Report of the West Hertfordshire Obstetrics and Gynaecology Services Stakeholder Group

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Report of the West Hertfordshire Obstetrics and Gynaecology Services stakeholder group - Contents

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Report of the West Hertfordshire Obstetrics and Gynaecology Services stakeholder group

1. History of the stakeholder group

Following a large number of complaints against two gynaecologists in Hemel Hempstead Hospital, an External Independent Review was commissioned by Hertfordshire Health Authority and BUPA Hospitals in 2001. It reported in March 2002.

The stakeholder group was established to oversee the implementation of West Hertfordshire Hospitals Trust's action plan in response to the findings and recommendations of the External Independent Review. The terms of reference of the group are summarised in Appendix 1.

Separate meetings were held between complainant representatives from Women against Medical Injustice (WAMI) and Bedfordshire and Hertfordshire Strategic Health Authority [1] to deal with concerns about the review process, the treatment of the consultants in question and the continuing clinical concerns of complainants. The successful outcomes of these meetings were reported at a meeting of complainants in May 2003.

The stakeholder group was tasked to oversee the plan, make recommendations about necessary improvements, and gather evidence that improvements were being made. The stakeholder group involved representatives from complainants, the Community Health Council representing patients, Primary Care Trusts, SHA and the West Herts Hospitals Trust which is referred to as the Trust through this report. Its first meeting was in September 2002.

The External Independent Review investigated concerns raised by patients about clinical management and the handling of formal complaints. The recommendations of

[1] Three names are used in this document for what is essentially one organisation, which underwent a change over the period that this report covers. 'Hertfordshire Health Authority' merged to become 'Bedfordshire and Hertfordshire Health Authority' in April 2002 and then became 'Bedfordshire and Hertfordshire *Strategic* Health Authority' in October 2002. References to the Health Authority (HA) or Strategic Health Authority (SHA) refer to this organisation.

the review fed into the West Herts Hospitals Trust Action Plan, which in turn informed the work of the stakeholder group.

2. Aim of the Report

The aim of the report is to evaluate the actions of the West Herts Hospitals Trust in response to the recommendations of the External Independent Review and assess the overall impact of these actions on the West Herts Hospitals Trust obstetrics and gynaecology service. The concerns identified by the stakeholder group will be used as the guideline structure for this evaluation.

3. Recommendations of the External Independent Review

Set out below is a summary of the main recommendations made by the external independent review.

Individual Performance Management and Communication

- Assessment and review - there should be a formal assessment and review of the consultants' interpersonal skills.
- Delegation and supervision – the trust should review policies for the supervision of junior doctors and the delegation of clinical work in obstetrics and gynaecology.
- Communication skills - the Trust should review the scope of its training in complaint handling, including communication skills.
- Links between primary and secondary care – the way communication flows between primary and secondary care.

Complaints and Counselling

- Documentation – complaints should be better documented.
- Information to the complainant - complainants should be better informed of their rights
- Bereavement counselling – the Trust should provide speedy bereavement counselling.

Organisational Learning – Overall Performance Management, quality systems and processes

- Learning organisation – the Trust should review its reporting mechanisms to ensure concerns arising out of the complaint process are identified and appropriately addressed.
- The Trust should ensure that standard of record keeping and the systems that support this are in line with current best practice

4. Methods of inquiry

The group met six times in the course of the year to review the Trust's progress and had two further meetings to agree conclusions and the final report. A Non-Executive Director of the Strategic Health Authority chaired the process. The group adopted a programme that covered the key issues raised in the review report and looked at the following areas:

Individual Performance Management and Communication

- The process of consultant appraisal to assure good performance, clinical supervision, communication skills training, and Trust/ PCT cooperation.

Complaints and Counselling

- The complaints process and the Patient Advice and Liaison service (PALS), bereavement counselling and the consent policy.

Organisational Learning – overall performance management, quality systems and processes

- Learning in the organisation - quality of care in women's services including clinical governance and risk management standards, audits, medical records, documentation.

The trust provided paper and verbal evidence of changes in policies, procedures and practice and of objective external assessments. They also answered any questions put to them by the group.

WAMI representatives were free to visit and wander around West Herts Hospitals Trust sites and services and meet staff.

The trust produced a file of evidence to demonstrate the impact of the reported improvements.

NB: All evaluation measures in this report are to an extent ongoing, and are correct at the time of the report being written.

5. Report

To meet its aim – *to evaluate the actions of the West Herts Hospitals Trust in responding to the recommendations of the External Independent Review and the concerns of the Stakeholder group and assess the impact of these processes on the West Herts Hospitals Trust Obstetrics and Gynaecology service* - this report takes concerns brought up by the stakeholder group in turn and evaluates the evidence provided by the Trust specific to that concern. It does not attempt to document all the positive changes initiated by the Trust. Its focus is more on the impact of the changes. In addition to information provided by the Trust, the report also includes the relevant clinical governance and other SHA performance indicators.

