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Altnagelvin Hospitals
Health and Social Services Trust

Clinical and Social Care Governance Report

From 1 April 2003 - 31 March 2004

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FOREWORD

This, our second Clinical and Social Care Governance Report marks the completion of the first stage of the development of a quality agenda within our Trust.

It also serves as a useful checkpoint to review what has been achieved in the past year against the targets which had previously been set.

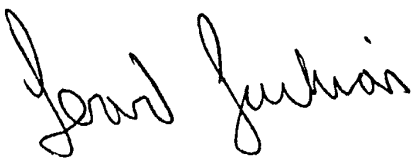
In our first year we focused on establishing accountability and leadership arrangements, assessing the Trust's baseline position, agreeing an action plan and putting in place appropriate reporting procedures.

It is now our task to oversee the implementation of that plan to help us identify and build on good practice, to assess and minimise risk of untoward events, to investigate problems as they arise and to ensure that lessons are learnt.

This report sets out information on how we have progressed in incorporating into the structures of our organisation the vital clinical governance arrangements and assurance controls that will help to improve professional standards and ultimately the quality of care that our patients receive.

The report further sets out our aims and targets for the year to come.

The report is therefore commended as a next step on our clinical governance journey and as an illustration of our continued commitment to the pursuit of clinical excellence.



G Guckian
Chairman Clinical and Social Care Governance Committee.

Section 1
CLINICAL AND SOCIAL CARE GOVERNANCE

1.1 INTRODUCTION

The Statutory Duty of Quality, set out at Article 34 of the HPSS (Quality, Improvement and Regulation) Northern Ireland Order 2003, commenced with effect from April 2003. The Duty of Quality initially applies to HSS Boards and HSS Trusts.

Clinical and Social Care Governance in Altnagelvin Hospitals H&SS Trust strives to encompass all the processes needed to achieve the highest quality clinical practice possible within available resources. It continues to build on the good and effective systems already in place and is based on a system of learning from mistakes in order to improve care in the future.

In Northern Ireland Circular HSS(PPM) 10/2002 was launched in January 2003 *Governance in the HPSS – Clinical and Social Care Governance: Guidelines for Implementation.*

This guidance enabled the Trust to formally begin the process of developing and implementing clinical and social care governance arrangements within Altnagelvin. It was considered in conjunction with guidance issued on the implementation of a common system of risk management across the HPSS and the development of controls assurance standards for financial and organisational aspects of governance.

Altnagelvin Health & Social Services Trust developed and implemented a strategy for delivering quality. The report provides details on the activities undertaken and those planned for the future, in the areas of Risk Management, Clinical Effectiveness, and Education and Training. It also outlines the accountability and assurance structures within the Trust for Clinical and Social Care Governance.

The success in addressing the quality agenda will be in the way in which we are able to make it a part of everyone's job.

1.2 LEADERSHIP AND ACCOUNTABILITY

Clinical and Social Care Governance places a statutory responsibility on Trusts for the quality of their services. Chief Executives will be held accountable for this. Arrangements have been put in place in Altnagelvin to enable the Chief Executive to discharge this responsibility and for the Trust Board to be assured of this.

Within Altnagelvin Health & Social Services Trust, the Director of Nursing and the Medical Director have been charged with the responsibility to put in place the necessary arrangements to implement the requirements of Clinical and Social Care Governance. They have also been delegated joint lead roles for Clinical and Social Care Governance within the Trust.

A Clinical Governance Steering Group was established in 2001 to examine the requirements of this duty of quality and to develop a Clinical and Social Care Governance Strategy for the Trust. The Strategy clarified the assurance and accountability arrangements emphasising that each clinical professional is accountable for the quality of the services he/she provides. This process is managed within the normal management arrangements of the Trust. Within the individual Directorates accountability rests with the Clinical Director.

The Clinical Director meets with members of Hospital Executive, (i.e. the Deputy Chief Executive and Director of Business Services, Medical Director, Director of Nursing, Directors of Finance and Personnel) in a Business Planning and Accountability meeting three times per year where Clinical and Social Care Governance forms a main item on the agenda.

The assurance systems are delivered through the Risk Management & Standards Committee and Clinical and Social Care Governance Committee to Trust Board. *(See appendix 1)*

1.3 CLINICAL AND SOCIAL CARE GOVERNANCE COMMITTEE

The Clinical and Social Care Governance Committee, which is directly accountable to Trust Board, is now chaired by Mr Gerry Guckian, Chairman of the Trust. This committee has formally met on 4 occasions during the year 1 April 2003 – 31 March 2004.

The Trust extends a warm word of sincere thanks to the outgoing chairman, Mr Denis Desmond for his sterling work in establishing and chairing the Clinical and Social Care Governance Committee and for bringing the quality agenda to its first stage of development.

1.4 RISK MANAGEMENT AND STANDARDS COMMITTEE

The Risk Management and Standards Committee is chaired by the Trust's Medical Director. The role of this committee is to provide assurance to the Clinical Governance Committee that appropriate mechanisms are in place throughout the organisation for managing risk. This committee has formally met on a quarterly basis from 1 April 2003 – 31 March 2004.

1.5 SUB COMMITTEES

The number of forums working as sub committees of the Risk Management and Standards Committee have increased. The titles of these sub committees are detailed below:

- Clinical Audit
- Infection Control
- Drug and Therapeutics
- Clinical Claims
- Health & Safety
- Near patient testing
- Clinical Incidents
- Blood Transfusion
- Health Records
- Clinical Ethics Committee
- Environmental Management Group

These sub committees continue to assist the Trust in assuring it is meeting its requirements under the clinical governance legislation.

1.6 PATIENTS COUNCIL

Altnagelvin Hospitals H&SS Trust developed a Strategy for Patient and Public Involvement. This document acknowledges the excellent work achieved by the Altnagelvin Patients' Council and is in the process of re-establishing the Patients' Council as the lynchpin of its strategy.

The Patients' Council is a sub-committee of the Trust's Clinical and Social Care Governance Committee.

The Patients' Council will aim to improve and increase the involvement of patients and the general public in planning future services, offering proposals for improving the quality of existing services and acting as a reference group for consultation on relevant policies and service developments. The Patients' Council will comprise nominees selected from communities and groups that represent the patient's viewpoint. Nominees will be sought through a media advertising campaign to help ensure openness and transparency.

