Witness Statement Ref. No. 046/2

NAME OF CHILD: Raychel Ferguson

Name: Stella Burnside

Title: Mrs.

Present position and institution:

Previous position and institution:
[As at the time of the child's death]
Chief Executive Officer - Altnagelvin Hospital Health & Social Services Trust ("AHHSST") until December 2004

Membership of Advisory Panels and Committees:
[Identify by date and title all of those since the date of you last witness statement]

I was a visiting Professor University of Ulster from 2005 – 2010
I am an appointed Commissioner - Equality Commission for Northern Ireland 2008 -2014
Just appointed member of Independent Monitoring Board, NI until 2016,
I was a member of the Board for Foyle Haven Centre for Street Drinkers 2008 -2012
I became a Board member of Oaklee Care Services Board, February 2013
Trustee of the Ulster Orchestra 2005 -2012

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

OFFICIAL USE:
List of previous statements, depositions and reports attached:

Ref:	**Date:**	

WS-046/1	01.07.2005	Inquiry Witness Statement

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

(1) Please provide the following information:

a) Your qualifications as of 2001 (please also provide a copy of your CV); Registered General Nurse, Registered Mental Nurse, Nurse Teacher, B. Phil. [Hons]. CV Attached.

b) Describe your career history before you were appointed Chief Executive, AHHSST;

Shortly after completing my A Levels I commenced General Nurse Training in Belfast City Hospital on 3rd July 1967. Training was a traditional apprenticeship with periods of "classroom education" interspersed between substantial periods of placement in ward and treatment departments. The Syllabus was prescribed by NI Council for Nurses and Midwives. Student nurses were the larger part of the Nursing workforce. After three years training I qualified and became a State Registered Nurse.

I worked on day duty and night duty in Belfast City Hospital. On night duty I was the nurse in charge of a surgical department of at least 4 acute surgical wards and sometimes eight surgical wards including the Urology wards and Trauma / Orthopaedic wards. I reported to the Senior Nursing Officer who was in charge of the Hospital.

This was an extremely busy department at a challenging time. This gave me a great development and learning opportunity which has underpinned my beliefs and directions since that time. I became aware of my need for more understanding of the human condition and the emotional effects on people who were patients. I then undertook Mental Health Nurse training.

Upon completion of my Mental Nurse training I worked in Windsor House as a Mental Health Nurse and in special practice with Behaviour Therapy and Group Work.

I undertook special Human Relations training in Group Work whilst in Downshire Hospital and continued to develop this area of special interest as a Human Relations Group Facilitator working through the Extra Mural Department QUB under the guidance of Mrs May Seth. Both these areas of interest were undertaken in parallel with my mainstream employment as a Nurse.

I trained as a Clinical Nurse Teacher [Royal College of Nursing, with Credit] and simultaneously undertook the first part of University of London Diploma in Nursing in the subjects of Physiology, Psychology and History of Nursing.

I worked as a Clinical Teacher in Belfast Southern Group School of Nursing covering clinical areas in Musgrave Park Hospital and Belfast City Hospital. Then moved to Central School of Psychiatric and Special Care Nursing and was Clinical Teacher in Purdysburn Hospital and Windsor House.

Following completion of the Certificate in Teaching Studies for Nurses [with Distinction] at Institute of Continuing Education, Magee College, Londonderry I worked as a Nurse Tutor in Central School of Psychiatric and Special Care Nursing and provided clinical teaching in Holywell Hospital.

I moved to Derry and worked in the Western Area College of Nursing where I taught General Nursing and Mental Health Nursing.

I was appointed to a seconded post in Magee College, NUU, by NI Council for Nurses and Midwives. I was responsible for the Co ordination and management of the Nurse Tutors Course. Following the merger of NUU and NI Polytechnical College my work extended to include teaching undergraduate nurses and to curriculum design and development with the Department of Nursing Studies at the University of Ulster.

Whilst working full time I completed a Bachelor of Philosophy degree with upper second class Honours and was awarded the Bigger Prize for Post Graduate students.