It should be noted that the intention of this report is to objectively assess the state of WHHT Women's Services now rather than to look back at what occurred at the time of the complaints.

Changes in the context of Healthcare

Before analysing the measures taken by the trust in relation to the key areas of the review it is important to note how the context of healthcare has changed. Since the period when the majority of complainants encountered the gynaecologists who were the subject of the review, the NHS as a whole has introduced a completely new approach to ensuring clinical quality.

Through Clinical Governance, responsibility for clinical quality has expanded from individual health professionals. Organisations now have a statutory duty of quality; this means that Trusts, through their boards and officers must put in place, at all levels

throughout the organisation, effective arrangements to assure and improve the quality of care. Progress in the development of clinical governance has meant that a considerable range of new controls, assessments, and learning processes have been introduced, which makes it much more likely that concerns about clinicians will surface and be addressed.
See appendix 2 for an overview for the organisations and groups that are responsible for maintaining an oversight on clinical quality.

The Strategic Health Authority has the dual role of holding organisations to account for the safe delivery of services and supporting the development of Acute and Primary Care Trusts. These roles have only become explicit since the old Health Authority (mainly responsible for financial management) changed into the Strategic Health Authority, (which for Beds and Herts happened in October 2002). The SHA performs its duties through a performance management system, incorporating a range of controls such as clinical and corporate governance. The SHA is accountable to the general public through maintaining a majority of 'non-executive directors' on the Strategic Health Authority board. (The SHA is also accountable through the normal lines of accountability to an elected minister of health).

Primary Care Trusts (PCTs) have a responsibility to ensure that the services that they commission on behalf of the local population are safe, responsive and of high quality. Monitoring of service delivery is carried out in partnership with local providers. This last year PCTs have been working with West Herts Hospital Trust to develop a 'Quality Bond' that will explicitly state the key quality performance measures it expects the Trust to meet.

5.1 Individual Performance Management and Communication

The External Independent Review raised the following issues:

- Assessment and review - there should be a formal assessment and review of the consultants' interpersonal skills.
- Delegation and supervision – the trust should review policies for the supervision of junior doctors and the delegation of clinical work in obstetrics and gynaecology.
- Communication skills - the Trust should review the scope of its training in complaint handling, including communication skills.

- Links between primary and secondary care – the way communication flows between primary and secondary care should be reviewed.

The Group wanted to see evidence that:

- Communication with patients by staff and the organisation as a whole had improved.
- Communication within clinical teams had improved
- That all junior doctors were supervised appropriately.
- That performance management of doctors was properly addressed.
- That concerns arising about consultants performance would be acted on.
- That management would deal effectively with problems.

What the Trust has done.

Since the complaints came to light, the Trust has had an almost complete turnover of management at executive level and in obstetrics and gynaecological services. The Trust co-operated with the General Medical Council performance and disciplinary committees. The consultants in question are no longer employed by the Trust and new consultants have been employed.

Appraisal

All consultants employed by the Trust now participate in appraisal. This requires them to reflect on their relationship with their patients and document examples of good practice or concern in their relationships with patients and the outcomes of complaints and how these have changed their practice. The Trust does ensure effective appraisal for all medical staff. About 97 % participated last year – the current round is not yet completed.

Patient Feedback

The Trust has demonstrated with questionnaire and patient feedback that current patients are happy with and positively like the consultants they have seen. This is confirmed by WAMI whose members have reported satisfaction with arrangements made by the Trust to deal with continuing clinical care.

RCOG

The Trust has introduced systems for the training and supervision of junior doctors. The Trust has recently been assessed by the Royal College of Obstetricians and Gynaecologists (RCOG) and approved as an appropriate setting for training junior doctors. This means that an external body is now satisfied that West Herts Hospitals Trust does provide appropriate training, supervision and delegation.

Communications

A number of forums have been established to improve decision-making, accountability and the general level of professional communication. These include consultant away-days, department/ ward/ managers meetings, weekly labour ward forum, perinatal board, perinatal risk meetings, modern matron and team meetings. Also there is an update newsletter and the Trust is commencing an audit into communication within the division.

National Clinical Assessment Authority (NCAA)

The NCAA is a new national body set up to advise trusts on how to deal with concerns about doctors' performance. The Trust has used the NCAA for support with concerns about their medical staff. The NCAA has also asked them to retrain a surgeon from elsewhere. This suggests considerable confidence in the Trust.

