Salisbury Health Care NHS Trust

Clinical Governance Report

2003 / 2004
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### Appendices

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1.0 Chairman’s remarks

We continue to make good progress in all areas of Clinical Governance. I am particularly proud of our achievements highlighted in the National Patient Survey Programme, as they directly benefit patients and lead to improvements in their care. In addition, I believe that we are at the forefront of Patient and Public Involvement in Salisbury Health Care NHS Trust. As well as our current ongoing activities through PALS and other operational groups, the recent implementation of a Steering Group that meets quarterly, involving representation of members of the public as well as patients and staff will ensure that the focus remains on issues that lead to improvements in patient care, through strategic development. We are still in the early stages of this initiative, but with the commitment from the public we are already making headway.

The strengthening of the team in Risk Management gives the Trust the opportunity to build on our progress towards achieving level 2 in Clinical Negligence Scheme for Trusts (CNST).

There is still more work to do in terms of data quality regarding the use of information. This is being addressed and given appropriate focus through an action plan, drawn up as a result of an audit by the Audit Commission on Information Management.

I would like to pay tribute to the Directorate for Clinical Effectiveness whose drive; energy and commitment have brought us to where we are today.

2.0 The Patients Experience

2.1 The patient experience is important to the staff in Salisbury. Service user views are sought through a wide variety of methods including

- National Patient Survey Program
  In January 2003, 850 patients were asked to complete questionnaires about their stay in the Accident and Emergency department and 850 patients who had attended our Outpatient service were also sent questionnaires. The results showed that most patients had a good experience whilst using our services. They felt they were treated with privacy and dignity and that they were given answers to questions in a way they understood. Work continued with the areas highlighted for improvement in the Inpatient survey from the 2002 Inpatient survey

<table>
<thead>
<tr>
<th>Area for improvement</th>
<th>Action taken</th>
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</thead>
<tbody>
<tr>
<td>Car parking – not enough of it at peak times and disabled parking not always in the</td>
<td>New car park area opened with an extra 200 spaces. Work with staff on using alternative methods to travel to work (green transport plan)</td>
</tr>
<tr>
<td>right area. This had also been highlighted by PALS during the year</td>
<td></td>
</tr>
<tr>
<td>Patients do not know who / which health care professional is speaking to them</td>
<td>Use of name badges as well as security cards has been agreed. These should be in place by the middle of 2004</td>
</tr>
</tbody>
</table>
A further two surveys were undertaken in January as part of the national program and the results will be made available shortly.

- **Through user and patient groups**
  For example, cancer patients have been meeting with staff to look at the way care is organised and to ensure that communication and information meets the needs of the patients. Focus groups have been held for patients who have had bowel cancer, prostate cancer and those undergoing chemotherapy. Action plans have been developed to improve things like information leaflets in these areas.

- **Patient Environment Surveys (PEAT)**
  Last year the PEAT surveys showed that patients found the food and cleanliness of the hospital to be good. The facilities directorate has also spent time with staff and patients looking at ways to further improve a number of issues including car parking, signage and mobility around the site. The PEAT survey for 2004 was undertaken in January and visited a number of areas across the Trust. The results have been submitted to NHS Estates but have not yet been validated.

- **Through our PALS Service**
  A number of themes have been highlighted by the PALS service. These include information giving, communication, car parking, waiting times for clinics etc.

<table>
<thead>
<tr>
<th>Area for improvement</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of patient property</td>
<td>Multi-professional group formed to review current protocol for the care of patient property. District audit asked to undertake an audit of our practice to highlight where improvements can be made</td>
</tr>
</tbody>
</table>

**2.2** Processes used to monitor and plan organisation of care from the patient’s perspective are best represented in our extensive use of care pathways. Patients are involved in the development of the pathways either through focus groups or surveys. Their views are invaluable and ensure the service we offer is based on the needs of the patients. There have also been a number of modernisation projects across the Trust for example the ‘booked admissions project’ where patients have been asked to keep diaries of their experiences.

