Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol **HSS–05–03(p.3)**

Dyddiad: Dydd Mercher, 26 Mawrth 2003
Lleoliad: Ystafelloedd Bwyllgora 3&4, Cynulliad Cenedlaethol Cymru
Teitl: Y Cynnydd a wnaed mewn ymateb i Adroddiad Kennedy ac Adolygiad Carlile

Diben

1. Gwahodd y pwyllgor i nodi'r cynnydd a wnaed o ran rhoi argymhellion Adroddiad Kennedy i drychineb Ysbyty Brenhinol Bryste ac argymhellion Adolygiad Carlile ynghylch Mesurau i Ddiogelu Plant a Phobl Ifanc sy'n derbyn Triniaeth a Gofal gan y GIG yng Nghymru ar waith.

Crynodeb

2. Mae Atodiad A sydd ynghlwm yn rhoi crynodeb o'r brif fentrau y mae'r Cynulliad, y GIG a Llywodraeth y DU wedi ymgymryd â hwy yn ystod y flwyddyn ddiwethaf ers i'r Cynulliad Cenedlaethol gyhoeddi ei ymateb i argymhellion Adroddiad Kennedy ym mis Chwefror 2002.

3. Mae Atodiad B sydd ynghlwm yn rhoi crynodeb o'r brif fentrau y mae'r Cynulliad, y GIG a Llywodraeth y DU wedi ymgymryd â hwy yn ystod yr wyth mis diwethaf ers i'r Cynulliad gyhoeddi casgliadau Adolygiad Carlile ym mis Gorffennaf 2002.

4. Cyhoeddwyd Adolygiad Carlile bum mis ar ôl ymateb ffurfiol Llywodraeth Cynulliad Cymru i Adroddiad Kennedy ac mae llawer o argymhellion yr Adolygiad yn debyg iawn i argymhellion Adroddiad Kennedy. At ddibenion y papur hwn rydym felly wedi cynnwys gwybodaeth am Wasanaethau Plant ym mhapur Adolygiad Carlile yn Atodiad B.

5. Cynhwysir rhestr lawn o argymhellion Kennedy a Carlile yn ymatebion ffurfiol Llywodraeth Cynulliad Cymru i'r adroddiadau hyn yn Atodiad C ac Atodiad D.

I'w Hystyried

6. Yr adroddiadau cynnydd yn Atodiad A a B.

Cydymffurfio

7. Nid oes gan y Cynulliad y pwerau angenrheidiol i ymdrin â'r **holl** argymhellion. O ganlyniad mae swyddogion o'r Cynulliad wedi bod yn cydweithio â swyddogion yn yr Adran Iechyd, a byddant yn parhau i wneud hynny, er mwyn rhoi rhai argymhellion ar waith, er enghraifft argymhellion ynghylch rheoliadau proffesiynol ac ailddosbarthu canllawiau i'r DU.

8. Mae'r Cynulliad wedi gweithredu a bydd yn parhau i weithredu o fewn ei bwerau datganoledig i wneud y trefniadau deddfwriaethol angenrheidiol fel y gellir rhoi argymhellion Adroddiad Kennedy ar waith.

Themâu Trawsbynciol

9. Mae gan argymhellion Adroddiad Kennedy ac Adolygiad Carlile oblygiadau mawr ar draws y Gwasanaeth Iechyd Gwladol, Llywodraeth Leol a Gwasanaethau Cymdeithasol.

Camau i'r Pwyllgorau Pwnc eu cymryd

10. Gwahoddir y pwyllgor i nodi'r papur

Jane Hutt
Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol

Cyswllt: Shaun Chainey, Is-adran Ansawdd GIG, ffôn 029 2082 5113

NID YW'R ATODIADAU AR GAEL TRWY GYFRWNG Y GYMRAEG

Annex A

PROGRESS REPORT ON THE KENNEDY REPORT ON THE BRISTOL ROYAL INFIRMARY

THE HEALTH AND SOCIAL SERVICES COMMITTEE 26 MARCH 2003

The Kennedy Report

Background

1. Professor Sir Ian Kennedy chaired an Inquiry into the outcome of children's heart surgery at the Bristol Royal Infirmary between 1984 and 1995. His report was published on 18 January 2001.

2. The Report concluded that between 30 and 35 more children, aged under one year, died after open heart surgery in Bristol than was typical of similar heart units elsewhere in the UK. This was not due to differences in the severity of the cases.

3. The Report exposed considerable flaws in the systems, culture and management arrangements in place within the organisation at the time; and highlighted a culture where little account was taken of the views and concerns of parents, where there was a shortfall in clinical audit practices, and where management actively discouraged open discussion and resolution of concerns raised by staff.

4. The Kennedy Report made 198 recommendations for change. Whilst the changes called for in the report were wide ranging, many of the recommendations focussed on the need for:

- improved professional regulation;
- a shift of culture by the NHS to one where it is acknowledged that medicine is not a perfect science, that even the best people can make mistakes, but when it does, lessons are learnt and shared
- patients to be genuine partners in the decision making process.