New staff

Representatives from WAMI met the new consultants and were very complementary about them. They were shown patient leaflets clearly explaining details of a particular procedure – what to expect and how it felt. This indicates that the consultants have an awareness of the importance of keeping patients well-informed and managing their expectations about procedures.

Links between Primary and secondary care

The Trust Chief Executive meets with Primary Care Trust Chief Executives on a regular basis in a joint forum. Primary Care Trust representatives participate in the Trust clinical governance committee. PCTs have been working with West Herts Hospital Trust this year to develop a 'Quality Bond' as mentioned earlier.

5.2 Complaints and Counselling

The External Independent Review raised the following issues:

- Documentation – complaints should be better documented.
- Information to the complainant - complainants should be better informed of their rights in respect of the complaint process.
- Bereavement counselling – the Trust should provide speedy bereavement counselling.

The group wanted to see evidence that:

- The complaints process works effectively.
- The complaints manager was properly supported
- There was cooperation in pursuing complaints by staff involved.
- Documentation and patterns in complaints were picked up and addressed.
- Bereavement counselling is now provided

What the trust has done:

The Trust has reconstituted the complaints team, introduced a new complaints process and appointed a new Quality Manager (January 2003). The staffing structure was completely revised. The Patient Advocacy and Liaison Service (PALS), Quality Assurance Team and the Litigation and Claims departments were reformed. The Watford Quality Assurance office was re-opened. The Quality Manager and the Trust Medical Director are now responsible for ensuring that all complainants receive a full and appropriate response and that consultant staff are available to meet complainants where necessary. Two new posts are now out to advert – a deputy quality manager and a deputy director for quality and risk.

In the clinical governance report 2002/2003 it was concluded that:

> *'The Trust recognised that their previous complaints procedure was inadequate and have decided to reconfigure their departmental structure to address this.'*

The report noted that a training strategy has already been devised to address complaints handling, breaking bad news, response letter writing and root cause analysis. The complaints training programme has already captured around seventy F and G grade nurses who cascade the training down within their teams. Additionally, intensive

training has been given to around 50 divisional managers, service managers and Modern Matrons, who also cascade the learning down. From April 2004 complaints training will be included in the induction programme for all new starters.

The CHI Action Plan Progress Report (August 2003) noted that all actions contained in the section ‘providing an efficient and user-focussed service complaints department’ were achieved.

The new Patient Advice and Liaison Service (PALS) – provides advice, support and information to patients and their families. PALS now operates across all four sites, with staffed offices on Watford and Hemel sites. A third PALS Officer post has been appointed. WAMI members have highlighted the introduction of PALS as the key to the Trust ‘turning the corner’, along with the ‘excellent complaints manager’.

A leaflet on complaints, ‘Making your Voice Heard’ has been printed. It explains the complaints process along with related areas, such as the role of PALS, comments cards and listening boards. The complaints procedure is now available on the Trust website and is actively being used. Comments cards, boxes and listening boards have been set up throughout the Trust. The Trust now focuses on local resolution and tries to meet with complainants, greatly reducing requests for independent review panels. The incidence of new independent review panels in the period April 2003 – February 2004 has fallen to half the number from the equivalent period in the previous year – 18 as opposed to 36. This shows strong evidence that the procedure is dealing more effectively with complaints at an earlier stage.

In the complaints trend management section of the Trust’s annual clinical governance report, there is clear evidence that the Trust is responding to complaints far more promptly than in the year 2002. There are other indicators of improvements in complaints trends - for instance - acknowledgement times for complaints have reduced to 24 hours (the Department of Health target is 48 hours). 62% were answered within 20 days in the quarter period up to September 2003. This has improved to 70% in the most recently published quarter to December 2003.

The Trust uses the DATIX database system for the logging of formal complaints, PALS complaints, claims and incidents in order to detect and act early on trends. Themes and

trends feed back to the Clinical Governance Manager and are reported in the Clinical Governance monitoring reports.

Figures for complaints in women's services have remained fairly static from last year to this, which is encouraging as one might expect the figure to rise given that the complaints system has become simpler, more accessible and better publicised. Total complaints for 2000, 2001 and 2002 were 107, 120, and 89 respectively. The most recent data for total complaints in women's services from the year to the end of February 2004 shows 99 complaints.

Bereavement Counselling

There is a dedicated bereavement counsellor for women's services. Bereavement counsellors are based at both the Watford and Hemel Hempstead sites. The counsellors also offer general counselling to Women's Services. Over the last two years, WAMI members requiring counselling have been referred to them.

5.3 Organisational Learning – overall performance management, quality systems and processes

The External Independent Review raised the following issue:

- Learning organisations – the Trust should review its reporting mechanisms to ensure that concerns arising out of the complaint process are identified and appropriately addressed.