The Trust is keen to ensure that this strategy and the proposed processes for bringing it to fruition are fair and equitable and in keeping with equality and human rights leglislation.

Section 2
CLINICAL EFFECTIVENESS

2.1 INTRODUCTION

Clinical Effectiveness is ensuring that patient care is both clinically and cost effective.

It is about applying evidence-based health care to ensure that the right treatment is matched to the right condition and it is right for the patient.

A range of activities has been developed in Altnagelvin Hospitals Health & Social Services Trust to promote clinically effective health care. These include Clinical Audit programmes, Practice Development, learning the lessons from clinical risk management issues and training and education for staff.

2.2 CLINICAL AUDIT

Clinical Audit is an essential and principal component of a programme of clinical effectiveness. Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through review of care against explicit criteria and the implementation of the necessary changes to patient care.

Action

During 2003 – 2004 the Trust has participated in 74 Audits and contributed to and maintained two National Databases and three Regional Databases relating to patient treatment and management.

Audit is only effective when meaningful changes in patient care occur as a result of the audit outcomes.

One example of meaningful changes, which have improved patient care, is around the management and monitoring of patients undergoing blood transfusions. Following a Trust wide audit on the management of adult patients undergoing blood transfusions, patient care has been modified and is now in line with the key recommendations found in the British Transfusion Guidelines for Practice.

2.3 CARE PATHWAYS

Care pathways consist of a number of elements. These include a plan of care, expected or anticipated, along with some form of timeline for delivering the care. They incorporate evidence based guidelines or standards and a system to chart variation from the agreed standard of care. Care pathways encourage multidisciplinary working and have the potential to reduce variations in the delivery of care.

Work on Care Pathways includes:

- Fractured Neck of Femur
- Elective Abdominal Hysterectomy
- Breast Cancer Surgery
- Surgical Pre-Assessment Pathway
- Care of the Dying Pathway

2.4 DOCUMENTATION

Accurate and timely documentation is the cornerstone of clinically effective care. Major Trust wide audits have indicated deficits in patient documentation.

A complete review of the nursing assessments has been undertaken over the last year resulting in a more clinically focused patient centred assessment process.

Work has also been completed on a range of key clinical forms to ensure the correct monitoring process for patients occurs. The range of forms include:

- Fluid balance charts.
- Head injury monitoring.
- Patient Controlled Analgesia.
- Management of intravenous access and monitoring of fluids/drugs.
- Monitoring of the patient with diabetes.

2.5 GUIDELINES

Clinical Guidelines are believed to have the potential to influence positively the quality and effectiveness of care received by patients.

The Trust has developed guidance to staff on the process for developing guidelines highlighting the correct method of quality assuring these. A tool to equality impact assess guidelines has also been devised and circulated. Once developed, the Risk Management and Standards Committee then ratify guidelines.

2.6 THE MANAGEMENT OF PATIENT MEDICATIONS

The management and administration of medications is a high-risk activity for any Trust.

To ensure staff are fully aware of the issues relating to the management of patient medication training an education day for staff has been developed which raises awareness of legislation, new policies and procedures in relation to medications and highlights individual accountability for staff.

A new medication kardex is currently being developed and is ready for piloting on some of the wards within the Trust.

2.7 CLINICAL INDUCTION

To support and facilitate staff when newly appointed to the Trust, a clinical induction day has been organised and runs on a monthly basis.

The programme includes key issues such as:

- Management of medical devices.
- Infection Control.
- Patient Documentation.
- Management of medications.

2.8 PREVENTION AND MANAGEMENT OF PRESSURE SORES

Pressure Sores are seen as a key quality indicator of patient care. A

training day is held monthly on the prevention and management of Pressure Sores and the Trust has ongoing monthly prevalence and incidence monitoring.

2.9 BENCH MARKING

The English "Essence of Care Document" has been adapted by NIPEC (Northern Ireland Practice Education Council) and the Trust is involved in bench marking the quality of care for patients in relation to:

- Promotion of patient privacy and dignity.
- Prevention of Pressure Sores.
- Nutrition and Hydration
- Promotion of self care

2.10 RESEARCH AGENDA

Research activity in the Trust includes:

- Collaborative Research with Cochrane Wounds Group – project to commence summer 2004.
- UK Dermatology Clinical Trials in Cellulitis.
- Fractured Neck of Femur Outcomes.
- Clinical Trials in Cardiology.
- Diabetes Research Projects in collaboration with University of Ulster:
  (a) Socio-economic deprivation and outcomes in type 2 diabetes
  (b) efficacy of self blood glucose monitoring in type 2 diabetes

- coeliac disease research
- colorectal disease research

2.11 USE AND MANAGEMENT OF MEDICAL DEVICES

The correct use of medical devices is an important aspect of safe patient care. Training and education of staff in the use of key pieces of equipment has been a priority for the Trust.

In the past year several training programmes have been set up and more than 500 staff have attended these programmes. The training includes:

- Correct use of syringe drivers
- Use of profiling beds
- Selection and Use of Specialised Bed Pressure Relieving Mattresses
- Glucometers
- Dressings

2.12 CLINICAL SUPERVISION

Clinical Supervision is a method of supporting the individual practitioner and reflects on their personal practice with a trained mentor facilitating the process.

The Trust has agreed training for both the supervisor and the supervisee and a programme to pilot the process of clinical supervision and evaluate the improvements in clinical practice has commenced.

Section 3
RISK MANAGEMENT

3.1 INTRODUCTION

Risk management is a process, which identifies, measures and controls activities, which put patients, employees and others at risk. It aims to eliminate or reduce those risks with a consequent improvement in patient care, staff well being and Trust reputation.

Altnagelvin Hospitals Trust recognises that risk management should be an integral part of the organisation's culture and become the business of everyone in the organisation. In the current year the Trust has made further progress in the development of risk management with the establishment of local risk management committees to review specific roles within their departments.