<table>
<thead>
<tr>
<th>Area for improvement</th>
<th>Action taken</th>
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<tbody>
<tr>
<td>Patients are not always prepared well enough for their discharge from hospital and communication from the hospital to the GP with regards a patient discharge is often not timely or comprehensive enough</td>
<td>Multi-professional group set up and new discharge summary developed that links medication ordering and electronic / fax mechanisms for communication – currently being piloted</td>
</tr>
<tr>
<td></td>
<td>Discharge Action Planning group set up to review process of discharge within the Trust and develop information and checklists</td>
</tr>
</tbody>
</table>
2.3 Patient and Public Involvement (PPI)

Between June and August 2003, an extensive assessment of all current PPI activity was undertaken. The views of the issues around PPI were heard from a wide representation of staff from all disciplines. Staff told us they needed support, tangible resources and clear advice about how to do more varied PPI work. These views were influential in helping develop the PPI toolkits, which have been distributed in hard copy to be used as part of the Clinical Governance Resources folder.

In future all updating of the toolkits will be done electronically using ICID.

Key features within the toolkit include the flowchart (appendix 2), which clearly explains the difference between PPI, research and clinical audit and guides staff on how to make a PPI application.

Another key feature of the toolkit is the examples of PPI activity undertaken by staff, all keen to share their experiences and for other staff to learn ‘how to do’ PPI.

An inter-professional group, the Patient and Public Involvement Group (PPIIG) meets every 2 weeks to review the PPI applications. They ensure all the potential projects are safe for patients and staff and up to standard. All PPI work across the Trust is held on a database, with each directorate clearly able to see what type of PPI activity is taking place and what difference it is making to patients.

The Patient and Public Involvement strategy has been written in collaboration with the PPI Steering Group, which is made up of equal numbers of staff, patients and members of the public. This group will influence our future strategic capacity and development in PPI.

3.0 Use of Information

3.1 Using information in the Trust has continued to improve over the past year. Clinical audit results highlight areas where improvements in services and care could be made, as do the results of the national patient surveys. Results from audit and surveys are made widely available to staff through ICID (Integrated Clinical Information Database), the Intranet and the Clinical Effectiveness newsletter. Presentations and discussions at the clinical governance half-day also enable staff to be made aware of the quality improvements underway.

There is good use made of themes highlighted from Incidents, Litigation, Complaints and PALS in the form of a CLIP report (see appendix 3). This report is developed quarterly and discussed at the Clinical Governance Operational group to ensure that appropriate Trust wide action is taken to learn from the information and to improve the systems / processes in the Trust.

3.2 Routine reports on workforce issues – absence, turnover etc. are made available to the Directorate Management teams. Benchmark data on staffing levels for specific disciplines and specialties is used when possible and referred to when changes in services are planned.

3.3 The priorities for the development of clinical information systems and information processes tend to be led by the requirement to provide information to support the national service frameworks, national audit program and the modernisation agenda. Cancer services have been an area of particular focus with
the development, via the Trust's clinical information system, of site-specific cancer registries. These registries meet the national information standards and definitions as well as meeting the clinical requirements for cancer specialists.

This year however, the Trust has formed a Clinical Information Group to oversee the development and implementation of an information strategy for the Trust. The results from a District Audit on our information systems and processes are being used as a basis on which to develop our program of work.

3.4 MINAP (myocardial infarction national audit program) data is used by the cardiology team to try and improve systems for example, to ensure fast access to thrombolysis treatment. The routine collection of CEPOD data (Confidential Enquiries into Patient Outcomes and Deaths) is undertaken and the published reports and recommendations are acted on by the clinical teams.

<table>
<thead>
<tr>
<th>Area for improvement</th>
<th>Action taken</th>
</tr>
</thead>
</table>
| CEPOD report highlights—  
  • Availability of medical records  
  • Medical record keeping often poor |  
  • Patient case note tracking introduced in January 2004  
  • Key record keeping standards developed and implemented |

3.5 There is a specific project in place at present to assess what information is routinely required by clinicians and how it might be made available through a variety of means (e.g. PAS data, clinical information systems, benchmarking data, risk triggers etc). This project will report in September. In the meantime, the Information Services department is increasingly making information available to clinicians about their performance to inform the appraisal process. Indicators such as the following are used: total activity trends, readmission rates, mortality rates, length of stay, activity by code (ICD10, OPCS4 and health resource group), new to follow up and DNA ratios.