Implicit in the review recommendations were that overall performance management systems and processes were in operation and sufficient.

The Stakeholder group wanted to see evidence that:

- The Trust was learning from its mistakes
- Quality of care in women's services had improved
- Quality of care was being monitored to include clinical governance, risk management standards, audits, medical records, and documentation.
- There were sufficient internal and external performance management measures in operation.
- Management had systems in place to deal effectively with future problems
- Improvements were sufficient to restore confidence in the service

What the Trust has done

The Trust has a large number of internal and external structures to monitor quality and performance in the Trust as a whole. It has introduced a number of forums and processes for ensuring learning takes place, such as risk management, critical incident analysis, complaints trends analysis and audits. The Trust has also participated in a number of external assessments and has received feedback from the SHA on their clinical governance plan and report. Trust representatives were very open in the group about problems and errors.

A guide to audit/ assessment structures is included in Appendix 2. The most salient indicators investigated by the stakeholder group are outlined below.

Clinical Negligence Scheme for Trusts (CNST)

The CNST scheme assesses Trust risk management systems. It includes record keeping, learning from experience, complaints handling etc. The Trust attained CNST level 1 in February 2002, a general assessment that covered maternity care, scoring 100% in 8 of the 9 measures. Revisions in the CNST system since then, with more criteria for the trustwide standard and a separate assessment with more standards for maternity care, mean that Trusts which have achieved the old CNST level 1 have to reapply for the new CNST Level 1. The Trust as a whole was assessed under the new CNST level 1 standard on 27th February 2004, and scored very highly (details of breakdown scores are presented in Appendix 4). This Trust wide CNST measure assesses generic risk systems across the Trust; maternity services are assessed differently as they have additional risk factors.

The Trust underwent a pre-assessment for the new maternity CNST level 1 measure in December. This looked at the following areas: organisation, learning from experience, communication, clinical care, induction training and competence, and health records (which closely match the focus of this report). This highlighted areas that may need improvement in order to achieve the full score for maternity, and the Trust have put into place an action plan to this end. The Trust is aiming to achieve the new CNST level 1 standard for maternity by the end of 2004. Progress will be monitored through the normal performance management channels of the Trust, PCT and SHA.

The Trust has recently passed the Risk Pooling Scheme for Trusts – this is similar to the CNST standard, comprising a general assessment of all risks including non-clinical measures. This looks at a range of measures including corporate accountability arrangements for risk management, risk management strategy, reporting and management of incidents, reporting and managing of complaints and claims and risk management training. A breakdown of scores is presented in Appendix 4. The Trust was congratulated for the high standard of documentary evidence provided for the assessor on the day of the assessment and have been advised to consider working towards Level 2 in the future.

Clinical governance data

SHA feedback on the trust's clinical governance report of July 2003 covering the period 2002/3 made a number of points including.

> "The trust is to be commended on its involvement of patients and carers in the planning and monitoring of services"
> "Clinical governance structures are in place…the trust encourages the development of leaders in clinical quality"
> "The previous complaints procedure was inadequate and (the Trust) will work to address it this year"
> "The section on 'staff focus' was well covered though we could find no mention of systems to deal with poor performance".

The mid-year clinical governance report has recently come out and has shown considerable progress. The SHA noted:

> "The Trust's report contained a note in response to the SHA comments on their clinical governance development plan, which covered the main points raised by the SHA and gave details of how these were being addressed. This was a very useful update and provided assurance that these areas were being covered by the Trust."
>
> "Overall the report demonstrated that the Trust is making sound progress in all the domains of clinical governance."

Critical incidents monitoring

Logging of incidents in all departments is extremely important. The Trust is complying in reporting serious untoward incidents. Also, the Trust has started to use the DATIX database system for logging incidents. This will enable the Trust to detect trends and act on them more promptly. Themes and trends feed back to the Clinical Governance manager and are reported in the clinical governance monitoring reports.

Commission for Health Improvement (CHI)

The Trust was assessed by CHI in 2002 and has set up CHI Action days to take forward the CHI action plan. Members of the stakeholder group have attended these and commented favourably on them. Progress against the WHHT CHI Action Plan was last formally reported in August 2003. Although the actions have largely been completed, a further update is due in March 2005.

In the interim, the Trust reports to the board regularly on all CHI indicators and it appears that the Trust has moved from a rating of 2 (which is about average for Acute Trusts) to a rating of 3, moving towards 4 in some areas.

Patient survey

An independent survey was carried out by the patients' panel surveying around 50 obstetric/ gynaecology patients, both on the ward and in the outpatient clinics on all hospital sites within the Trust. The findings were generally very positive about the Trust. 100% asked to see the same doctor again. At least 90% stated that their doctor inspired confidence, the language used by the doctor was easily understood and any delay was explained.