Risk Management is central to the Clinical Governance agenda and provides the focus for identifying where practices and activities are less than optimal. Once identified, weaknesses can be addressed and acted upon. This will ensure that high quality, effective treatment and care is delivered and that where things do go wrong they are quickly addressed and lessons are learnt to help prevent re-occurrence.

In March 2002 Altnagelvin Trust introduced a computerised risk management system. The system has 5 modules :- complaints, accidents, incidents, claims and a risk register. The information assists the Trust to identify and prioritise key risks and will help inform the Trust wide Risk Register, enabling the Trust to develop action plans to

reduce risk to patients and the organisation itself. The data is also shared with Directorate Managers who use the information to ensure that they manage risk within their area.

3.2 CLINICAL RISK

Risk Management can be viewed as an essential quality system and one, which is a fundamental part of a total approach to quality improvement. It brings with it quality benefits to the whole range of services being provided by the Trust. A major component of the management of clinical risk is an agreed system for the reporting of clinically related patient incidents.

3.2.1 Clinical Incidents

Incident reporting offers a framework for the detection of untoward incidents and near misses, which enables action to be taken, lessons to be learnt, practices to be reviewed and improved and information to be shared to prevent any recurrence.

A Clinical Incident reporting system was launched by the Trust in February 2000 and it is already providing information, which can be acted upon to improve patient care. All specialties are encouraged to report any incident which has a potential or actual adverse clinical outcome, not expected to occur in the routine course of clinical events.

In the year from 1st April 2003 to 31st March 2004, 42,802 patients were treated as inpatient and day cases. There were 628 Clinical Incidents reported. This equates 1.47% of patient activity. None of the incidents resulted in serious harm or injury to patients. Comparative

figures for the previous year 2002/3 indicate that 41,249 patients were treated as inpatient and day cases. There were 339 clinical incidents reported and this equated to 0.82% of patient activity. The Trust's Clinical Incident Committee reviews all clinical incidents and ensures that appropriate action has been taken following an incident to prevent a recurrence. Evidence from the NHS in the UK would suggest that there would be an expected rise in numbers of incidents initially as a result of increased awareness of the importance of reporting. Issues identified from clinical incidents have impacted on training throughout the Trust eg documentation; equipment training.

In August 2002 the Department of Health funded a medicines governance project to focus on the reporting and reviewing of medication incidents. A Governance Pharmacist was appointed for Altnagelvin Trust to address governance issues involving medication. The Trust actively encourages staff within this Trust to report medication incidents so that the lessons learnt can be shared throughout Northern Ireland. Due to the success of the project the Department of Health announced in March 2004 that it proposes to fund medicines governance pharmacists on a permanent basis. The Medicines Governance Pharmacist within Altnagelvin Hospital works in close liaison with the Risk Management Department to address issues identified from Clinical Incidents and is a key member of the Trust's Clinical Incident Committee.

As reported last year, within the Women and Children's Directorate, the Obstetrics and Gynaecology specialties have agreed lists of reportable events recommended by their Professional Bodies. An Obstetric Risk Management Committee was established to review

issues identified from reportable events. Within the past year the Committee has become even more active and has continued to make a number of recommendations for audit, improved guidelines and improvements in practice eg clinical protocols/development of growth charts and new guidance on fundal height measurements Building on the success of the work being done within the Women and Children's Risk Management Committee, other Directorates and Specialties have established local risk management committees and these will be further developed in the coming year.

3.2.2 Clinical Negligence Claims

Regrettably, on occasions, patients feel that the treatment they have received does not meet the standard they expected and as a result they proceed to take the matter to litigation. The Trust harnesses the information gained as a result of the claims process and ensures that lessons learnt are disseminated throughout the organisation.

As at 1st April 2003 the Trust had 205 outstanding clinical negligence claims. In the year to 31st March 2004, 53 new claims were received, 24 were withdrawn and 8 were settled. Comparative figures for last year show 185 outstanding clinical negligence claims as at 1 April 2002. In the year to 31 March 2003, 44 new claims were received, 11 were withdrawn and 13 were settled.

In addition to the valuable information that can be obtained from litigation, complaints and incidents it is essential that Clinicians constantly review their practice to identify clinical risks that can be acted upon to improve patient care.

3.2.3 Complaints/Commendations

In 2003/2004 the Patient's Advocate Office received 229 complaints from 202 complainants. Comparative figures for the year 2002/3 show 200 complaints received from 155 complainants.

There were 240 enquiries and 2,871 commendations in relation to services provided by the Trust. Comparative figures for the year 2002/3 show 189 enquiries, 3,030 commendations in relation to services provided by the Trust.

During the year there were thirteen requests to the Convenor of the Western Health and Social Services Board for Independent Review. Six of these requests were not referred to a Panel. Three requests were referred to a Panel. One referred back to the Trust for further local resolution. Three requests are still under consideration. From the thirteen requests to the Convenor one request was made to the Ombudsman.

3.2.4 Complaints Procedure

A complaint can be made to any member of staff or by contacting the Patient's Advocate, Ground Floor, Altnagelvin Area Hospital, Glenshane Road, Londonderry, BT47 6SB. Telephone [redacted]

Complaints are acknowledged in writing within two working days. During the year 2003/2004, 196 complaints were responded to in 20 working days and 33 complaints were responded to in more than 20 working days.

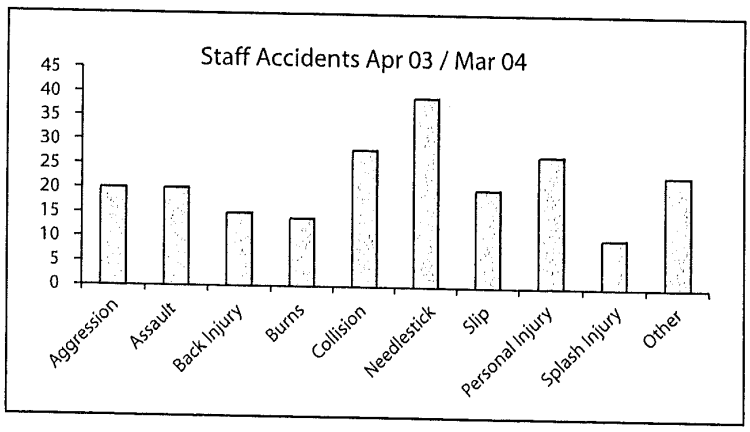
COMPLAINTS BY CATEGORY

Subject	No.	Subject	No.
Access to premises	13	Discharge & Transfer arrangements	12
Access to records	1	Hotel/support/security	8
Admission delay/ cancellation (inpatient)	9	Other	33
Transport late arrival /non arrival	1	Patients Privacy & Dignity	4
Appointments, delay/ cancellation (outpatient)	13	Policy & commercial decisions	4
Clinical Diagnosis	10	Professional Assessment	1
Communication/ information to Patients	28	Staff Attitude	39
Confidentiality	5	Treatment & Care (Quality)	37
Waiting Times (Outpatients)	5	Treatment & Care (Quantity)	1
		Waiting Times (A. & E.)	5