3.6 The development and rollout of ICID has made making information about clinical evidence, guidelines, referral protocols etc. available to all staff in the Trust much easier. Use of information for staff is in line with information governance standards – data protection and Caldicott guardian principles.

3.7 The Trust has been working very hard at improving data quality and confidence in the reported activity data. A data quality action plan was created mid way through the year and is now close to completion. One of the actions from this plan was to increase the volume of clinical coders in the Trust and also reduce the volume of uncoded Inpatient episodes. The Trust has also worked through the Information Quality Assurance process and has achieved an ‘Amber’ score. This score suggests that we are well on the way to achieving good data quality but still have some work to do.

3.8 The Trust participated in an Information Management audit delivered by the Audit Commission. The results from the audit were positive in that, whilst significant improvement is required, it was recognised that the Trust is giving due priority to information management issues and that it is heading in the right direction. The Trust has developed an action plan to meet the recommendations made within the audit report.

3.9 The use of Information Services by clinicians to inform them about their practice has increased considerably during 2003/4. A number of consultants
routinely make use of the department and the information available will be advertised more fully during 2004/5.

4.0 Processes for Quality Improvement

4.1 Risk Management

There is a robust risk management system in place across the Trust. The Risk manager reports to the Director of Nursing who is the nominated Executive lead responsible for risk management in the Trust.

4.1.1 There is a Clinical Risk Group chaired by the lead Consultant for clinical risk (presently a Consultant Anaesthetist). This group reviews and takes appropriate action on trends in all clinical risks with particular attention to the more serious risks. It co-ordinates the achievement of CNST standards. The group also oversees the serious incident recommendations and commissions the clinical audit department to undertake audits of the recommendations as required. The clinical risk group reports to the Clinical Governance Operational Group and onward to the Clinical Governance Committee. Quarterly reports are also provided to the Clinical Management Board and Operational Management Board.

4.1.2 The Trust has a single incident reporting system. All incidents are entered onto a central database (DATIX) and actions / follow up for organisational risk, Health and Safety and Clinical Risk are undertaken by the most appropriate person / group. Monthly reports are sent to the Clinical Risk Group to undertake work on reducing trends and for sharing lessons learned from Directorate investigations.

4.1.3 There is a Trust wide risk register, which is populated by the Directorate management teams. Work during 2003/04 focused on clinical risk profiling and triggers. Work has now started on broadening the Directorate Risk Registers to incorporate a Directorate wide review of all key risks against the service plan, which could jeopardise the organisation achieving its corporate objectives. The work already carried out with the specialist teams shall continue to inform the Directorate exercise and in turn the Directorate Principal risks shall inform the Trust Board within the Assurance Framework.

4.1.4 The Trust retained CNST level 1.

<table>
<thead>
<tr>
<th>Good practice</th>
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<tbody>
<tr>
<td>Consent to examination or treatment</td>
<td>The Trusts consent policy and forms for examination and treatment were redesigned in order to fully comply with Department of Health guidance. Following CNST feedback the policy and forms were relaunched at the Clinical Governance half day in January</td>
</tr>
<tr>
<td>Medicines Governance Group</td>
<td>An Oral and Enteral Syringe Policy was developed in recognition of the risk posed by preparing medication intended for oral administration in an injection syringe. This has resulted in the differentiation of syringes for both purposes and use of an oral syringe, which is incompatible with IV access ports.</td>
</tr>
</tbody>
</table>
A Rapid Tranquillisation Policy was produced as a result of a Serious Incident Inquiry. This details what drugs to give, how often and in what sequence in acute events. Rapid Tranquillisation Packs are available within key areas as a result.

The Pre Operative Assessment Checklist was redesigned to ensure relevant information only was included. This was as a result of a reported incident, which showed poor compliance with completion of the old forms due to questions about relevance of some of the data fields.

A Risk Report card is currently being piloted and is due to roll out within the Clinical Directorates. This report card will be populated with all the facts and figures and changes to practice which have resulted from incident and near miss reporting. The Directorate reports shall feed into an overarching Trust Report card which shall be available to all staff. This will enable us to monitor performance and learning within Risk Management.