70% or more gave an excellent rating for their feelings during the consultation with the doctor, how the doctor attended to their problem, feeling able to ask questions, their overall feelings, the procedure being fully explained and for outpatients being seen on time. 50% or more ranked the following as 'excellent': information given, adequate nursing attention on the ward environment. The only scores of 'poor' were in the following areas; was the complaints system fully explained to you? (80%), food (15%), explanation for delays (5%).

That the complaints system was not routinely explained to patients may not be a severe criticism as long as information is available when needed. Information should be available without patients having to ask for it and the process should be as simple and confidential as possible – a great deal of progress appears to be happening towards this goal.

This survey clearly indicates that patients now feel more confident about their doctors and the way they are being treated.

6. What remains to be done

- Whilst the general progress in managing the complaints procedure has been good, complaints analysis needs to bed in to the culture so that complaints feed back into clinical governance, up to the top team and back down again to become part of the accepted culture of a learning organisation.
- The Trust has shown good evidence of the existence and use of performance measures and progress of these are largely in the public domain. The Trust needs to continue to show that the systems that are in place are being used.
- There is evidence of good practice in establishing processes for ensuring continuing quality improvement. The Trust needs to ensure that these are equally well developed across all services and to continue to evaluate their impact.

7. Review of the Process

The stakeholder group periodically reviewed its process during the year as well as in the final meeting. See appendix 3 for verbatim comments made at that meeting.

At times it was a difficult process for both trust and complainant representatives. The year started with anger, defensiveness and mistrust. Early meetings were tape recorded as complaints' representatives had little reason then to trust NHS personnel. Without noticing after a few meetings as confidence built up, the tape-recorder was no longer used. The willingness of the Trust representatives to speak "off the record" and trust the group with confidential, sensitive information was significant in the growing trust in the group. Complainant representatives felt by the end of the year that when they asked questions they were given honest answers.

The willingness of the trust to engage with the group (there were often 6-8 representatives including the Chief Executive and Medical Director), and to involve challenging patient representatives in other internal meetings, demonstrated a tangible and growing culture of patient involvement and openness.

One of the challenges of the year was to move from exploration of the new processes introduced by the Trust to evaluation of evidence of the impact of these. The file of information provided by the Trust was an important factor in the completion of the stakeholder groups' work and its being in a position to say that the Trust had made the changes recommended by the Independent Review and that the situation that gave rise to the review would not happen again, and to express confidence in the Trust's women's services. As one complainant representative said, '*I would be happy to send my daughter and grandchildren to the hospitals in this area – I couldn't have said this before'*.

8. Summary

The Trust responded well to the External Independent Review, and has made big changes. Since 1998, the management of the Trust as a whole and women's services in particular have experienced a complete turnover. There is some evidence that processes now exist to ensure quality, for example, CNST Level 1 standard and clinical governance data shows continuing improvements. The stakeholder group's eyewitness accounts of the working of the Trust and feedback from other users of the service indicate this improvement is real. This is further backed up by a satisfaction survey that shows patients feel comfortable with their doctors and other staff and feel informed about their treatment. Objective external feedback – e.g. from RCOG (the Royal College of Obstetricians and Gynaecologists), the SHA (Strategic Health Authority) gives further indications of improvement.

Clinical supervision, communications and performance management are clearly taken seriously; there are numerous well-attended meetings and processes to ensure professionalism. Doctors whose performance falls below standards are managed with the support to an external body – National Clinical Assessment Authority (NCAA).

The complaints process was not 'user friendly' and has been overhauled. It is clearly being used more now; there is now a leaflet and a proper process to assist complainants. This process is being audited to track trends. Similarly, the process for the reporting of serious untoward incidents is in place but will need to show evidence that it is being used as will the way that complaints feed into the clinical governance process.

Many items specified in this document refer to measures that are still in progress (e.g. CNST standards, other audits) or are part of a continuing evolutionary process. Consequently this document should form part of a baseline, against which progress can be reassessed in the future as part of the normal performance management arrangements.

The Trust has been very cooperative throughout the stakeholder group process and has shown a willingness to explore and address the problems that were identified. The changes that have been put in place should act as a firm foundation for restoring public confidence and for continuing to improve the services provided to patients.

Report of the West Hertfordshire Obstetrics and Gynaecology Services stakeholder group - Appendices

Appendix 1 - Summary of the terms of reference of the group

The stakeholder group looked at implementation of West Hertfordshire Hospitals NHS Trust's (WHHT) action plan in response to the findings and recommendations of the External Independent Review Panel Report relating to Obstetrics and gynaecology services. The report was published in March 2002 and the Health Authority accepted the Trust's action plan in July 2002.