Process we have adopted

5. The Assembly's formal response to the Kennedy Report was issued in WHC 2002/019 on the 19th Feb 2002. Whilst paralleling the UK Governments response in may ways, it set out to reflect the context in Wales and recognised that the Assembly, the NHS and partners shared the responsibility for taking forward many of the recommendations.

6. The NHS in Wales was charged with implementing the recommendations contained in the report and ensuring that they become part of the standard of delivery within services in the NHS. They were also specifically required to develop Action Plans in respect of 50 recommendations identified as requiring direct action at Health Authority/Trust/LHG level.

7. A Circular was issued in January 2003 which set out the expectations for

the preparation of Service and Financial Frameworks. The Minimum standard targets to be achieved were clearly outlined in the guidance and will form a key part of the Trust and Local Health Board performance assessment process.

UK and Welsh Assembly Government Developments

8. Even before the Kennedy Report was published, there was a shift in focus by the UK and Welsh Assembly Governments toward the NHS and a number of new structures had been introduced which focused on the quality of care provided, and which helped to begin a cultural shift within the NHS by investing management time and focus on quality of care. The structures included:

The National Institute for Clinical Excellence (NICE) - was set up as a Special Health Authority for England and Wales on 1 April 1999. It is part of the National Health Service (NHS), and its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice". NICE guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques, and procedures) and the clinical management of specific conditions.

In addition, NICE has established a 30 strong group of people, drawn from all parts of the community, known as the Citizens Council. The Citizens Council will:

- keep NICE in touch with public opinion;
- provide a perspective on technical issues, such as the levels of evidence NICE should consider; and
- give NICE non-technical, common sense advice.

The Commission for Health Improvement (CHI) set up on 1st April 2000 to improve the quality of patient care in the NHS across England and Wales through assessing clinical governance arrangements. For many years it has been apparent that the standard of care offered by the NHS in England and Wales has varied greatly, for example, between hospitals, between departments in the same hospital. CHI aims to address this issue of variation and has a programme underway which aims to ensure that every NHS patient receives the same high level of care. CHI also work closely with the Social Services Inspectorate in Wales in areas where health and Social Services come together.

CHI ensures accountability to patients, the public, Parliament and the National Assembly for Wales by:

- ensuring independent and authoritative information on health care is published to inform patient choice and public debate;
- identifying both good practice and poor performance in health care;
- identifying, where needed, the worst NHS performers to prompt the necessary action to make sure services approve; and
- reporting direct to the public and Parliament what is happening in the NHS.

National Service Frameworks (NSFs) are designed to ensure the NHS delivers top quality services for everybody, no matter where they live. They spell out the standards of care patients can expect to receive for their condition / illness regardless of where they live in Wales. The following NSFs have been developed in Wales ;

- Coronary Heart Disease NSF published 3rd July 2001
- Diabetes NSF standards published 29th April 2002.
- Mental Health NSF published 29th May 2002.

NSFs for Children's Services, Older Person's and Renal Services are also being developed.

The National Patient Safety Agency (NPSA) was as set up as a Special Health Authority in July 2001; a partnership agreement between the Assembly and the NPSA under section 41 of the Government of Wales Act was agreed in May 2002. The prime purpose of the NPSA is to implement and operate a national system for reporting and learning from adverse incidents and near misses across the NHS. The new system will help provide the evidence to change practice or behaviour to reduce the potential for adverse incidents recurring by sharing learning and by devising and implementing national safety solutions.

By collecting and analysing data on adverse events, NPSA will be able to;

- Identify trends and patterns of avoidable adverse events;
- Provide feedback to organisations to enable them to change their working practices;
- Help develop models of good practice and systems solutions at national level; and
- Support ongoing education and learning.

The NPSA's adverse events reporting system is currently undergoing testing and development and will be rolled out in 2003. In parallel with this, the NPSA will also run training for all staff.

National Clinical Assessment Authority (NCAA) was established as a Special Health Authority in April 2001, as part of the modernisation of the NHS to improve the standards and quality of our health services. The aim of the Authority is to provide a support service to NHS health authorities and primary care, hospital and community trusts, the Prison Health Service and the Defence Medical Services when they are faced with concerns over the performance of an individual doctor. It is there to provide support to doctors in difficulty and to boost patient confidence in the NHS.

In order to help doctors in difficulty, the NCAA provides advice, takes referrals and carries out targeted assessments where necessary. The NCAA's assessment involves trained medical and lay assessors. Once an objective assessment has been carried out, the NCAA will advise trusts or health authorities on the appropriate course of action. The NCAA is established as an advisory body, and the NHS employer organisation remains responsible for resolving the problem once the NCAA has produced its assessment. The Welsh Assembly Government has established a Service Level Agreement for the NCAA service to be provided in Wales and NCAA will be opening an office in Wales soon.

Council for Regulation of Health Care Professionals The Kennedy Report called for an improved framework for professional regulation which brought together all healthcare regulatory bodies (Rec 39/40). This has resulted in the establishment of the Council for Regulation of Healthcare Professions. This Council will come into being on the 1st April 2003. The membership is made up of representatives of each of the healthcare regulatory bodies (() and 10 lay members, 3 of whom represent the interests of Wales, Scotland and N. Ireland. Officials from the Assembly have worked alongside DH in the appointment of all lay members.