4.2 Clinical Audit

4.2.1 The Clinical Audit Department is within the Directorate for Clinical Effectiveness ensuring strong links to clinical risk and evidence-based practice. A Consultant ENT surgeon undertakes the strategic lead.

The Clinical Management Board oversees the annual audit programme and quarterly reports are sent to Directorate teams and our local PCT Chief Executives.

4.2.2 No resources are released unless an audit proforma has been completed and approved by the clinical audit group. This group meets every three weeks to approve audits and release resources e.g. medical record retrieval, assistance with design. Membership of the group consists of the Clinical Audit strategic lead, R&D co-ordinator, Directorate Manager for Clinical Effectiveness and audit facilitators. They also monitor completion of approved audits and implementation of recommendations.

Priority for approval is for:
- National audits and NICE guideline audit etc.
- Audit of implementation of recommendations from adverse incidents / clinical reviews
- Clinical Governance Committee commissions
- Sub Committee commissions including Resuscitation Committee, Hospital Transfusion Committee Himp groups etc.
- Individual department / clinician request - complex, simple

4.2.3 The clinical audit award was again undertaken this year. There were six finalists who presented their audit projects on the clinical governance half day in March and the audience voted for the winner and runner up. This year the awards
went to the Plastics department for the audit on wound healing time in split skin graft donor sites, which led to the introduction of a new technique for dressing donor sites, which dramatically reduced slippage rate. The runner up was the surgical departments audit of the right iliac fossa care pathway.

4.2.4 A number of Trust wide audits have also been completed this year and action on the recommendations continues. A program of auditing NICE guidance also continues.

<table>
<thead>
<tr>
<th>Audit topic – examples of Trust wide audit</th>
<th>Action on recommendations</th>
</tr>
</thead>
</table>
| Clinical record keeping                   | • Key standards agreed and process for disseminating these to the clinical teams agreed  
  |                                           | • Agreed that clinical record keeping should form part of the mandatory training program  
  |                                           | • Rolling audit program designed with the clinical teams undertaking the audit and the clinical audit team undertaking trustwide analysis and report |

4.3 Clinical Effectiveness Programmes

4.3.1 The clinical effectiveness team has worked closely with clinicians over the past year in a number of specialties to develop guidance in response to national and local priorities.

<table>
<thead>
<tr>
<th>Area of work</th>
<th>Action taken</th>
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<tbody>
<tr>
<td>Establishing and working with multidisciplinary teams to localise and make relevant national guidance</td>
<td>Working with the diabetes HImP group to produce localised information from four NICE guidelines and one NSF.</td>
</tr>
<tr>
<td>Responding to serious incidents highlighted through risk management</td>
<td>The Development of “top tips to a speedy recovery” in response to a number of different complaints and incidents, in order to empower and inform patients at the bedside</td>
</tr>
<tr>
<td>Working with clinical teams to respond to recommendations and outcomes of clinical audits</td>
<td>Splenectomy – Guidance and patient information has been developed, following recommendations from a clinical audit, and is awaiting committee approval. This will enable us to ensure consistency of approach to prophylactic treatment and to reflect national thinking.</td>
</tr>
</tbody>
</table>
Clinical Record Keeping - Clinical record keeping standards have been developed in response to a clinical audit for dissemination to all clinical staff in the first instance and then new starters on induction.

Working with clinicians wanting to develop guidelines to improve service delivery, or where there is inconsistency of approach

The project team has been working with the Burns Team to develop an integrated care pathway for adult burns patients as part of an overall service improvement project, linked to Academic Centre for Health Care Improvement

- **4.3.3** The Trust has a Trust R&D Strategic Plan (8) in line with the *NHS Strategic Review of the NHS and R&D funding in the new NHS*. The R&D Strategic Plan aims, firstly, to improve the quality, management and accountability of R&D within the Trust, and secondly, to ensure that the portfolio of R&D is conducted in accordance with the guidance from the Department of Health.