In particular the objectives of the stakeholder group were to:

i) Oversee the implementation and progress of the Trust's Action plan.

ii) Make recommendations about any additional service or organisational developments or improvements that would enhance the quality of Obstetric and Gynaecology services.

iii) Make recommendations about any additional developments or improvements that will ensure that Trust's PALS service and complaints process deal appropriately with patients' concerns.

iv) Agree the information that will be needed to judge whether the these and the measures outlined in the action plan were having the desired outcome

v) Measure the improvements in Obstetric and Gynaecology services and the Trust's complaints process resulting from the Action Plan, and ensure that the views of patients were central to this.

vi) Ensure that progress with the implementation of the Action Plan was communicated widely through Trust and Strategic Health Authority board meetings to patients and members of the public.

Appendix 1 - Summary of the terms of reference of the group – membership of the group

The membership of the Stakeholder Group was as follows: members' names have been included where they have given consent:

i) WAMI – 2 Members Pat Slade, Anastasia Insley

ii) Other complainants – 2 Members

iii) West Hertfordshire Hospitals NHS Trust – 5 Members, including the Trust's Medical Director: Val Harrison, Howard Borkett-Jones, Gary Etheridge, Lynn Hill, Morag Olson, Robin Douglas

iv) Bedfordshire and Hertfordshire Strategic Health Authority – 2 Members: Mona Walker, Jane Halpin, Andrew Morgan

v) Dacorum PCT – 1 Member: Tanith Ellis

vi) St. Albans and Harpenden PCT – 1 Member: Heather Moulder, Pauline Walton,

vii) Watford and 3 Rivers PCT – 1 Member: Rachel Allen

viii) North West Herts. Community Health Council – 1 member: Peta Gunson, who was a member of the NW Herts Community Health Council until it was disbanded in December 2002 and then joined the Patient and Public Involvement Forum which has a similar function.
Councillor Tony Swendell, (St Albans City and District Council), was a Community Health council member, but also represented the complainants.

Chair: A Non-Executive Director of the Strategic Health Authority, Mary Porter, chaired the Stakeholder Group.

The Group reported to the Strategic Health Authority Board through the Clinical Governance Committee.

The Group existed for 18 Months meeting bimonthly and was serviced by the Strategic Health Authority. The report was written by Peter Hopkins.

Appendix 2 – List of monitoring, clinical assessment and quality controls

The following is a list of measures and systems that facilitate control and monitoring of the delivery of clinical services, and medical training. The list is not exhaustive, but illustrates the multiple levels of assessment that take place.

NATIONAL ORGANISATIONS

CNST — Clinical negligence Scheme for Trusts

Monitors the Trust's quality control systems, recognising that well developed systems expose Trusts to lower litigation risk. The scheme requires compliance with a very large range of standards which relate to the way services are designed, and the facilities available to staff and patients. The scheme also monitors the systems for the training and supervision of junior staff, both nursing and medical.

RPST — Risk Pooling Scheme for Trusts

Similar to CNST, but also includes a general assessment of all risks, including non-clinical.

NCEPOD — National Confidential Enquiry into Peri-operative deaths

This is a national audit programme which reviews on a continual basis, any deaths occurring in hospital after surgery. The enquiry has made numerous recommendations over the years, and is one of the main agencies which has emphasised the need for senior supervision of junior surgical and anaesthetic staff, particularly in complex emergency surgery.

CESDI & CEMD — Confidential Enquiry into Still births and Deaths in infancy and The Confidential Enquiry into Maternal Deaths

These are similar to NCEPOD, but specifically cover the issues of risk around pregnancy and childbirth. Maternity services routinely submit all details of maternal and infant deaths to the enquiry. These two organisations merged their remits in April 2003, and have now been superseded by CEMACH: Confidential Enquiry into Maternal and Child Health.

District Audit — Undertakes audits on behalf of the Audit Commission, of the arrangement and delivery of care by specific services in the hospital, on a rolling basis. These analyses are detailed, and aim to compare the service pattern against best practice in the country. Recommendations are made and followed up over one to two years.

NICE — National Institute for Clinical Excellence

An organisation formed in 1999, to set out best practice across the full spread of medical services in the NHS. NICE makes recommendations, both on the use of specific treatments (such as new drugs), and also on patterns of service provision. There are details of pathways of care in

National Service Frameworks (NSFs), which are standards to which all services must aspire. A NSF for children is currently being developed

CHI — Commission for Health Improvement

Undertakes detailed, regular routine reviews (inspections) of clinical governance systems within a Trust (WHHT was reviewed by CHI in 2002). Based on concerns expressed to it or as directed by the Secretary of State, CHI can also undertake fast track reviews or investigations into areas of specific major service failure. CHI is being replaced by CHAI – Commission for Health Audit and Inspection – which combines the functions of health systems audit (previously undertaken by the Audit Commission), and CHI. CHAI is now responsible for regular monitoring of the quality indices which give rise to Trusts' Star ratings.

