Portsmouth HealthCare NHS
NHS Trust

STRICTLY CONFIDENTIAL

MINUTES OF A MEETING OF THE CLINICAL GOVERNANCE PANEL HELD ON THURSDAY 21ST FEBRUARY 2002 IN THE COMMITTEE ROOM, ST JAMES HOSPITAL

Present	**Apologies**	**In Attendance**
Mr G Heaney	Mr A Silvester	Ms S Jones
Miss J Knight	Mr A Wood	Mrs F Cameron
Mrs A Monk	Dr E Thomas	Mr P King
Mr M Millett	Mr A Horne	Mrs L Green
Dr I Reid	(East Hampshire Primary Care Trust)	Mr I Piper (Chief Executive Designate F/G Primary Care Trust)
		Dr P Old (Acting Chief Executive, IOW, Portsmouth and South East Hants Health Authority)
		Mr R Palmer

Note: Miss J Knight, CHC representative on the Panel, elected to attend the meeting as an observer as she did not wish her involvement in the meeting to conflict with her CHC role.

Action

1. Purpose of Meeting - Focus on Gosport War Memorial Hospital

1.1 This extra meeting of the Panel had been convened, with the full Board invited to attend, to be fully briefed on the current position with respect to the police and CHI investigations at Gosport War Memorial Hospital, to review the action taken by the Executive team to date, and to determine any further action required.

2. Police Investigation

2.1 It was noted that the formal feedback from the police had been received on 7th February 2002: a letter dated 5th February 2002 from Hampshire Constabulary enclosing three independent medical reports (dated July 2001, October 2001 and December 2001 respectively) commissioned by the police in the course of their enquiries. These had been shared in full with members.

2.2 It was noted that this was the first occasion that the Trust had seen these reports.

2.3 Mr Palmer highlighted a number of apparent inaccuracies in one of the reports (by Professor Ford). In view of the fact that the police had disclosed the reports to other organisations (UKCC, GMC) it was agreed to write to Hampshire Constabulary with a copy to those organisations.

2.4 At a recent meeting between representatives of the Health Authority, the Trust, the Regional Office, CHI and the police, the latter had reported that they were not pursuing their investigation, would be writing to relatives informing them of this decision, and offering them an interview to discuss it if they wished.

3. Executive Team Response

3.1 The Notes of the Executive Team held on 7th February 2002 were noted. The aim of that meeting had been to decide what immediate action to take regarding (a) the five individual staff named in the reports (Note: the criterion used was whether they were safe to practice i.e. that there was no risk to patients from their continuing to work); (b) assuring the Board that CURRENT practice at the hospital meets recommended standards. The panel reviewed the decisions taken to test if these were robust enough, and to determine what more needed to be done.

4. Named Individuals

4.1 So far as the three named nurses were concerned *(Note 1.5 of the Executive Team notes refers)* the rationale behind the Executive Team's decision not to suspend was noted. A key factor in this had been an assumption that the UKCC had had a copy of the July 2001 report in their earlier investigation of these nurses when they found no case to answer. There seemed to be some confusion about whether the UKCC did or did not have the report at that time. However, Dr Old reported that the police had told him that they had sent the report to the UKCC.

4.2 Dr Old commented that the Trust as employer should not be relying on the UKCC but considering itself whether any disciplinary action were needed. In discussion, the key test was clarified as follows: (a) given the context in 1998, had the Trust known then the overall picture of nursing practice as painted by all three reports, what disciplinary action (if any) would it have taken with respect to these three nurses?; and (b) if it would have taken any such action then, what if anything needs to be done to execute that today? It was agreed to ask Mrs Cameron and Dr Thomas to meet formally to consider this, with the outcome reported to the next meeting of the panel.

4.3 So far as the consultant was concerned *(Note 1.6 of the Executive Team notes refers)*, the rationale behind the Executive Team's decision not to suspend was noted. A key factor in this had been that the report's criticisms related to the consultant's supervision of junior staff rather than their own clinical practice. Mr Palmer questioned this on the basis of the notes of one of the cases involved. Dr Reid responded that the patient in that case was well

known to the consultant and it was hard to reach a conclusion on the basis of the case notes record alone.

4.4 It was noted that the GMC would soon decide whether or not to investigate the matter further. Once the outcome of this was known, Dr Reid and Dr Old would meet to decide what (if any) action should be taken. It was agreed that irrespective of the GMC Dr Reid would pursue the criticism in the reports about the supervision of junior staff and take whatever action was appropriate.

4.5 So far as the General Practitioner/Clinical Assistant was concerned *(Note 1.7 of the Executive team notes refers),* Dr Old and Dr Reid had liaised closely following the Executive Team meeting. It was noted that the doctor had voluntarily: (a) withdrawn from the hospital Bed Fund; (b) already arranged for her out of hours responsibilities at the hospital to be covered by HealthCall; and (c) agreed to stop prescribing opiates/benzodiapan etc. in general practice. The position would be reviewed monthly.

4.6 Miss Knight voiced a concern about the potential impact of the prescribing restriction on the continuity of care for patients in a long term relationship with the doctor. Dr Old confirmed that the doctor's colleagues in the practice were supporting the doctor in prescribing and so there need not be an adverse effect for individual patients.

4.7 It was noted that the doctor had been referred to the GMC. The latter had decided to take the matter to an Interim Orders Committee, which would meet within two weeks. Once the outcome of this was known, Dr Old and Dr Reid would meet to decide what further action (if any) should be taken.