3.3 HEALTH AND SAFETY

The Health and Safety at Work Order is the primary legislation covering the requirement of employers to provide, as far as is reasonably practicable, a safe environment for their employees. Altnagelvin Hospitals Health and Social Services Trust takes its responsibilities in relation to Health and Safety very seriously. Accident reporting can provide the Trust with valuable information on where to focus attention to improve Health and Safety of Staff, Patients and Visitors. The information system assists in identifying trends and areas for improvement. Managers are required to undertake an investigation of all incidents to identify any defects in health and safety factors and to ensure that appropriate action is taken to prevent further similar incidents occurring.

In the year to 31st March 2004 216 staff accidents were reported. This equated to 8.6% of the staff employed.



The data indicates that the areas for attention, in relation to accidents to staff, are Aggression and Assault, and Needle Stick Injuries. Back/

musculo skeletal injuries amongst staff are also an area which the Trust continues to address.

Aggression and Assault

In January 2002 the Trust commissioned an external company to undertake a risk assessment in relation to violence in A&E. A project board and project team was established and the team was charged with the task of implementing the recommendations. The key recommendations related to improvements in Environment, Staff Training and Security. The Trust has undertaken the recommendations and in the past year structural changes to the A&E Department have helped to improve the security of staff. Security arrangements throughout the Trust are kept under constant review and all staff are encouraged to report incidents of verbal and physical abuse so that the Trust is able to identify areas of concern and take appropriate action.

Back Injury

In October 2002, the Trust appointed for a 2-year period an Ergonomic Assessor to address back care problems amongst Hospital Staff. 15% of long-term absentees have returned to work under supervision and on the job risk assessments has changed work practices in a number of areas. Due to the success of the appointment the Trust has agreed to extend the post for a further 2 years.

Needle stick Injuries

It is noted that needle-stick injuries are the highest category of staff accidents. To try to reduce the incidence of such incidents the Risk Management Department undertook a high profile campaign to remind staff of the safe disposal of sharps. In addition, following every sharps

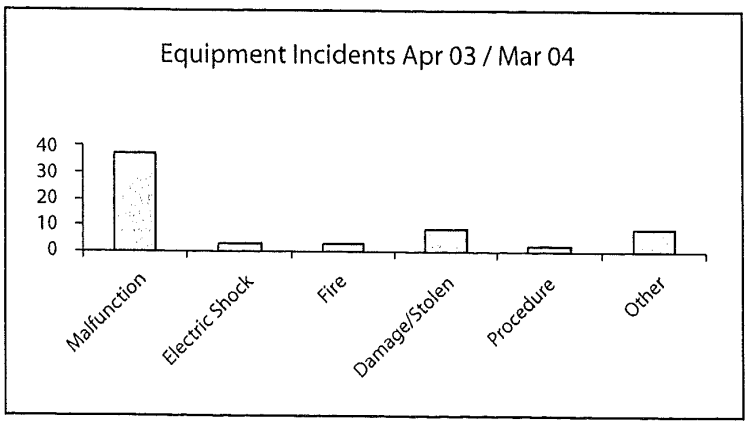
incident, a risk assessment is undertaken to look at the system in the individual area to identify any failures in procedures.

Equipment Incidents

Whenever medical devices are used it is important that they are suitable for their purpose and maintained in a safe and reliable condition. Altnagelvin Trust has systems in place to ensure the safe and effective use of devices.

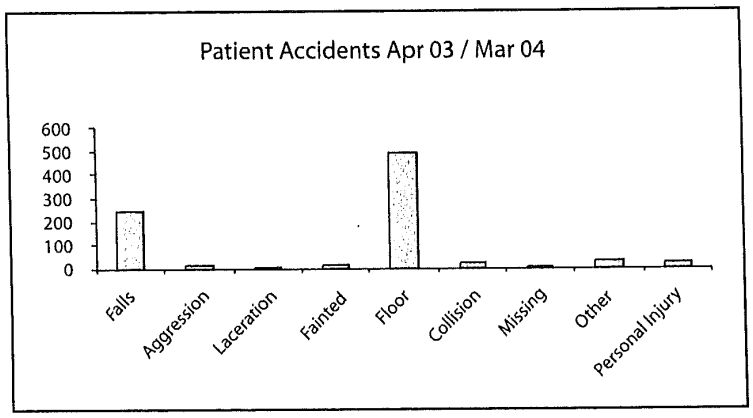
The Northern Ireland Adverse Incident Centre (NIAIC) requires Trusts to report equipment incidents to ensure that when defects are noted the information can be shared with users of equipment throughout Northern Ireland. Altnagelvin Trust actively encourages staff to report equipment incidents to the Trust. The Trust's Technical Equipment Manager acts as the reporting Officer to the NIAIC.

In the year to 31st March 2004 there were 63 equipment incidents reported. This compares to 31 equipment incidents reported last year. Each incident is investigated by the Trust and necessary action is undertaken to try to reduce the risk.



Patient Accidents

Staff are encouraged to report any incident involving a patient, to provide the Trust with an indication of the areas of risk associated with their care. In the year to 31st March 2004 there were 861 patient accidents reported which equated to 2.01% of patient activity. Comparative numbers for last year show that there were 777 patient accidents reported which equated to 1.9% of patient activity.