NPSA — The National Patient Safety Agency

(*from their website*). *The NPSA is a Special Health Authority created in July 2001 to co-ordinate the efforts of the entire country to report, and more importantly to learn from mistakes and problems that affect patient safety.*

As well as making sure errors are reported in the first place, the NPSA is trying to promote an open and fair culture in the NHS, encouraging all healthcare staff to report incidents without undue fear of personal reprimand. It will then collect reports from throughout the country and initiate preventative measures, so that the whole country can learn from each case, and patient safety throughout the NHS can be improved.

The NPSA has developed techniques and set up training programmes to support Trusts to investigate and remedy problems.

STAR RATINGS — A national system of assessment of the performance of Trusts, which takes into account, financial, organisational, and clinical quality performance, including waiting times, and clinical outcomes (e.g. death rates after emergency surgery)

REGIONAL ASSESSMENTS

SAC Visits — Specialty Advisory Committee (of a Royal College, e.g., Royal College of Obstetrics and Gynaecology)

The SAC assesses the appropriateness of a service for the training of junior staff. It takes note of the ratio of senior staff to junior staff, and the arrangements for supervision and training. SAC approval is required before a training programme can be set up. Training programmes are then subsequently monitored, by direct inspection of the facilities of the service, and by confidential feedback from trainees. Unsatisfactory reports from trainees, can, and occasionally do result in the withdrawal of a trainee from an individual Consultant, and if a widespread problem, withdrawal of the training programme altogether.

DEANERY INSPECTION	The Regional Postgraduate Dean undertakes annual inspections of the training available to all levels of postgraduate trainees – Pre-registration House Officers, Senior House Officers, and Specialist Registrars. The focus of the dean's visit is particularly on the quality of the education offered to trainees. Confidential interviews are conducted with trainees, and anonymised feedback is given to trainers. Areas of particular weakness are also reported immediately to the Hospital's Post Graduate Tutor, and to the Medical Director and Chief Executive, in order for deficiencies to be addressed.
REGIONAL ACTION TEAM (Junior Drs Hours)	Monitors the Trust's implementation of the rules with regard to the reduction of hours of work for junior doctors. Failure to comply with legislation results in fines for the Trust, and the possibility of withdrawal of trainees. Assessment includes confidential feedback from trainees.

TRUST ASSESSMENTS

CLINICAL GOVERNANCE MONITORING	The Trust monitors a range of clinical indices on a monthly basis, including the number and type of complaints, the timeliness of responses, and the number of complaints that have been re-activated, or in which there has been a request for an independent review. Clinical Governance monitoring is also a regular feature of the monthly internal performance monitoring of the Clinical Divisions
APPRAISAL	All consultants and junior medical staff participate in annual appraisal. This follows a developmental approach, in common with the Trust's appraisal policy for non-medical staff, and aims to focus clinicians on objectives for further learning and career progression.
DRUG AND THERAPEUTICS COMMITTEE	Oversee drugs in use in the hospital, and has a particular role in monitoring and regulating the introduction of new drugs, to ensure that there is a sound body of evidence for their effectiveness before they are introduced.
NEW MEDICAL DEVICES COMMITTEE	This committee undertakes a similar role for the introduction of new devices, as the Drug and Therapeutics committee does for drugs. The evidence for the efficacy of new equipment can be scrutinised before their introduction.

OTHER AGENCIES ADDRESSING DEFICIENCIES

NCAA	The National Clinical Assessment Authority Is a National body that is designed to support Trusts (on request) if they need to address an area of weak performance affecting an individual doctor. The emphasis is on very detailed assessment of performance, including occupational health assessments, and identification of retraining needs where these are apparent. A period of retraining may then be authorised under supervision of a senior mentor.

INDIVIDUAL ACCOUNTABILITY

GMC	Every doctor has direct professional accountability to the General Medical Council. There is an extensive code of practice, entitled 'Good Medical Practice', which constitutes the standard of conduct expected of a doctor. Any doctor found in serious breach of this standard can be referred to the GMC for investigation.

Appendix 3 - direct quotes from the stakeholder group from the final meeting with the Trust

There was a lot of anger at first.

It was important that we stopped the tape recorder in the early meeting, and were honest about the things that were happening.

We don't record these meetings now: we trust you.

If we had not broken through the barrier of trusting each other, we would not have been able to get to this stage.

We are much more honest with each other than at the beginning.

A lot of what we have done is about culture.

I would like to think that we have changed the culture.