Other Actions taken by the Welsh Assembly Government

Patient Involvement and Patient Focus

9. One of the key issues raised in the Kennedy Report was the need for patients to be actively involved as partners in the decision making process. This was an issue picked up in 'Improving Health in Wales' which was published September 2001, and every NHS trust and local health group have been required from 2002, to produce annual action plans setting out their proposals for patient involvement and patient focus. This process was supported by the Welsh Assembly Government through the production of "**Signposts – A practical Guide to Public and Patient Involvement in Wales".** In 2003, NHS bodies will be required to provide an assessment of the impact of the previous years public involvement activity, as well as setting out new initiatives. Again guidance will be provided by the Assembly to support this process. These actions have been reinforced by Section 11 of the Health and Social Care Act which came into force on 1st December 2002. This places a duty on NHS organisations to involve patient and the public in decision making and in the planning and delivery of health services.

10. The Assembly is committed to obtaining continuous feedback about the effectiveness of patient and public involvement, which will in future encompass actions across the Health and Social Services remit. The Assembly will be carefully monitoring progress in this area, including any specific actions relating to children's issues in the wake of Kennedy and Carlile. Other actions relating to patient and public involvement, which, whilst not children or age specific, can be applied across the spectrum of health care are :

- working with the NHS to introduce **patient awareness training** programmes for front line and senior staff which will include patient and public involvement and effective communication.
- working with the **Commission for Health Improvement (CHI) and Office for Public Management (OPM)** on the development of indicators for measuring the effectiveness of patient and public involvement. This will form a part of CHI's clinical governance inspection regime and will merge with the Assembly's performance management framework in due course.
- working with the **Association of Welsh CHCs (AWCHC)** with a view to establishing methodologies for obtaining patient/use feedback on their experiences of the NHS and the provision of guidance on local healthcare services.
- seeking powers in the **NHS Wales Bill** to strengthen the role of CHCs in their support of patients. This will include the provision of patient advocates across the 9 CHC 'federation' areas of Wales.
- introducing **Patient Support Officers (PSOs)** in a number of NHS locations across Wales, which will deal with patients/public concerns as they arise, including children specific issues. PSOs and Patient advocates aim to bring a more integrated approach and a more sensitive handling of issues and concerns before they escalate into formal complaints.
- introducing **'expert patients'** which involves a user-led self management training programme for patients with chronic conditions.
- the publication of the **new Health and Social Guide for Wales**.' This replaces the 1996 'Patients Charter, but differs in that the 'Guide' covers health and social care. It shows how people can access services, how to get information and advice, and what improvements can be expected in future. The 'Guide' is also applicable to children.

- developing **a new NHS complaints programme** which is demonstrably independent, open and easy to use. A final version of the new complaints guidance will be issued in April 2003; and
- introducing proposals that patients have the right to receive copies of correspondence about themselves e.g. from GP to consultant. A steering group has been set up to oversee the planning and implementation of this initiative in Wales.

Improved Professional Regulation.

11. **The Kennedy Report** concluded that there was a tragic combination of key health professionals who either failed to reflect on their practice, or grasp the seriousness of what was going wrong, and many of the recommendations were around the need for improved professional training and regulation. There was also an issue around the inability of NHS organisations to respond to whistleblowing allegations. With this in mind the following initiatives have been taken forward by the Assembly in partnership with the NHS in Wales.

12. **Policy on 'Whistleblowing'**

A Welsh Health Circular was issued in October 1999 entitled 'The Public Interest Disclosure Act 1998' which required every NHS Trust and Health Authority to have in place local policies and procedures which comply with the provisions of the Public Interest Disclosure Act 1988. The minimum requirements of local policies should include:-

i. the designation of a senior manager or non-Executive Director with specific responsibility for addressing concerns raised in confidence which need to be handled outside the usual line management chain.
ii. Guidance to help staff who have concerns about malpractice to do so reasonably and responsibly with the right people.
iii. A clear commitment that staff concerns will be taken seriously and investigated.
iv. An unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

And should prohibit:-

i. confidentiality 'gagging' clauses in contracts of employment and compromise agreements, which seek to prevent the disclosure of information in the public interest.

The NPSA national reporting and learning system will also have a facility for NHS staff to report directly to it if they feel unable to do so via their own trust policy and arrangements. This will be able to be done by web based reporting or via a confidential telephone reporting facility. A similar facility will also be in place for patients and the public to report. Arrangements are currently being developed for the management of such in order to commence national implementation later in 2003.

Finally, guidance is currently being developed on how the Welsh Assembly Government deals with serious adverse incidents that are reported, or with general clinical concerns that it becomes aware of. This will ensure that incidents and issues are dealt with in a systematic and consistent manner and that investigation arrangements are robust and appropriate. As part of this a WHC will be issued to Trust and LHB Chief Executives advising of the type of incident that should be brought to the attention of the Assembly and the process to follow.