The two highest categories of accidents involving patients are Patient Falls and Patients found on floor. In an effort to address the concerns the Trust established a Falls Group in 2000 to design a falls risk assessment. A number of control measures were put in place, in particular for some vulnerable patients specialist alert equipment was purchased.

As part of the risk management process and the review of incidents it was noted in April 2003 that patient falls continue to be the highest category of accident involving patients. The Trust's computerised risk management system also enabled us to identify particular patients who are at risk. The risk management department assisted wards in

undertaking specific risk assessments for high-risk patients and a new 'low bed' was piloted with great success. The Risk Management and Standards Committee recommended the establishment of a Falls group to examine strategies for the Assessment and Prevention of falls within the In-Patient population of AAH, to create a Pathway of Care for Older People who fall or are at risk of falling and to develop a Trust Policy on the prevention of falls. The multi-disciplinary group are also working closely with colleagues Regionally who are attempting to address the issue and internally with the Documentation group who are developing the patient assessment tool.

3.3.1 Risk Assessment

The key to accident prevention is risk assessment. Under the guidance of the Risk Management Department, Directorates have continued to undertake and review risk assessments in all Departments. The assessments are undertaken by Departmental risk assessors who have been nominated in all individual wards/departments. The Risk Management Director and the Risk Management Project Sister provides guidance and assistance to staff on a range of Health and Safety issues.

Risk assessment is also a statutory requirement and departments are required to keep risk assessments under review to ensure safe systems of work.

The Trust's COSHH Policy (Control of Substances Hazardous to Health), was reviewed and re-launched during the year. The Risk Management Project Sister undertook training for the Departmental COSHH assessors to assist them in undertaking assessments in the individual areas.

3.3.2 Decontamination

In 2002 the Department of Health asked Trusts to undertake an audit of Decontamination practices. Altnagelvin Hospitals established a Decontamination Committee and compiled an action plan to address any shortfalls in practices. The Decontamination Committee continues to work to address outstanding issues. The process is led by the Project Sister Risk Management and the Medical Engineering Manager. The Medical Engineering Manager is required to provide the Risk Management and Standards Committee and Clinical and Social Care Governance Committee with an annual report providing assurance on compliance with Department of Health's Decontamination guidelines by 31st March 2004.

3.3.3 Mental Health Steering Committee

A key Health and Safety concern for all organisations is Stress. To try to address and to assess the extent of the problem within Altnagelvin the Trust established a Mental Health Steering Committee. The Committee recommended that a Stress audit be undertaken and in January 2004 the Trust commissioned an external organisation to undertake the survey. Questionnaires were distributed to every member of staff employed in the Trust. The survey is completely anonymous and confidential. The Trust is committed to implementing the recommendations from the audit.

3.3.4 Environmental Management

Altnagelvin Hospitals H&SS Trust believes that the effect of its activities on the environment is of significant importance. As an integral part of its commitment to ensure the health and well being of the community the Trust will do its utmost to contain the environmental impact of its activities to a practical minimum.

To achieve this the Trust has established an Environmental Management Group consisting of senior departmental managers with the aim of working to develop an Environmental Management System (EMS) compliant with ISO 14001.

3.4 RISK REGISTER

In the past year individual Directorates, Wards and Departments have been encouraged to prioritise their risks. A fledgling organisation wide risk register is being developed to ensure that significant risks are recorded, actions identified and implementation tracked. The Risk Register is a working document identifying major risks for the Trust. The Clinical Governance Co-ordinator has used the DATIX computerised risk management system to grade the risks for the register. The Risk Management and Standards Committee will use the document to inform the Clinical Governance Committee of the action required to control these major risks to ensure that the Trust can meet its business objectives.

The key risks for Altnagelvin are:

- Clinical
- Health and Safety
- Estates and Environment Risks
- Financial Risks

3.5 CONTROLS ASSURANCE

Controls assurance is essentially a process that will enable HPSS

organisations to provide evidence that they are doing their reasonable best to manage themselves so as to meet their objectives and protect patients, staff, public and other stakeholders against risks of all kinds. Chief Executives, as accountable officers, are required to report on this issue to the Department of Health Social Services and Public Safety to provide an assurance that there is an organisation wide system of risk management in place throughout the Trust.

Controls assurance was first introduced to the NHS in 1999 however the DHSSPS has begun to develop standards that will focus on key areas of risk within the HPSS and provide a vehicle for Accountable Officers to report the extent to which risk is being effectively controlled. The DHSSPS have launched 6 standards which Trusts in Northern Ireland are required to comply with by 31-3-04.

- Governance (Core standard)
- Risk Management (core standard)
- Medicines Management
- Human Resources
- Medical Equipment and Devices
- Financial Management (Core standard)

Altnagelvin Hospitals Trust has undertaken the audits and has reported compliance (for all controls assurance standards above) to the Clinical Governance Committee, Trust Board and the DHSSPS – See appendix 2. The completion of these audits has enabled recommendations and action plans to be identified to the Risk Management and Standards Committee who have a responsibility to ensure that the Trust can focus attention on any deficiencies identified by the Standards.

An additional 8 standards are being launched by the DHSSPS in the coming year and Trusts will be required to audit and report on these in addition to re-audit of the 6 standards already audited by 31-3-05.

Section 4
EDUCATION AND TRAINING

"It is the education and training received by professional staff that will determine to a very large extent the quality of service provided. It is the application of their education and training in the clinical setting that is fundamental". (Lurgan et al 1999).

Through the staff appraisal system the individual training needs of clinical professionals are identified and the Trust is committed to ensuring that where possible these training needs are met.

Participation in Continuing Professional Development by medical staff is reviewed during staff appraisal by Clinical Directors. Participation in continued professional development ensures the quality of care provided to patients is of the highest possible standards.

The increasing development of medical education at Altnagelvin is a major strategic goal for this hospital. The Trust provides a high standard of medical education, both at undergraduate and postgraduate levels. In recent years, there has been a substantial growth in medical education activity at Altnagelvin, and the Trust is now recognised as a major teaching centre for delivering high standards of undergraduate and postgraduate medical education.

4.1 UNDERGRADUATE MEDICAL EDUCATION

Altnagelvin has established a good reputation for teaching medical students, delivered in the main by consultant staff. The majority of our

medical students are from Queens University, Belfast, with the numbers having steadily increased over the last few years.