There will always be mistakes made, but being open and honest is important.

People are reassured that when they ask a question, they will get an honest answer.

We don't feel excluded any more – that feeling has gone.

You have been very keen that we [the stakeholders group] should understand what you are doing.

The patients' panel is bringing the public in, to be involved.

If patients have got questions, they know where to go.

It was all down to communication at the end.

You [the Trust] were upset – but that was because you are passionate about what you do.

It was understandable that you [the staff] were angry – but we have got through that now.

The system failed patients *and staff.*

I feel that this has been a lot of hard work – I wondered, will it achieve anything? – I can honestly say that I am very happy with what has been achieved.

I would be happy to send my daughter and grandchildren to the hospitals in this area – I couldn't have said that before.

Appendix 4 – breakdown of scores for CNST and RPST

Clinical Negligence Scheme for Trusts (CNST)

The Trust underwent a reassessment of CNST for the Acute Trust (including Gynaecology) on 27 February 2004. It was successful in retaining its level 1 status, attaining the high scores previously awarded in 2002 in the following standards.

Standard 1	Learning from Experience	100%
Standard 2	Response to Major Clinical Incidents	87%
Standard 3	Advice and Consent	100%
Standard 4	Health Records	94% (highest achievable score given merger)
Standard 5	Induction, Training and Competence	100%
Standard 7	Clinical Care	100%

The Trust produced a variety of new documentation as part of ongoing development within the Trust as evidence:

Standard 1 ~ Learning from Experience

The Trust is in the process of implementing a new electronic risk management Database (Datix), Single Incident Reporting Form and Incident Reporting Policy and procedure.

Standard 2 ~ Response to Major Clinical Incidents

The Trust's Serious Incident Policy has recently undergone revision and will now be incorporated into the Incident Reporting Policy. Further work has been identified to bring this policy up to full 100% compliance with CNST guidance.

Standard 3 ~ Advice and Consent

The Trust's Consent to Treatment Policy has recently undergone further revision to ensure it meets Department of Health guidance. This has now been achieved and reflected in the 100% score awarded by the CNST assessor.

Standard 4 ~ Health Records

An improvement upon the score awarded 2 years ago from 87% is reflected in the incredible amount of work being undertaken in this area and progression of the Medical Records Strategy. The high scores awarded are a reflection of new standard medical case notes being implemented throughout the Trust and the streamlining and merging of medical records and numbering since the Trust was last assessed.

Standard 5 ~ Induction, Training and Competence

Considerable work has been put in place around this standard and again this was reflected in the maximum score awarded. The Training Department has recently started implementing its Training Strategy, which encompasses all the requirements of the various performance measurements (CNST, RPST, Controls Assurance etc). Trust induction and staff updates have been reviewed and a new programme commenced in January 2004.

This standard also looked at the Infection Control Policy and programme for hand hygiene and hand care, a new criterion introduced this year. The Trust is very proud of the vast amount of initiatives and education provided by the Infection Control Team around hand hygiene and this again is reflected in maximum scores being awarded for this particular criterion.

Standard 7 ~ Clinical Care

The standard assessed the quality of the Trust Discharge Policy and Blood Transfusion Policy both of which are fully implemented within the Trust.

This standard also looked at the management around the Infection Control Programme and Team, which again are new criterion introduced this year. The maximum scores awarded for these criteria reflect the huge amount of hard work and dedication of key staff working within the Infection Control Team.

Risk Pooling Scheme for Trust (RPST)

West Hertfordshire Hospitals NHS Trust underwent the Risk Pooling Scheme for Trust (RPST) assessment on 10 February 2004 and was successful in achieving Level 1 status.

RPST at level 1 is concerned with putting the foundations in place for Risk Management. These ensure robust mechanisms are in place to facilitate a high degree of patient and staff safety.
The Trust was assessed against a variety of standards as follows:

Criterion	Compliance	Non Compliance	Partial Compliance
1. The Corporate Accountability Arrangements for Risk Management	100%	0%	0%
2. The Risk Management Strategy	100%	0%	0%
3. The Risk Management Organisational Structure	93%	0%	7%
4. The Reporting and Management of Incidents	88%	6%	6%
5. The Reporting and Management of Complaints and Claims	79%	14%	7%
6. The Risk Management Process	78%	13%	9%
7. Risk Management Training	79%	7%	14%
8. Independent Assurance	93%	7%	0%
Overall Results	**86.8%**	**9.9%**	**3.3%**

The organisation was congratulated for the high standard of documentary evidence provided for the assessor on the day of the assessment and have been advised to consider working towards level two in the future.

Gary Etheridge
Director of Nursing, Midwifery & Quality
10th March 2004

Nikki Moore
Trust Risk Manager