Upon the introduction of Unit General Management in Northern Ireland in 1990 I was appointed as Unit General Manager for Foyle Community Unit of Management and established the new Unit, within the Western Health and Social Services Board. This post offered me the opportunity to lead and develop a new system of accountability in general management of services. To achieve these goals I worked closely and openly with staff and with service user groups to nurture a culture of openness and responsiveness to the needs of clients and patients and to manage services in more open and flexible way in accordance with the needs of the communities we served

Upon completion of three years in Foyle Community Unit I applied and was appointed Unit General Manager in Altnagelvin Group of Hospitals in January 1993.

This post provided the opportunity to lead the organisation towards a vision for excellence, as a District General Hospital, in an era of rapid technological change. The development of an organisational structure, involvement of clinicians in management and developing a culture of openness and accountability were undertaken with the participation of a wide range of staff to encourage a collegiate approach and shared learning in multidisciplinary teams.

In 1996 I led the Altnagelvin Hospitals application for Trust Status and was appointed Chief Executive by the Altnagelvin Hospitals HSS Trust Board in April 1996.

Throughout my career I have served on Professional Boards, Voluntary Boards and Committees and have been appointed to Public Bodies.

c) Describe your work commitments at the AHHSST from the date of your appointment to June 2001; I have been unable to retrieve a copy of my own job description and so give a general description of my accountability.

See attached Job Description for my successor which gives a front page description of lines of accountability. I believe that HPSS Management Executive archive should be able to provide a sample job description which they issued for all Trust Applications.

As a Unit General Manager [UGM] I had been accountable to the General Manager of Western Health and Social Services Board and was responsible for the effective and efficient planning and management of the services provided within the unit. The post of Unit General Manager required that all staff were ultimately accountable to the UGM.

In brief my post in Altnagelvin had a wide range of "work commitments" for which I was accountable to the General Manager of WH&SSB. Among the major issues were, planning and business case development for the Strategic Capital Development of Altnagelvin Area Hospital, leadership and management of the hospital organisation, the maintenance of efficient services and effective financial management. Simultaneously the hospital's Tower Block Building was re-clad. I ensured the development of a management system that secured accountability [Clinical Directorate model] maintained sound financial management and developed services to the required standards of the day and delivered that accountability to the Western HSS Board.

Following the trends in UK government policy from 1980's in Northern Ireland onwards the expectations of the public were increasing, technology was advancing, earlier diagnosis was becoming achievable and evidence of clinical outcomes was allowing consideration of clinical effectiveness which was driving greater specialisation in the Medical and other professions. The patterns of hospital care, which had served their communities for so long, no longer were able to meet the demands of more specialised diagnosis or treatment. Hence the heritage of a hospital in every community, [e.g. Co Tyrone – Dungannon, Omagh, Castlederg, Strabane.] serving the acute hospital needs of the local population, became challenged by the new standards expected because of the increasing capacity for diagnosis and treatment by more specialised Clinical Experts.

Previous planning assumptions needed to be challenged and patients, public and professions became engaged in the plans for re shaping the provision of acute hospital services.

It appears to be the case that Northern Ireland HPSS, Health Services Policy, reflected the political philosophy that prevailed at Westminster /Whitehall at any given time. The trends were similar albeit that pace of structural change and professional influences were introduced at a slightly later time in NI.

The Management Executive of HPSS in Northern Ireland promoted the move to "self governing Trust status" for all Units of Management. I led the management of change and developed the application for "self governing Trust status. The Application was assessed by an External Assessment Team, [which was appointed by HPSS Management Executive] and AHSST was granted Trust Status under the Establishment Order HPSS [1996].

The "work commitments" briefly outlined above were increased. The challenge was to build new strategies to enhance, sustain, develop healthcare services which would meet the new managerial framework and accountability and the demands of a Purchaser / Provider contracting environment with Commissioning HSS Boards and GP Fundholders negotiating with the Trust for services/contracts and service level agreements.