13. **Inter-Professional Learning and Partnership Working.** 2 pilot sites have been funded to promote shared learning and partnership working. The first is the development of a common database for clinical placements for all students at UWCM (6 professions) which will facilitate shared learning for students on clinical placements. The 2nd is the development of a multi-professional module in palliative care being developed by Swansea University and UWCM.

14. **Leadership.** The Centre for Health Leadership (CHL) is conducting a project on behalf of the Assembly to provide an in-depth assessment of the effectiveness and implementation of consultant appraisal in order to identify good practice and to disseminate key lessons for the future to key stakeholders. CHL has also launched a number of new multi-disciplinary leadership programmes, notably "Leading performance" for senior managers and clinicians and " Pathways to Leadership" for executive directors and experienced senior managers. These programmes are part of "Pathways to Performance" the new framework for continuing professional development for managers. This initiative will employ e-learning and web-based approaches to enable wide and easy access to development resources for all managers in NHS Wales and will eventually enable them to gain academic credits in work based learning. A joint initiative between Welsh Assembly Government and the RCN has been launched to improve leadership skills of senior nurses.

15. **Top priority** has been given by both the Director and the CMO in 2003, to improving the working relationship between clinicians and managers.

16. **Staff Development.** Work has begun on the development of a Life Long Learning Strategy for all staff in the NHS. It will be published in April 2004. This strategy will be addressing the training and CPD requirements of all staff employed in NHS Wales. It will draw together the requirements
required by the professional regulatory bodies and those of the service and develop a framework that can be used across Wales. It will build upon existing developments for CPD already in place in Wales.

17. **Health Professions Wales** has been established to support the continuing professional development of nurses, midwives, health visitors, allied health professions and healthcare scientists. It will also promote and support education and training for all healthcare support workers. Health Professions Wales is in a position to facilitate shared learning as part of professions continued professional development and support worker education and training.

18. **Managers.** The Institute of healthcare manager's Code of Conduct for managers launched in April 2002 has been adopted by the NHS in Wales and from April 2003 compliance with the code will form a mandatory part of all NHS managers contracts of employment in Wales. Implementation is supported by the Centre for Health Leadership through its "Pathways to Leadership " initiative. Pathways to Leadership is a flexible and innovative programme providing a challenging and stimulating learning opportunity for successful managers and health professionals who want to develop their managerial and leadership skills further. Its aim is to strengthen leadership and management skills in NHS Wales to take forward change and service modernisation.

19. **Clinical Governance Developments**

The National Assembly recognises that clinical governance sits at the centre of the quality agenda and that's successful development and delivery is crucial to overall success and on going improvements in quality.

In September 2001 a consultation document, *Clinical Governance- Developing a Strategic Approach*, was issued to the NHS in Wales which re-affirmed the quality agenda and aimed to ensure high standards of care, eliminate inequalities and to continuously improve the health service in Wales. This document will be updated to reflect work on performance indicators which is being addressed through a Performance Management Task and Finish Group which is developing a " balanced scorecard approach" and also current developments in theNational Patient Safety Agency.

The results of an all Wales audit of clinical governance " *Clinical Governance – The First Twelve Months "* was issued in September 2001 which provided baseline information on NHS organisations and highlighted ways in which clinical governance can be strengthened in Wales.

It has been confirmed that NHS bodies in Wales have arrangements in place for the implementation of Clinical Governance in accordance with the guidance which has been issued by the Welsh Assembly Government. NHS bodies in Wales prepare clinical Governance annual reports that are submitted to the Assembly. These reports indicate a high level of local commitment to quality improvement and implementation of clinical governance. However structures, activity, progress, compliance and reporting arrangements vary considerably across Wales. Further guidance has been issued in areas where clinical governance annual reports can be strengthened.

Work has also started on developing a better process for dealing with Untoward Serious Incidents which come to the attention of the National Assembly and it is proposed that a new WHC will be issued over the coming months.

20. **Patient Safety**

Over the past year considerable progress has been made towards achieving the recommendations within Kennedy that relate to adverse incident (sentinel event) reporting:

- As previously mentioned earlier in this paper, an agreement between the Assembly and the National Patient Safety Agency (NPSA) was signed in May 2002 which enables the Agency to function in the same way in Wales as it will in England.
- A national reporting and learning system is in the final stages of development prior to national implementation from summer 2003 onwards. Three Welsh sites are currently testing the system. This will apply to all sectors providing NHS funded care. An all-Wales Project Board is in place to oversee and advise on implementation issues.
- Work is ongoing to develop the public reporting system. This will be tested in the next couple of months. We are working closely with the CHC on this.

The success of a national reporting system is very dependent on the development of an open and fair culture within organisations. The NPSA are working on a number of products to nurture this, and these will be available (free of charge) to all organisations. These include:

- Production of a training programme and materials to enable NHS organisations to investigate adverse incidents in a systematic way using root cause analysis. Four members of staff from each organisation will receive this training during 2003/04.
- Development of an incident decision tree to assist in dealing with staff issues following an adverse incident and in particular to help determine the appropriateness or otherwise of suspension
- Production of a video and other materials for use within induction programmes to bring patient safety onto the agenda.