In addition to Queens University, Belfast medical students, the Trust also teaches medical students from other Universities such as NUI Galway and Dublin, Trinity College and RCS Dublin, Keigzi International Medical School and many other overseas medical schools.

4.2 POSTGRADUATE MEDICAL EDUCATION

Postgraduate medical education is delivered in the hospital through the Postgraduate Clinical Tutor, responsible for delivering the requirements of the postgraduate medical and dental education contract, in partnership with the College Tutors, Educational Supervisors and other medical staff. There is an active postgraduate teaching programme in all disciplines in Altnagelvin offering a comprehensive programme to all Senior House Officers and Specialist Registrars.

Training was provided on the following topics to Senior House Officers:

- ATLS principles – Chest and abdominal trauma
- Head injury – Cervical spine x-ray evaluation
- The shoulder joint – injuries to the upper limb
- The hand – injuries to the lower limb
- Poisoning
- Sepsis – Antibiotics use
- Dermatology
- The ECG

- Respiratory emergency medicine
- Neurological emergencies
- Obsetrics and Gynaecology
- Psychiatric emergencies
- Legal/ethical issues
- Endocrine/metabolic emergencies
- GI/liver/renal emergencies

The Trust also supports the General Practice Vocational Training Scheme, teaching six GP Registrars and 16 Senior House Officers at Altnagelvin. This is provided by two local GPs and supported by contributions from our medical staff.

4.3 ALLIED HEALTH PROFESSIONALS (AHPs)

AHP services provided by Altnagelvin have a strong commitment to student teaching with both Physiotherapy and Dietetics Departments providing student places each year.

Within Physiotherapy there is a Clinical Tutor with well established links with the University of Ulster and the Physiotherapy Department facilitates approximately 40 students on 6 week placements each year for undergraduates and two 12 week placements for MSc students. Increasingly, the department is also facilitating requests for placement from local undergraduate students studying Physiotherapy in the UK.

The Dietetic Department have recently received accreditation from the Health Professions Council which will enable this Department to provide a wider range of dietetic student placements.

Continuing Professional Development is important to these practitioners in increasing their skill base and extending their expertise. Both professional groups identify their CPD through the appraisal process with Physiotherapy operating to a CPD path linked to a career planning pathway.

In service education forms an important component of the CPD plan for these groups with regular formal sessions for the staff presented by their colleagues.

The establishment of an AHP Development Centre within Northern Ireland is a recent development for these professional groups. The purpose of the Centre is to facilitate and enhance the delivery of local post graduate training, both professional and personal, required by the individual AHP professions and their specialties.

This will be an important addition to the resources available to these groups in the future.

4.4 NORTH & WEST IN-SERVICE EDUCATION CONSORTIUM

In this second Clinical Governance Report we continue to focus on the importance of education and training of Nursing Staff by the North and West In-Service Education Consortium and the backup provided in that respect.

The North and West In-Service Education Consortium recognises that continuing professional education is essential for Nurses, Midwives and Health Visitors in order to ensure continuing accountability for the

quality of the care they provide to their patients and clients. Therefore, to provide high quality in-service education programmes that will enhance nursing care, disseminate nursing knowledge and promote evidence based practice, each year the Consortium conducts a training needs analysis through which it seeks to listen and discuss with practitioners and managers their professional in-service education needs and aspirations.

During the period 1 April 2003 – 31 March 2004, the Consortium delivered to Altnagelvin Hospitals Trust, a wide variety of in-service programmes primarily for nursing staff and the attendance figures for this period totalled almost 1370. With specific reference to the Clinical and Social Care Governance agenda, it was pleasing to note that the following programmes received favourable support:

- Manual Handling
- Legal Aspects of documentation in Nursing Practice
- Intravenous Additives
- High Dependency Nursing
- Neo-natal Cannulation
- Induction Course for Nursing Auxiliaries
- N.V.Q. – Underpinning Knowledge
- SARS
- Infection Control
- Clinical update cannulation
- Syringe Driver Training
- Basic Life Support
- ALERT Course
- Inhaler Oxygen and Therapies

- PEG Feeding
- Drugs and Alcohol Awareness
- Care of the Dying
- Violence and aggression
- Training on consent forms
- DM and PAS Training

In addition, the opportunity to receive accreditation for learning that occurs in the workplace, was availed of by 51 nurses who successfully completed work-based modules delivered by the Consortium. These modules, validated by the University of Ulster, are accredited at 20 CATS points at Level 2, and can contribute in part to the attainment of the Diploma in Higher Education in Professional Development in Nursing (Work-Based Learning Pathway).

Again, and with specific reference to the Clinical and Social Care Governance agenda, it was pleasing to note that the following work-based modules attracted good support:-

- Introduction to Research
- Promoting Evidence Based Practice
- Anaesthetic Nursing
- Cancer Care Nursing
- Palliative Care Nursing
- Diabetes Care

The delivery of a work-based module focusing on Clinical and Social Care Governance was particularly welcome this year.

Finally, our six-month post delivery evaluation reports for the period 1 April 2003 – 31 March 2004, have revealed positive comments from participants about the manner in which such programmes contribute to improving the quality of their practice and ultimately the quality of patient care they deliver.

Section 5
OBJECTIVES

Last year's report identified the action plan for the year 2003/4 and we are pleased to report progress in the following pages:

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
STAFF BASELINE ASSESSMENT *The foundation for the action plan was a baseline assessment of the knowledge of Altnagelvin H&SS Trust employees in relation to Clinical and Social care Governance.*	Quarterly clinical governance newsletter published. Web page available on Trust's intranet site. Series of seminars to raise awareness of staff.	Continue to produce quarterly Clinical Governance newsletters. Ensure newsletter is available on the Trust's intranet site. Continue with a further 2-3 awareness sessions for staff.

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
QUALITY *The Hospital Quality Improvement Programme (HOSQIP) involves a range of initiatives designed to improve the patient's experience of care. The strength of this programme is the improvement of the entire multi-disciplinary team/s in development of good quality initiatives.*	Each ward/department developed a hospital quality improvement project.	Each ward/department will be required to develop a HOSQIP project to be implemented and audited in the year 2004/5. A Senior Nurse Quality Assurance will take up post and will work with Directorate Management Teams to provide leadership and support to this activity through identification of a Directorate Facilitator to meet regularly with the Ward/Department Teams and receive reports on progress and assist with problem solving.

