>
<tr>
<td>Competent &amp; Capable Workforce</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Safe Environment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning from Experience</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Score</td>
<td>10/10</td>
<td>9/10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
</tr>
<tr>
<td>Compliance achieved per standard</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Overall compliance achieved</td>
<td>Yes</td>
<td>49/50</td>
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</tbody>
</table>

Detailed scores can be found in the organisation’s evidence template which is a separate document that records the evidence reviewed and the compliance awarded at the assessment.

These scores indicate that the organisation was successful in achieving compliance at Level 3 of the standards and as such will receive a 30% discount from their CNST and RPST contributions. The discount will be applied from the beginning of the financial quarter following the date of the assessment visit for the following 36 months thereafter or until such time as the organisation undergoes further assessment.

In accordance with NHSLA and scheme requirements, the organisation will need to be re-assessed against the standards no later than the anniversary date of the last assessment, i.e. by Thursday 27th June 2013. Organisations that request an early assessment may choose to be assessed at any time. It is important to note that organisations which perform badly 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.
Chart 1: Comparison of the organisation’s self-assessment to actual assessment outcome
Overall summary of the organisation's compliance

Guy's and St Thomas' NHS Foundation Trust was successful in demonstrating compliance with the Level 3 requirements of the NHSLA Risk Management Standards for Acute Trusts 2010/11, scoring 49 out of 50.

Key recommendations for the future

Guy's and St Thomas' NHS Foundation NHS Trust are to be congratulated on the excellent outcome of this first Level 3 assessment against the updated NHSLA Risk Management Standards, achieving a score of 49 out of 50. The hard work undertaken by the organisation over the last two years to ensure that risk management processes are embedded has been rewarded.

The evidence template was accurately populated with the relevant approved documentation at Level 1 that described the implemented processes and the methods of monitoring the processes required for a Level 3 assessment. Evidence was provided in both paper and electronic format. Additionally, throughout the two day assessment, further supporting evidence was presented by members of the team to evidence implementation of the post monitoring action plans. At future Level 3 assessments the organisation are reminded that implementation of the post monitoring action plans should be presented with the monitoring evidence. Although at this assessment evidence of the post monitoring action plans was not initially presented with the evidence for every criterion it was available on request and was provided in a timely manner, which supported the impression that the monitoring process was embedded within the organisation.

There was involvement from senior staff and board members throughout the assessment, which demonstrated the importance of risk management within the organisation.

The organisation is reminded that all related policies and procedures should be accurately cross referenced on the front sheet of each approved document and recorded in the related documents row in the document control box. For example the Risk Management Policy (July 2009) refers in the text to the Mandatory Training Policy (May 2010) but the policy is not included in the related documents row in the document control box. Neither was the Risk Management Policy (July 2009) cross referenced in the designated place within the Mandatory Training Policy (May 2010).

The organisation appears to have made significant progress since the last assessment in the ability to identify all staff groups who have attended training in line with the risk management topics identified in the NHSLA Risk Management Standards for Acute Trusts 2010/11. There is still work to be completed around the timeframe in which a permanent member of staff can remain non-compliant in relation to identified training. The organisation is advised to increase the sample size used in the audits to monitor the process for following up those who failed to attend and ensure they are proportionate to the number of staff who had failed to attend.

A variety of audits and reports were reviewed at the assessment and some would appear to be more beneficial to the organisation than others in relation to the way the audits or reports were written. All audits and reports should have an action plan, that as a minimum has a responsible lead and a date for completion attached to each action. For example the Patient Information “Spot Check” Audit Acute Medicine...
(April 2009) lacked an action plan that had specific, measurable, achievable, realistic, timely (SMART) objectives as well as a named responsible lead and a completion date for actions.

There was also evidence of audits that, whilst compliant against the monitoring described in the approved document at Level 1, would have benefited from a wider review of the applicable practice processes; these are discussed in the body of this report.

Areas of good practice were identified throughout the assessment, for example the organisation’s approach to the process for monitoring/receiving assurance that registration checks are being carried out by all external agencies (e.g. NHS Professionals, recruitment agencies, etc.) used by the organisation in respect of all temporary clinical staff.

There were also areas of innovation and good practice, for example the risk assessment tool used for vulnerable adults.

The organisation is reminded that during the Level 3 assessment, with the exception of the minimum requirements carried forward, the Level 1 requirements of the approved documentation were not reviewed or assessed. It is therefore recommended that the organisation reviews the approved documents in relation to the minimum requirements at Level 1.
2: Assessment Results

Standard 1: Governance

Overview

Effective functioning of the board, managerial leadership and accountability, and the organisation’s systems and working practices will 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 clearly defined and there should also be clear lines of individual accountability for managing risk throughout the 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 processes. All relevant employees, whether permanent or temporary, should be registered with the appropriate professional body and have undergone the required employment checks prior to working within the organisation.