Another key role for the agency is to learn lessons and to devise safety solutions to national problems. They are already working closely with other bodies, NHS estates, purchasing authorities and industry on devising solutions to help make the NHS safer.

21. **All Wales Medicines Strategy Group**

An All Wales Medicines Strategy Group has been established as an ASPB this year. The group will address all issues relating to medicines and prescribing including good practise on the safe use of drugs. The Group has lay membership and meetings are held in public.

22. **The Clinical Governance Support and Development Unit (CGSDU)**

CGSDU has been established as part of the NAW. CGSDU comprises a multi-disciplinary team, established to support, develop and further strengthen clinical governance throughout the NHS in Wales. The work programme includes:

- delivering a programme to support teams making quality improvement in the workplace – the Clinical Governance Development Programme;
- delivering a programme of work to create the vision of what clinical governance should look like at Board level and to deliver it;
- improving the capacity of the service to develop and support multi-professional team working in the workplace with an Effective Teams programme;
- facilitating Clinical Governance Learning Networks to support organisations, clinical governance leads, facilitators and others. These help to create, capture and spread good practice;
- providing direct training and information, and provide the opportunity for the sharing of lessons; and
- supporting the NHS in Wales in specific areas – e.g. implementing CHI recommendations and establishing a working relationship with NCAA.

23. **Paediatric Critical Care Network**

A Paediatric Critical Care Network has been developed which has undertaken multidisciplinary audit and feedback sessions in all Trusts. Certified paediatric one day life support courses have also been held locally in district general hospitals, and investment by SHSCW in terms of training has increased development opportunities in all Trusts. Guidance has been produced in conjunction with the NHS on the Standards of Caring for Critically Ill Children.

Action taken by the NHS in Wales

24. It is complicated to identify on an all Wales basis the progress made by

the NHS bodies as Trusts and LHGs have often started from different positions. Quite clearly, some Trusts had already undertaken work in many of the areas identified in the Kennedy Report, and developed solutions on a local basis. Examples of initiatives taken by the NHS in response to the recommendations, include:

Patient Partnership

Some organisations have set up steering groups or patient working groups to assist them in taking forward the development of their patient partnership initiatives.

Local partnerships have been developed between Trusts and LHGs and occasionally LAs, to engage in joint processes.

Guidance issued by the Assembly on patient consent to treatment has already been, or is in the process of, being implemented.

Many NHS organisations in Wales have undertaken a baseline assessment of patient and public involvement which provide evidence of good practice, and are proposing to set up patient forums and patient councils to further inform them in the development of services.

All Trusts have produced patient Partnership Strategies and Action Plans In order to encourage a change in the change of culture between the health care professional and the patient to one of equal partnership.

Where work was already in hand on areas identified in the recommendations, Trusts will continue with the development and application of current good practice. They will promote this philosophy through education/information campaigns and also by the provision of staff training. The development of local Patient and Public Involvement Strategies will also help to facilitate greater openness.

Communicating with Patients

Communications Strategies have been revised following new guidance issued by the Welsh Risk Pool and training requirements are being updated and amended.

Bereavement Counselling Services are recognised as a specific recommendation of Kennedy. Good practice has been identified in many areas but further work is ongoing in many organisations. A sum of £200K will be made available by the Assembly from April 2003 to progress this work.

Feedback From Patients; Many organisations are undertaking regular surveys to assess patient views on the delivery of services. Where specialist units do not exist, formal complaint units have been set up in many organisations to deal with complaints.

Responding to Patients when things go wrong. Work is ongoing with NPSA, Assembly Pathfinder scheme and as part of the Review of the National Complaints System. Many organisations are reviewing current practice to ensure that a patient is informed of any adverse incident that occurs in respect to their treatment.

Competent Health Care Professionals

Much of the work in this area is being taken forward by the Welsh Assembly Government but will be supported by the development of initiatives like continuous development performance reviews, medical appraisals, periodic revalidation etc.

NHS organisations are ensuring staff receive appropriate training. Some Trusts are considering the need for ongoing training as part of their IM&T developments and managed clinical networks. The education, training and continuing development of health care professionals is a large area of work being taken forward as part of both current and long term development.

Some organisations have worked closely with universities in Wales to ensure that training for healthcare professionals takes into consideration the particular requirements between healthcare professionals and patients.

NHS organisations are ensuring that the necessary training for clinicians who hold management positions is being addressed, and that clear protected time is available for these functions.

Work to be Done

25. Over the past 18 months since the Kennedy Report was published a considerable amount has been achieved by both the Welsh Assembly Government and the NHS but further work is required to ensure that Wales is fully compliant.