**4.3.4** The Trust recognises that Research Governance should not be considered in isolation from Clinical Governance, and the Trust R&D Management Committee co-ordinates their activities to ensure the framework recommendations are implemented in a timely manner. The Clinical Governance assessment framework for use in the Trust incorporates the requirements for assessing progress in R&D within section six and covers the essential standards of research governance.

**4.3.5** There is a systematic approach to Clinical Effectiveness education and training within the Trust. Attendance at these workshops has increased this year. Workshops for all staff and across all specialities are run 'in-house' on the following:

- Finding the Evidence and Critical Appraisal (CASP)
- Evidence to audit
- Cochrane database training
- Poster workshop
- Clinical audit methodology
- SWICE databases (Regional library databases)
- Stats. 1 How Many People Do I Need in My study
- Planning & Evaluating a New Service
- How to Write a Research Protocol
- Stats. 2 Confidence Intervals
- Presenting your Research Results
- Research & Ethics

**4.4 Complaints**

Last year the Trust treated 35,203 in-patients, 16,889 day cases, 33,446 patients through Accident and Emergency. From this, we received 224 complaints. A slight decrease of 23 over last year. We have had 2 requests for Independent Review this year. One request was refused by the Convenor; the other request remains under consideration.

Our performance for responding to complainants within the timescales has again improved this year and is (waiting for close of year). The Trust welcomes comments from users of its services, as it is one of the ways we
can see how we are performing and if appropriate take corrective action. Over the last year monitoring of actions taken following investigation of a complaint has become more robust.

<table>
<thead>
<tr>
<th>Areas where improvements have been made due to patients’ complaints</th>
</tr>
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<tbody>
<tr>
<td>A protocol has been agreed for the use of Anti-Embolic Stockings and is available to read on ICID. A Patient Information leaflet which describes deep vein thrombosis, the purpose of prophylaxis and how patients can assist with its effectiveness has also been developed.</td>
</tr>
<tr>
<td>Clinical Radiology Process Redesign and Action Plan has ensured that reporting of CT and MRI scans are not delayed and reported within agreed timescales.</td>
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</table>

5.0 Staff focus

5.1 Reports of progress towards to achievement of the action plan contained within the Trust’s Human Resources Strategy were produced for the Trust Board at their June 2003 and January 2004 meetings. The reports showed good progress towards the achievement of the targets contained in the action plan.

5.2 Building on the achievement of the Investors in People (IiP) Standards within each Directorate by April 2003, the Trust as a whole achieved the standard in January 2004. The IiP assessment process showed that each member of staff across the Trust had an individual performance review within the last year, where this was appropriate, and they had personal/professional development plans (PDP’s)

Directorates reported as part of the performance management system that they had developed training plans as part of their service planning process, based on service needs and the PDP’s of staff.

5.3 In November 2003, the Trust agreed a ‘mandatory training’ grid which had been developed by the Trusts’ Education and Workforce Development Committee (EWDC). The grid specified the types of training that should be considered mandatory for Trust staff, the groups to which that type of training applied, and the lead trainer. At the same time attendance of mandatory training was being increasingly recorded using the Trusts PRISM payroll/personnel database, enabling reports related to course attendance to be produces.

Expanding and developing the availability and delivery methodology of mandatory training became a focus for investment of training funds during 2003/2004, with additional resources being allocated to fire safety, manual handling and infection control training provision.

It will now be possible for each Directorate to identify mandatory training needs for their staff, and monitor the delivery and take up of that training.

5.4 A ‘Lifelong Learning Strategy’ was developed as a result of exclusive consultation, led by the Education and Workforce Development Committee. The strategy was agreed and introduced across the Trust in early 2004.

The strategy provides a framework within which the Trust can achieve its need to ensure it develops and maintains a workforce with appropriate knowledge and skills.
to deliver its service plans in both the short and medium term (the strategy has a five year action plan attached).

5.5 The Academic Centre for Health Care Improvement links work placed learning and quality improvement methodology. Multidisciplinary teams in surgery, burns service and modernisation projects are currently undertaking improvement work whilst accessing academic credit for the work. The NHSU (NHS University) visited the Trust during the year and acknowledge that the work here is ahead of many other NHS organisations.