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
CLINICAL AUDIT *Clinical Audit is seen as an important vehicle for moving the quality agenda forward. It is already an established activity within the Trust, however, it is important to keep the momentum moving and to ensure that all clinical staff see audit as an integral part of their everyday work.*	All Directorates participated in clinical audit activity during the year 2003/4.	Each speciality will be required to submit to Risk Management & Standards Committee a list of the recommended audits from their Royal College. Each speciality will be required to undertake a clinical audit of one of the professional guidelines issued by the Royal Colleges or other Professional/Standards Body. This will not replace all other audit activity within the speciality but this is one audit that will be expected to have been through the complete audit cycle. The changes in practice that have come about as a result of audit activity will be reported to the Clinical & Social Care Governance Committee by the speciality in their Directorate Report. Each directorate will be required to submit their audit strategy to the Clinical Audit Committee. During the year 2004/5 a list of prioritised audits will be compiled on behalf of the Clinical and Social Care Governance Committee to be commissioned from the appropriate Directorate, or if applicable to more than one Directorate, commissioned from the Clinical Audit staff.

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
CARE PATHWAYS *Care Pathways, developed from evidence-based standards, is another means of improving quality of care of patients.*	Work continues on the following Pathways:- Fractured Neck of Femur Elective Abdominal Hysterectomy Breast Cancer Surgery Surgical Pre-Assessment Care of the Dying. The Care of the Dying pathway was piloted in one medical ward and an evaluation carried out which showed improvement to the quality of patient care. It is now planned to extend this pathway to other clinical areas.	Each speciality will be required to develop at least one Integrated Care pathway, subject it to the audit cycle and report on outcomes.

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
ESTABLISHMENT OF RISK MANAGEMENT STRUCTURES		
Ownership of the Risk Management agenda by Directorates and Clinical Professionals within Specialties is critical to successful risk elimination.	The Clinical and Social Care Governance Committee acknowledges the commitment of the Women and Children's Directorate who have Risk Management structures set up within Paediatrics, Obstetrics and Gynaecology. The Committee also acknowledges the commitment of the Medical & Ambulatory Care Directorate in setting up their Risk Management Committee for care of the elderly and stroke services (Wards 20, 21 and 22).	This incoming year, each remaining Directorate will establish its own Risk Management Committee, which will be supported by staff from the Risk Management Department. The remit of these committees will be to continue to review risks, incidents and complaints within their own department and proactively plan to reduce, control or eliminate them. All incidents will continue to be reported to the Risk Management Department as well as to line managers as at present.

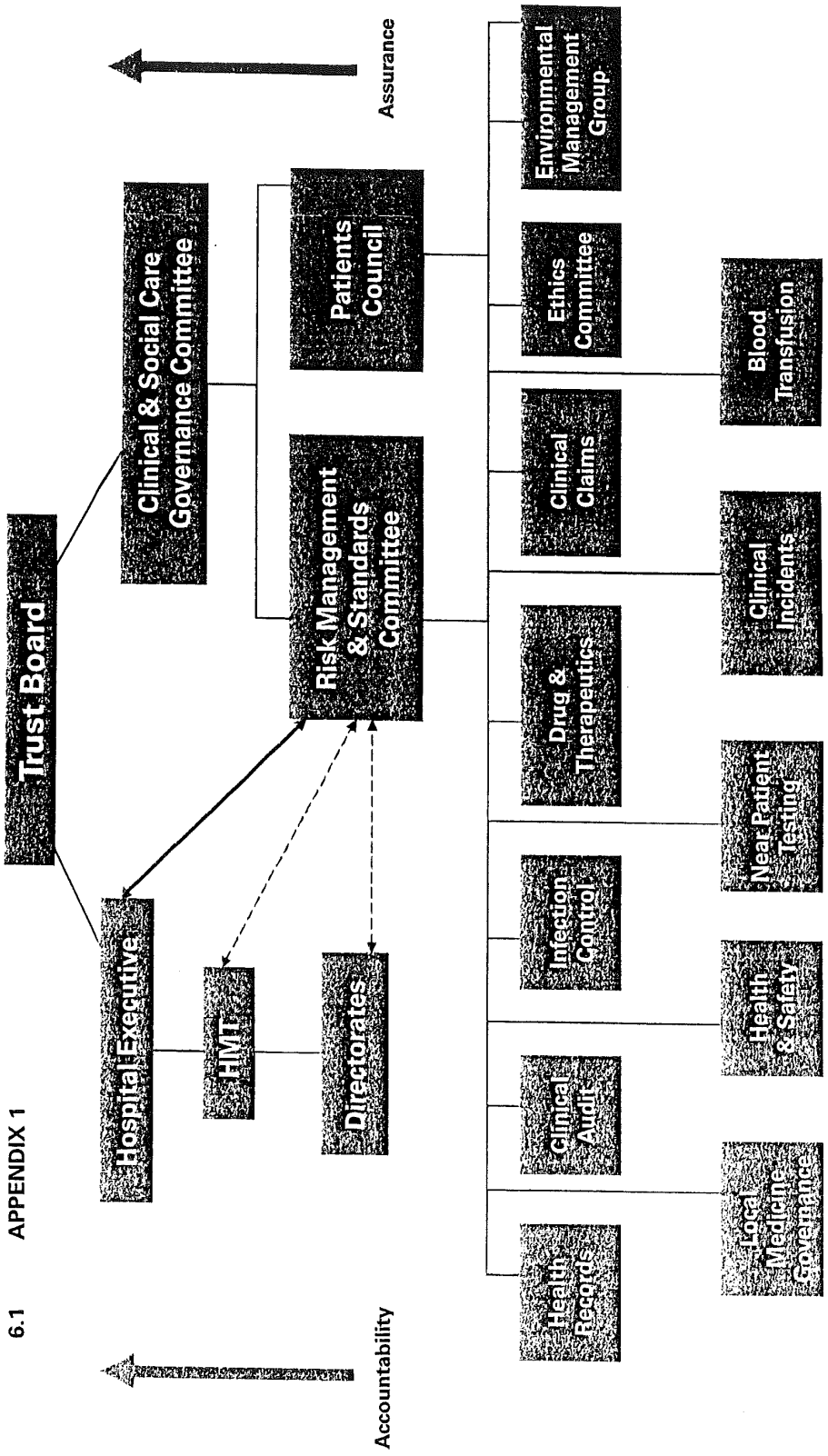
OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
RISK ASSESSMENTS *A proactive programme of Risk Assessment which identifies actual or potential risks and puts in place action plans to reduce, control or eliminate risk, can contribute to improved quality of care.*	Each ward/department was required to review their risk assessments during the year 2003/4 and put in place an action plan and evaluate the effectiveness of the assessments in reducing, controlling or eliminating the risks.	Each ward/department must ensure that risk assessments are up-to-date in compliance with the management of Health and Safety at Work Regulations, COSHH Regulations and Manual Handling Regulations and other legislation as appropriate to the department. They will be required to report on this to the Clinical and Social Care Governance Committee.