26. The action plans drawn up Health Authorities, NHS Trusts and Local Health Group were reviewed in September 2002, and while it was recognised that work in many areas was ongoing, a number of the plans were identified as requiring further development. The Service and Financial Frameworks (SAFF) circular issued in January 2003 identified specific targets for Trusts and Local health Boards, aimed at mainstreaming the Kennedy recommendations into the normal delivery of services in the NHS in Wales. The Kennedy Report recommendations will therefore form a key part of the Trust and Local health Board performance assessment during 2003/04 and beyond.

27. The Welsh Assembly Government will continue to support the NHS in enhancing the quality and safety of care offered to patients in Wales through sustained improvements in service and professional regulation.

Annex B

PROGRESS REPORT ON THE CARLILE REVIEW OF SAFEGUARDS FOR CHILDREN AND YOUNG PEOPLE TREATED AND CARED FOR BY THE NHS IN WALES

THE HEALTH AND SOCIAL SERVICES COMMITTEE 26 MARCH 2003.

The Carlile Report

Background

In September 2000, the Minister for Health and Social Services invited Lord Carlile of Berriew QC to chair a panel of experts to undertake a review of safeguards in place to protect children and young people treated and cared for by the NHS in Wales. The decision to establish the Review arose from the evidence to the North Wales Child Abuse Tribunal (Waterhouse). The former Welsh Office gave an undertaking to the Tribunal that all allegations would be properly investigated by the appropriate agencies and that it would ensure that patients at such units in Wales were receiving proper care and were adequately safeguarded against abuse.

The Carlile Report contained 150 recommendations for improving standards and increasing safeguards for children and young people. The report highlighted the need to put children and their safety at the heart of the NHS and the rights afforded to children. It recognised the need to ensure that everyone who has contact with children is alert to the possibility of abuse. The report took the view that developing a culture of awareness of child abuse throughout the NHS will be the best possible way to protect young patients.

The report identified that it was essential to recruit appropriately trained staff to provide safely for the health needs of children and it made a number of recommendations to strengthen human resources policies throughout the NHS. It recognised the need for rigorous recruitment procedures as well as endorsing the need to have proper well-developed policies for handling whistleblowers and disciplinary procedures and supporting those against whom allegations have been made. It also emphasises the need to have sufficient numbers of staff in key posts

The report recognised the important role of designated doctors and nurses for child protection at the strategic level and named doctors and nurses for child protection in trusts and recommends that the posts have protected time to allow them to undertake their duties and makes recommendations as to their location in the re-organised NHS.

The report made recommendations with regards to hospital and specialised medical care. It built on the Kennedy report into the Bristol Royal Infirmary and makes recommendations in a number of areas such as accident and emergency departments and children who are treated on adult wards.

Most sick children are not admitted to hospital for treatment. Their contact with the NHS is via their family doctor, health visitor, school and practice nurses, dentists and opticians. The report made recommendations to increase awareness of child protection issues in these professionals. Health visitors and school nurses are both commended for the excellent work that they undertake. The report recommended that the role of the school nurse is strengthened and that proper career paths are developed to encourage nurses into this important area of work.

The needs of those young people who are especially vulnerable were also considered. This includes those with mental health problems, children cared for away from home and those in secure settings. The report made a number of recommendations to ensure that these vulnerable groups have access to good quality health care. Here the report draws lessons from a case study of Gwynfa undertaken as a retrospective review of events. As well as drawing the lessons from this case study the report concludes that all actions that ought to have been taken in respect of the allegations have been taken.

Process we have adopted

The Welsh Assembly Government published its response to the Carlile Review in July 2002. NHS bodies were required to identify their level of compliance and to produce an action plan to take forward implementation.

A Circular was issued in January 2003 which set out the expectations for the preparation of Service and Financial Frameworks. This included the following target "To ensure that relevant safeguards in the Carlile Report are in place to ensure that children and young people are adequately protected from harm while in the care of the NHS" This is designated a "continuous improvement target" and there is therefore an expectation that substantial and demonstrable progress will be made and will form a key part of the performance assessment process. The results of the 2003/4 SAFF are awaited.

Subsequent developments

Since the issue of the Carlile report there have been a number of national developments that directly impact on child protection in the NHS;

a) All Wales Child Protection Procedures and Protocols

These procedures, launched by the Minister in May 2002, were funded by the Assembly and produced by the multi-agency 22 Area Child Protection Committees (ACPC) to provide a common framework for ACPCs to use in fulfilling their responsibilities as set out in the guidance issued by the Welsh Assembly Government "Working Together to Safeguard Children". The Welsh Assembly Government provided funding that enabled the ACPCs to produce the procedures.

Work is well underway on the development of model protocols covering child protection issues around substance misuse; domestic violence and sexual exploitation/prostitution.

b) Criminal Records Bureau

The Criminal Records Bureau came into operation in spring 2002 but suffered major operational problems. Last September, the Home Secretary appointed an Independent Review Team (IRT) to take a fundamental look at the strategy and

operations of the Bureau. The IRT has identified a number of fundamental weaknesses in the CRB end to end process which have prevented the Bureau establishing the capacity to meet demand for higher level disclosures efficiently and to acceptable quality and timeliness standards. The review team's report sets out ten recommendations for addressing these weaknesses. These recommendations and the Government's proposals for taking them forward were announced in a written Ministerial statement on the 27 February.