5.6 The use of ‘professional panels’ as part of the ‘raising concerns policy’ for the various healthcare professional is innovative. The panels are made up from staff at the ground level and have right of passage to the Chairman of the Trust if needed. The panels are supported by the Medical and Nurse Directors who will report any trends to the Clinical Governance Committee. As well as the staff survey, this should allow staff to offer up views and opinions as well as concerns about patient care.

6.0 Leadership, Strategy and Planning

The Trust has ensured that the principles and systems for clinical governance are embedded throughout the Trust to ensure the delivery of safe, high quality care for our patients.

6.1 The Medical Director is the designated clinical lead for Clinical Governance within the Trust. The Head of Clinical Governance supports this role through the Directorate for Clinical Effectiveness, which brings together the departments of clinical audit, research and development, care pathway and guideline development, knowledge and library services, education facilities and patient information. There are strong working links with PALS, complaints, information, risk management and learning.

6.2 The Clinical Governance Committee continues to discharge its responsibilities.

Membership of the committee reflects the seven pillars of clinical governance.
The membership is as follows:
Non Executive Director - Chair
Non Executive Director
Chief Executive
Medical Director - Trust Lead Clinician for Clinical Governance
Nurse Director - Executive Lead for Risk Management
Director of Human Resources
Head of PALS
Head of Clinical Governance Strategic lead for Clinical Risk
Lay person representing patient interests by Salisbury Community Health Council
Lead GP (or Nurse in absence) for Clinical Governance South Wiltshire PCT

6.3 The Committee meets on a quarterly basis with the minutes made widely available via Directorate teams and the Intranet. Major issues affecting the Trust across the pillars of clinical governance are reviewed at each Clinical Governance Committee meeting. This includes external issues such as CHI investigation findings from other Trusts, external inquiries etc. to ensure the Trust learns from others as well as incidents reported / areas of good practice highlighted within the Trust. Sub committee’s report to the Clinical Management Board (CMB) with exception reports onwards to the Clinical Governance Committee. There is a Clinical Governance agenda item at each Trust Board meeting.
6.4 The Clinical Governance Operational group is made up of the Clinical Governance leads from all the Clinical Directorates and the management leads from each of the aspects of clinical governance. The role of the group is to implement actions as outlined by the Committee, monitor progress against action plans and share good practice across the Directorates. It also has a role in the future development of clinical governance systems in the Trust and enabling communication flows up and down the Trust structure.

6.5 There are performance management meetings monthly where each Directorate management team meets with the Executive Directors. Clinical Governance issues are discussed every three months and progress against agreed action plans is monitored.

6.6 Clinical governance objectives are included in the Trust service plan and the health communities' local delivery plan.

6.7 The Trust has six clinical governance half days per year where multiprofessional teams’ come together to discuss and improve aspects of clinical governance. Action plans are developed following these half days and feedback via the Intranet means staff are kept informed about Trust progress. Attendance is good and evaluation of the days shows that staff feel able to participate in the discussions (see appendix 4)

<table>
<thead>
<tr>
<th>Clinical Governance Half Day</th>
<th>Topic</th>
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<tbody>
<tr>
<td>May 2003</td>
<td>Risk Session</td>
</tr>
<tr>
<td>July 2003</td>
<td>Clinical Negligence Scheme for Trusts (CNST) accreditation, thrombo-embolic prophylaxis</td>
</tr>
<tr>
<td>September 2003</td>
<td>Raising concerns</td>
</tr>
<tr>
<td>November 2003</td>
<td>Patient involvement, clinical audit, Research and development – how to get involved</td>
</tr>
<tr>
<td>January 2004</td>
<td>Consent form, infection control, ‘Do Not Attempt Resuscitation Audit (DNAR) policy</td>
</tr>
<tr>
<td>March 2004</td>
<td>Clinical audit awards</td>
</tr>
</tbody>
</table>

7.0 Child protection

7.1 The Trust completed the self assessment audit on child protection systems following the publication of the Victoria Climbe report. This process was overseen by CHAI (The new Health care Commission). The audit showed that Salisbury had good systems in place. The Trust has developed an action plan to improve on the three areas where further work was highlighted.