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
USER INVOLVEMENT *It is a requirement of the DHSSPS to involve users in the planning and delivery of services. Within Altnagelvin Hospitals, H&SS Trust users are involved in a number of different ways.*	Altnagelvin Hospitals Health & Social Services Trust developed a Strategy for Patient and Public Involvement.	A Patient and Public Involvement Strategy was submitted to the Clinical and Social Care Governance Committee and this has been consulted upon. This document acknowledges the excellent work achieved by the Altnagelvin Patients' Council and recommends re-establishing the Patients' Council as the lynchpin of its strategy. The Patients' Council will be a sub committee of the Clinical and Social Care Governance Committee. The Patients' Council will comprise nominees selected from communities and groups that represent the patient's viewpoint. Nominees will be sought through a media advertising campaign to help ensure openness and transparency.

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
REPORTING ARRANGEMENTS *It is important, particularly for the assurance of Trust Board, that there are robust systems for the reporting of Clinical Governance issues.*	Each Directorate was required to report the progress being made on the action plan. The Reporting Template for Directorates was reviewed and re-issued to ensure coherence and consistency. Reviews of Directorates' performance have taken place at Performance Management meetings. Quarterly and half yearly Directorate reports were submitted to the Risk Management & Standards Committee and Clinical & Social Care Governance Committee. An annual Clinical and Social Care Governance report was also published.	Each Directorate is required to report, on a quarterly basis, the progress being made on the Action Plan. The Reporting Template for Directorates will continue to be reviewed and re-issued to ensure coherence and consistency. Review of Directorates' performance will continue to take place at Performance Management meetings. A quarterly report will be submitted to the Risk Management and Standards Committee, Clinical and Social Care Governance Committee, and will incorporate the Directorate Reports. Quarterly Risk Management and Clinical Effectiveness Reports will be issued to Hospital Executive and Hospital Management Team. An annual Clinical and Social Care Governance Report will be published.

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
CORPORATE GOVERNANCE *Corporate Governance is the system by which the Trust directs and controls its functions.*	In the past year a Risk Register has been produced. The Risk Management and Standards Committee will use the document to inform the Clinical Governance Committee of the action required to control the major risks to ensure that the Trust can meet its business objectives. Controls Assurance is a process that will enable Altnagelvin H&SS Trust to provide evidence that they are doing their reasonable best to manage themselves to meet their objectives and protect patients, staff, public and other stakeholders against risks of all kinds. Altnagelvin H&SS Trust has undertaken audits and reported compliance to the Clinical Governance Committee, Trust Board and the DHSSPS.	Training will be delivered to directorates in relation to the completion of Controls Assurance Standards. An Audit will take place in relation to the additional 8 Controls Assurances Standards. Training will be delivered to directorates to enable them to operate a Risk Register at local level.

OBJECTIVE/CONTEXT	PROGRESS 2003/4	TARGETS FOR 2004/5
EDUCATION TRAINING		
Integral to delivery of high quality patient care is having staff who are knowledgeable, skilled and competent. This can only be achieved by a continuing professional development for staff within the Trust.	To support and facilitate staff when newly appointed to the Trust, a clinical induction day is held on a monthly basis. The programme includes key issues such as:- Management of medical devices Infection control Patient documentation Management of medications During the year consent training was provided to all staff.	Each Directorate will be required to ensure that each member of staff can participate in an individual staff appraisal. Each Directorate will be required to produce a Directorate Training Plan, based on the outcome of the Staff Appraisal System. Altnagelvin Hospitals Health & Social Services Trust is committed to developing the leadership and management skills of its staff and has commissioned the *Leading an Empowered Organisation* facilitated by Leeds University – this programme will continue to be delivered in the year 2004/5.


6.1
APPENDIX 1
Trust Board
Clinical & Social Care Governance Committee
Patients Council
Assurance
Environmental Management Group
Ethics Committee
Blood Transfusion
Clinical Claims
Risk Management & Standards Committee
Clinical Incidents
Drug & Therapeutics
Near Patient Testing
Infection Control
Health & Safety
Clinical Audit
Local Medicines Governance
Health Records
Hospital Executive
HMT
Directorates
Accountability

6.2 APPENDIX 2

HPSS Controls Assurance Standards issued in 2003/04 - Reference Table on Applicability and Expected Levels of Compliance.

Standard	Applicable to:	Progress expected in 2003/04
1. Financial Management **(core standard)**	All HPSS bodies	**Substantive (Expected by 31.03.04)**
2. Governance **(core standard)**	All HPSS bodies	**Substantive (Expected by 31.03.04)**
3. Human Resources	All HPSS bodies	**Moderate**
4. Medical Devices & Equipment Management	All HPSS Trusts and NI Blood Transfusion Service Agency. Partially applicable to HSS Boards, Central Services Agency, NI Regional Medical Physics Agency and Health Promotion Agency	**Moderate**
5. Medicines Management	All HPSS bodies except the NI Guardian ad Litem Agency	**Moderate**
6. Risk Management **(core standard)**	All HPSS bodies	**Substantive (Expected by 31.03.04)**