Plans to strengthen protection arrangements for children and vulnerable adults by setting up a new unit to administer applications for criminal record checks on behalf of the voluntary organisations in Wales was announced on 7 March. The Wales Council for Voluntary Action (WCVA) has been commissioned by the Assembly to provide this essential service to voluntary organisations in Wales.

The CRB undertakes checks on the suitability of people who work in sensitive positions with children and vulnerable adults. Applications to the CRB for criminal records disclosures are administered by "registered bodies". Some organisations have been unable to obtain checks on volunteers and staff because few organisations registered with the CRB provide this service to voluntary organisations in Wales and those that do charge a high price.

A working group was established to the review the situation and make recommendations on the way forward. The working group recommended the establishment of a new unit to administer CRB applications on behalf of voluntary organisations in Wales. The Assembly has provided £219,000 to the WCVA to set up the unit which is expected to be operational by September this year.

c) Handling the Victoria Climbie Report

The report of the Inquiry into the death of Victoria Climbie, made to the Home Secretary and the Secretary of State for Health, was published on 28 January 2003. The recommendations fall into four categories :

- policy issues for consideration by the Welsh Assembly Government;
- England/Wales policy issues for consideration jointly with the Department of Health and/or the Home Office;
- issues around existing good practice for implementation by agencies; and
- good practice principles not generally in force within agencies and which therefore require some further consideration.

The Welsh Assembly Government will be making its own response to the report in the spring.

Actions taken by Welsh Assembly Government

Since the issue of the Carlile Report many actions have been taken by the Welsh Assembly Government; detailed below are some of the more important actions we have progressed:

a) Guidance to the NHS on human resources policies

The Welsh Assembly Government issued a Circular in 2003 to the NHS on the human resources issues relating to the Carlile Report recommendations. This brought together the good practice relating to the checks required before an NHS body makes any appointment.

b)Advocacy

An Advocacy Task Group has been established to review the provision of Advocacy services across Wales. The review will look initially at advocacy in respect of complaints from children in social services and the NHS. The Children's Commissioner for Wales Report (published 26 February) *Telling Concerns* sets out recommendations in respect of Advocacy and will inform developments of the Task Groups programme.

b) Child and Adolescent Mental Health Services (CAMHS)

The original allegations of abuse related to children in an inpatient child and adolescent mental health unit. The CAMHS strategy "Everybody's Business" set out the Welsh Assembly Government's strategy for CAMHS and an Implementation Group was established in 2002 to take forward this strategy. The strategy is a 10-year strategy and there is a large agenda of work. Progress on the implementation of the strategy will be via the SAFF and the specialist implementation team.

c) CAMHS Nurse Consultant Posts

The Carlile Report raised issues of staffing and training within CAMHS. The Welsh Assembly Government has approved three CAMHS nurse consultants. These consultants will take forward the post registration education and training agenda as well as working clinical sessions.

d) Training course for CAMHS nurses

The Welsh Assembly Government is working with the Universities of Glamorgan and Bangor to produce specific training for CAMHS nurses. The proposal is to have a 'tiered' approach ranging from diploma to masters level in line with student's level of experience and the requirements of his or her role in the service. The course will be clinically based and will probably be built up from 'core' taught components, such as research methodology, developmental psychology etc with specific components 'bolted on' to produce an award in 'Child and Adolescent Mental Health'. Although this course would be primarily aimed at nurses, it would be open to students from all disciplines.

e) Training re Children's Rights

The provision of training on children's rights is to be included in the annual reviews of our education providers. Following the annual reviews the Assembly will collate the information to ensure that training objectives are being met. The Assembly will ensure on-going monitoring.

f) Critical Incidence Reporting

The Welsh Assembly Government is currently working with the NHS and the National Patient Safety Agency (NPSA) to develop and pilot a new national reporting system. We are also supporting a secondee from the NHS to project manage implementation in Wales. A draft consultation document *The Management of Patient-Related Serious Adverse Incidents and Other Clinical Concerns* is currently being considered by Assembly officials.

g) GP Training and Procedures

Training for contractor professions was recognised by Carlile as an important safeguard. The All Wales Designated Doctors and Nurses Group were commissioned by the Assembly to formulate and cost a programme which would further develop child protection training for Primary Care Teams in Wales. The proposals have been received by officials and are currently under consideration and will be determined shortly. The Welsh Assembly Government is taking forward the recommendation for the inclusion of a child protection component in GP training with the Postgraduate Deanery at University Wales College of Medicine.

h) All Wales Designated Professionals (Child Protection)

In the light of NHS re-organisation, consideration was given to the future arrangements for providing a strategic lead on child protection matters in the NHS as the designated doctors and nurses are currently employed by health authorities. The recommendation of the Carlile Report that they should transfer to the new National Public Health Body to be established from April 2003 was accepted. The National Public Health Body will be required to provide an annual report to the National Assembly and this will include child protection matters in the NHS generally and future progress on the implementation of the Carlile Report across Wales.

i) School Nursing Review

The Carlile Review recognised that school nurses were an important resource and safeguard for children. It recommended that the *Review of Health Visiting and School Nursing Services in Wales (2000)* be fully implemented. This is being taken forward as part of the *An Action Plan for Primary Care in Wales* and work is being commissioned on the future roles and responsibilities of primary and community nursing including an action plan to take forward the recommendations health visiting and school nursing.

j) The Children's National Service Framework (NSF)

The development of the Children's NSF began in September 2002 with the establishment of six External Working Groups (EWG) to take it forward as follows:

- Children and young people suffering from acute and chronic illness or injury;
- Maternity;
- Children and young people in special circumstances;
- Disabled children and young people;
- Healthy children and young people;
- Mental health and psychological well-being of children and young people.