A score of ten out of ten was awarded in this standard.

Key findings and recommendations

Evidence presented for this standard demonstrated full compliance for the monitoring of the processes implemented as described within the approved Level 1 documents. There are no further comments for this standard other than those detailed in the executive summary.
Standard 2: Competent & Capable Workforce

Overview

The organisation has a responsibility to deliver a safe service to patients by ensuring all staff are appropriately skilled. To ensure that both temporary and permanent staff are adequately equipped to work in a healthcare 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 as well as facilitating staff safety and wellbeing.

A score of nine out of ten was awarded in this standard.

Key findings and recommendations

3.2.4 Supervision of medical staff in training.

Compliance has not been awarded for this criterion.

The organisation had not demonstrated that quality control and quality improvement measures were in place to exceed the PMETB requirements for supervision. These are set out in Domain 6 of the PMETB generic standards for training as determined by the evidence available through the Quality Framework, which includes data from the National Survey of Trainees and Trainers, information from Annual Deanery Reports (ADRs), Annual Specialty Reports (ASRs) and Visit to Deanery Reports.

In order to achieve compliance at future Level 3 assessments the organisation must achieve a score of 3 awarded by PMETB against the PMETB generic standards.

3.2.5 The organisation has an approved documented process for ensuring a systematic approach to risk management training for all permanent staff that is implemented and monitored.

Compliance was awarded for this criterion.

The assessors randomly selected the investigation of incidents, complaints and claims training and inoculation incident training from the NHSLA training needs analysis (TNA) minimum data set, for assessment.

It appeared that inoculation incident training was recorded as being delivered and reported as part of the health and safety training in the training needs analysis. However the training prospectus stated that it was being delivered and reported as part of infection control and prevention training. The organisation is advised to clearly state where inoculation incident training is being delivered and reported to in the Mandatory Training Policy (May 2010). The evidence reviewed indicated that the training was delivered and reported in line with the health and safety statement.

The organisation must also clearly state the follow up process for those who fail to attend training; although a process was described it was not as explicit as it could be. If there is more than one process for following up those who fail to attend training this must be clearly documented in relation to the staff group or training it is applicable to.
Standard 3: Safe Environment

Overview

It is essential to provide a safe and secure environment in order to facilitate high quality clinical care. The environment should be safe for staff, patients and their visitors in order to prevent accidents, injury and disease. Risk of violence, bullying, harassment, and stress should be managed and minimised and the workplace should be one in which sickness absence can be managed sensibly and effectively.

A score of ten out of ten was awarded in this standard.

Key findings and recommendations

3.3.3 The organisation has an approved documented process for managing the risks associated with safeguarding adults that is implemented and monitored.

Compliance was awarded for this criterion.

Compliance was achieved as the evidence demonstrated the monitoring statements in the Safe Guarding Adults Policy (February 2010), however the audit would have been more robust and beneficial had the practice described in the flowcharts within the Safe Guarding Adults Procedure (August 2009) been included in the audit. The annual report would also have benefited from the inclusion of the action plan detailing the completed actions as a significant amount of work had been achieved throughout the year.

3.3.6 The organisation has an approved documented process for managing the risks associated with inoculation incidents that is implemented and monitored.

Compliance was awarded for this criterion.

There was evidence of a variety of occupational health service reports reviewed by a range of committees, for example the Infection Control Committee, Trust Infection Control and Decontamination Assurance Committee and the Trust Health and Safety Committee. The inoculation incident case reviews provided as evidence would have benefited from being expanded to include an audit of the appendices of the Management of Body Fluid Exposure Protocol Occupational Health Service (June 2009) as the appendices described the practice to be implemented. A short report bringing these areas together may assist in the monitoring of implementation in future.

3.3.8 The organisation has an approved documented process for managing the risks associated with the harassment and/or bullying of staff that is implemented and monitored.

Compliance was awarded for this criterion.

Compliance was achieved as the evidence demonstrated the monitoring statements in the Promoting Dignity and Respect at Work (July 2009), however the audit would have benefited from the practice as described in the Workplace Mediation Procedure (July 2009) also being audited as it was part of the organisation’s approach to the
management of harassment and bullying. Mediation would appear to be utilised and effective within the organisation in relation to the management of harassment and bullying.
Standard 4: Clinical Care

Overview

The care provided within a clinical environment should be of the highest quality. To support this, robust guidelines and policies should be in place for all clinical care procedures. Some of the higher volume and higher risk processes have been selected for assessment by the NHSLA, namely: patient identification, consent, blood transfusion, medicines management and resuscitation. Care should be provided in such a way as to minimise the risk of hospital associated infection. It is particularly important to ensure patients have clear information when undergoing procedures and that accurate information is shared during transfer and discharge. To underpin these care processes, systematic approaches must be in place to ensure there is effective communication between staff, patients and others and that high standards of record keeping are consistent across the organisation.