5. Audit of Current Clinical Practice

5.1 The scope of the two audits commissioned by Dr Reid and Dr Thomas was noted. These aimed to review all 68 current inpatients on the three wards. Dr Old suggested that any audits need to be retrospective (of discharges) as well as current (of inpatients) and this was agreed.

5.2 Dr Reid would finalise the brief for the audit of prescribing with the district pharmaceutical officer and the regional pharmaceutical adviser. He was also reviewing the Controlled Drugs Register for the wards from 1995.

5.3 Mrs Cameron and Dr Thomas would revise the brief for the concurrent audit of record keeping of pain management, nutrition and fluids,

5.4 It was expected that both audits and the review of the Controlled Drugs Register would take place in March, with the outcomes reported to the panel (or its Primary Care Trust equivalent).

6. Other Issues Arising from the Police Reports

6.1 Medical cover: It was noted that arrangements were considerably more robust than in 1998:

a) a full time staff grade doctor Monday to Friday, with locum cover provided for annual leave.

b) additional consultant sessions at the hospital to ensure weekly ward rounds throughout the year.

Local out of hours cover was still provided by the GP Practice. The contract for this was an annual one, giving an opportunity to include specific quality standards when next due for renewal. In addition, it was agreed to formalise arrangements for nursing staff on what to do out of hours if unsure of the response from the GP Practice. Mrs Cameron undertook to produce written guidelines.

6.2 The discussion raised the wider policy issue of the level of medical cover in community hospitals and other isolated peripheral units. The CHC had been concerned about this for some time, arguing for equitable access to appropriate 24 hours medical care irrespective of whether inpatients were in a large acute hospital or a local hospital bed. It was also noted that in this district alone considerable funding was tied up in out of hours contracts with local GP practices for community hospitals. The CHI team were aware of this as a key clinical governance issue for intermediate care nationally, and it was expected that they would make recommendations about it in their report. It was agreed to re-visit the issue once the CHI report was available.

6.3 Policies and Procedures: Relevant policies had been revised, and no further work was identified in this respect.

6.4 Supervision: It was noted that the issue of effective supervision of junior staff and how this could/should be undertaken was being pursued by the Elderly Medicine consultants as a group. It was agreed that when in place these arrangements would need to be audited regularly.

6.5 For nursing staff clinical supervision arrangements were in place for F and G grade nurses, but less formally so for other grades. It was agreed to ask Dr Thomas and Mrs Cameron to review current arrangements to see how these might be strengthened within the resources available.

6.6 Training: It was noted that since 1998 specific training had been provided for staff in ALERT and CPR. The gerontological nursing development programme for community hospitals for all F and G grade nurses commenced in September 2001, in conjunction with the RCN, and was going well to date. It was agreed to review training provisions once the outcomes of the audits were known.

6.7 Rehabilitation/Palliative Care: Dr Old asked whether clinical policies were now robust enough to ensure that patients admitted for rehabilitation were appropriately treated, with a clear process for any change in care plan toward palliative care. Dr Reid confirmed that the function of Daedalus and Dryad Wards had been formally clarified as rehabilitation and continuing care respectively. It was agreed to ask the Daedalus multidisciplinary team to: (a) undertake an exercise reviewing patient outcomes against goals in referral letters to demonstrate the rehabilitation focus; (b) review the ward clinical policy to ensure clarity of purpose, referral guidelines etc.

6.8 Communication with Patients and Relatives: This was a key theme in the reports, and much had been done since 1998 to improve it. It was a key part of the gerontological nursing programme. It was agreed that Dr Reid, Miss Knight, Dr Thomas and Mrs Cameron meet to review the current position and to explore what else might be done.

7. Learning Points for Complaints Handling Process

7.1 A number of observations were made:

a) Investigation of a complaint needed to be undertaken by someone from outside the service concerned. This was not routinely so in 1998 but was so today.
b) The robustness of independent scrutiny appeared to vary. The Trust needed to explore ways of making the investigation process more effective.
c) In the specific GR case, the Trust did not mount its own internal investigation when the police commenced their inquiry. With hindsight it was clear that it would have been better to have done so, and a number of issues might have been identified for action sooner as a result.
d) Dr Reid commented that the 1998 cases/issues pre-dated the implementation of clinical governance. The latter had had a positive impact in empowering clinical staff to raise concerns and providing mechanisms for identifying and resolving problems.

8. Publicity

8.1 Further media coverage was likely at some stage, particularly through the GMC investigation process. There was concern about the impact of this on both patients, relatives and staff. It was agreed that a further Health Authority/Trust meeting be arranged to prepare for this. Miss Knight asked that the CHC be kept informed

9. Commission For Health Improvement Investigation

9.1 The Terms of Reference for the CHI team's independent audit of a sample of recent inpatient episodes were noted.

9.2 The panel also noted the decision recorded in the Executive Team meeting notes (note 2 refers) regarding the issue of informing relatives.

10. Handover to Primary Care Trusts from 1st April 2002

10.1 It was agreed that a final meeting of the Clinical Governance panel would be arranged in late March 2002 with clinical governance leads from Fareham & Gosport and East Hampshire Primary Care Trusts to:

(a) receive the reports of the internal audits and other feedback as above, and decide what (if any) action to take on their findings.

(b) ensure clarity of responsibility for the ongoing monitoring and management of the process.

Distribution:
Those present, apologies and in attendance; Chair, Fareham & Gosport Primary Care Trust

g:\trust_hq\people\lorna\tboard\clinpan.doc\6 March, 2002/dh