The recommendations of the Carlile Report, the Kennedy Report and the Review of Children with Special Health Needs as well as other key policy documents will all be addressed within the standards. It is anticipated that the NSF will be available for consultation in the summer.

k) The Director of Healthcare Services for Children and Young People

The post is currently advertised and it is anticipated that an appointment will be made in April .

l) Practice Guide to Investigate Allegations of Abuse against Professionals and Carers by Children Looked After

In 2000, the Assembly issued the above to social services departments across Wales. The contents are being reviewed in the light of the Waterhouse, Kennedy, Carlile and Laming reports with a view to extending it to other groups of professionals. Tenders have been invited for the work and are presently under consideration and will be determined shortly.

m) Accident and Emergency and Minor Injuries Units

In October 2002 a paediatric nurse was seconded to the Office of the Chief Nursing Officer to review services in Wales providing Accident and Emergency and/or minor injury care and treatment to children and young people. The intended outcome of the review, which is due to finish at the end of May 2003, is that children and young people in Wales will be assured an appropriate level and quality of care and treatment, in line with recognised guidelines, protocols and procedures for good practice.

Actions by the NHS

NHS bodies were required to make returns identifying their level of compliance with the Carlile Review. This showed that significant measures are already in place implementing recommendations contained in the Carlile report. In these areas it is anticipated that work will continue with the development and application of current good practice. In addition the Trusts will be encouraged to promote this child protection awareness through training and information campaigns. This section of the report highlights a number areas of seemingly good practice in the NHS; we propose to work with the All Wales Designated Professionals (Child Protection) on promulgating areas of good practice:

a) The North Glamorgan NHS Trust has appointed a Training and Development Manager and Officer to deliver multi-agency training on the rights of a child for untrained and ancillary staff in addition to trained staff.

b) The North East Wales NHS Trust collects information on critical incidents relating to child protection procedures. These are reported to the designated doctor and discussed at the Trust Child Protection Committee. Directorate managers are notified of non-compliance and additional training is offered where appropriate. Compliance is monitored by named professionals every six months. The Trust Child Protection Committee reports to the Board on an annual basis. All board members will receive level 2 child protection training. Newly appointed trust and board members will receive level 2 child protection training as part of their induction programme.

c) In North West Wales NHS Trust area, GPs are attending child protection awareness training sessions provided by the Primary Care Training Facilitator.

d) In Bro Taf Health Authority, It has been agreed by LHB's that child protection will form part of the clinical governance framework for monitoring GP's performance.

e) Gwent Health Authority Child Protection Procedures have been completed and distributed to all Primary Health Care staff in the Gwent area. Child Protection training linked to CPD for nominated professional groups is being provided.

f)The A&E departments at Nevill Hall Hospital and the Royal Gwent Infirmary have secure pin numbers to enable faster access to the Child Protection Register.

g) Cedar Court (an inpatient child and adolescent unit part of Conwy & Denbighshire NHS Trust) has clear policies and procedures set out for the duties placed on employers and staff In place to ensure the safety of children in their care when outside NHS Premises. Some of the allegations that led to the Carlile report occurred away from the unit.

h) Cardiff and Vale NHS Trust has a dedicated ward – East 2A at Whitchurch Hospital for young people within adult mental health services if an emergency CAMHS admission is required. If admission to adult services is appropriate then all clinical areas who do admit children/ young people or where children/ young people have access to services to be advised by Child Health/Child Protection Services regarding issues of child protection staffing, children's rights and work practices.

i) The Welsh Ambulance Services NHS Trust's nominated Officer for child Protection has worked closely with Designated Child Protection Professionals in North Wales to develop a training programme for trainers within the Trust. Arrangements are now in place for the delivery of the programme.

j) All LHG's in the Iechyd Morgannwg Health Authority area have commenced child protection training with GP's. GP Vocational Trainees attend child health surveillance training which has child protection components.

In Conclusion.

There is clear evidence that child protection in the NHS is given a high priority and that a number of measures are in place to safeguard children and young people. There is has been much good work on the implementation of the recommendations contained in the Carlile report. However areas that need strengthening have been identified. Future work will be targeted at these areas. Furthermore, child protection is a matter that requires continued vigilance and all Trusts will be encouraged to continue to review and update safeguards to ensure that children and young people in the care of the NHS are adequately safeguarded from harm.