A score of ten out of ten was awarded in this standard.

Key findings and recommendations

3.4.1 The organisation has an approved documented process for managing the risks associated with the identification of patients that is implemented and monitored.

Compliance was awarded for this criterion.

The Patient Identification Policy (June 2009) did not include how the following minimum requirement ‘procedure to be followed in cases where misidentification occurs’ was going to be monitored. The monitoring of the minimum requirement was documented in the Untoward Incident Policy (July 2009). Whilst evidence of monitoring of the few cases of misidentification was evident the organisation may wish to consider including the incidents reported in relation to misidentification in the next patient identification audits.

3.4.11 The organisation has an approved documented process for managing the risks associated with the prevention and management of venous thromboembolism that is implemented and monitored.

This criterion is a pilot for 2010/11 and sits outside the 50 criteria which each organisation is formally assessed and scored against. As an additional pilot criterion it does not feature in the scoring.

In order to test the validity of the criterion organisations were encouraged to provide evidence for each of the minimum requirements. There was insufficient time to review the evidence provided.
Standard 5: Learning from Experience

Overview

All healthcare organisations should have in place robust systems for the reporting, management and investigation of adverse events (incidents), ill health and hazards, including those that result in no harm, which will help to facilitate organisational learning. Organisations should apologise and explain what happened to patients who have been harmed as a result of their healthcare treatment. Concerns, complaints and claims, when examined in conjunction with all reported adverse events, 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, complaints and claims. The sharing of lessons learnt from one service to other areas of the organisation helps to ensure that any system failures discovered during investigations are addressed by the organisation as a whole and pockets of good practice are not isolated. Organisations should consider and implement appropriate external guidance to enable the organisation to operate as safely as possible.

A score of ten out of ten was awarded in this standard.

Key findings and recommendations

3.5.1 The organisation has an approved documented process for ensuring that all clinical audits are undertaken, completed and reported on in a systematic manner that is implemented and monitored.

Compliance was awarded for this criterion.

This is a pilot criterion for 2010/11 and as such a positive score has been awarded.

In order to test the validity of the criterion organisations were encouraged to provide evidence for each of the minimum requirements. Whilst compliance has automatically been awarded, there was insufficient time to review the evidence provided.

Evidence presented for this standard demonstrated full compliance for the monitoring of the processes implemented as described within the approved Level 1 documents. There are no further comments for this standard other than those detailed in the executive summary.
3: Appendices

Appendix A: The NHS Litigation Authority

Background

The NHS Litigation Authority (NHSLA) is a Special Health Authority, which was 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, known as the Existing Liabilities Scheme (ELS). 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.

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

Membership of the schemes is voluntary and open to all NHS trusts, NHS Foundation 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 relevant NHSLA Risk Management Standards.

The NHSLA Risk Management Standards for Acute Trusts, Primary Care Trusts and Independent Sector Providers of NHS Care are set out within a single manual containing a number of organisation specific criteria against which the relevant type of organisations are assessed. There are separate standards manuals for mental health & learning disability trusts, ambulance trusts and maternity services.

Further information about the NHSLA can be found on the NHSLA website at www.nhsla.com.

Advice on the standards and general aspects of risk management, and copies of NHSLA publications, can be found on the NHSLA website.

Post assessment reporting

Once the annual assessment cycle is completed, the assessment team will meet to review the overall findings and make recommendations. The team then produces a national overview of risk management activities across England in relation to the standards. This document includes both a summary of the findings and recommendations for improvement.
Benefits of assessment

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, contractors, 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 adverse 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.

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.

Assessment results and links with other organisations

Results and findings from NHSLA assessments are used in a variety of ways by other bodies. These include the Care Quality Commission, Health and Safety Executive, Monitor, the National Institute for Health and Clinical Excellence and the NHS Counter Fraud and Security Management Service.

Elements of the NHSLA assessment take assurance from work undertaken by auditors on behalf of the Audit Commission and compliance with the Postgraduate Medical Education Training Board (PMETB) minimum requirements for clinical supervision set out in Domain 6 of the PMETB generic standards for training.
Appendix B: Contacts

Assessment/Report enquiries

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

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