The learning environment in Altnagelvin was built upon the early foundation of team building, the development of Clinical Directorates and the HosQIP and early audit work. The information and theory then featuring in the literature of Quality Improvement was Clinical Governance as models of assurance for corporate and clinical governance emerged.

A Trust chief executive was an Executive Director member of the Trust Board and was accountable directly to the Chairman of the Trust Board. The role of Chief Executive was one of an Accountable officer [to Permanent Secretary] and significantly one of leadership for the organisation. I worked closely with my team, the Trust Board and clinical colleagues to develop a shared vision for improving quality of care and treatment and a culture for improvement.

Our Trust developed an inclusive [multi disciplinary] approach to the development of strategy and to the organisation of the Trust. We developed Business Cases which are the basis of the re development capital project and the organisation of specialist services in keeping with the best

available evidence. An example of this is the cultivation of Clinical Teams which led to an agreed approach to referral for people suspected of having cancer. When NI Report on Cancer Services was published [Campbell Report] the Altnagelvin Referral Guidelines for GP's was cited as an example of good practice.

In 1997 one of the early challenges in this new and emerging culture of the NHS came to Altnagelvin when a potential problem was indicated. The culture for improvement and openness led to an investigation into potential "failed sterilisations." In a spirit of honesty and openness the Trust undertook an internal review to examine risk of "sterilisation failure." The Trust then made a plan and was proactive and open in pursuing its duty of care to the identified patients.

Leadership of and accountability for improving services was largely welcomed by professionals who accepted their responsibility for leading clinical improvement. The Chief Executive of a Trust was an Accounting Officer in direct line to the Permanent Secretary who, in turn, provided assurances to Parliament for the proper use of public finances. If I recall correctly, I had to sign an Assurance and Management Statement assuring my adherence to Financial Memoranda and Standing Financial Instructions affirming due diligence in the conduct of financial matters.

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d) What was the role of the Accountable Officer and what were its functions, accountabilities and responsibilities, and was this reduced to writing by 2001? If so please provide a copy of the same. I believe that I have outlined in the previous answer. I believe this information has already been submitted to the Inquiry.

2 Please also provide a copy of:

a) The Code of Conduct and

The Code of Conduct and UKCC Code of Conduct. Please find attached.

b) The Code of Accountability to which you were subject in 2001.
I believe that management executive issued some guidelines following the N Nolan Report, but I am unable to access that information. I further enclose Code of Conduct for HPSS Managers dated November 2003.

3. In respect of the prediction in the Annual Report 1998-1999 (at Ref: 321-004gi-044) ***"From 1st April 2000 Chief Executives will be responsible for not only the financial performance of the Trust but will have clear accountability for quality in the clinical setting"*** **please state:**

a) Whether this proved to be accurate;
The legislation which would introduce the "Duty of Quality" was not enacted until 2003 and the expectation expressed in the Annual Report 1998-1999 was not fulfilled until 2003.

b) The date from which the Chief Executive became responsible/accountable?
Each Chief Executive was an Accounting Officer in line with the standing financial instructions and probity in Health and Social Services. The Permanent Secretary was the direct line to Government and wrote to each Chief Executive on their appointment and subsequently when deemed necessary. These were commonly referred to as "Dear Accounting Officer" [Dear AO] The statutory duty of quality requiring new arrangements for Clinical Governance only came into force following the Quality Improvement and Regulation Order, Northern Ireland. [2003]

4. In respect of the quality of healthcare provided by the AHHSST in 2001, what did you consider to be:

a)Your own professional responsibility;
I was a Chief Executive with the responsibility for the effective and efficient planning, delivery and sound financial management of the Altnagelvin Hospitals HSS Trust. The essential criteria for the post did not require nursing or health care qualifications.
I maintained my Nurse Registration and therefore behaved with due regard to my professional code of conduct and accountability in accordance with UKCC.

b)Your own ethical responsibility;
The ethics which underpinned my conduct as a Chief Executive were informed by my belief in respect and regard for each person, honesty and openness in the conduct of my work and fairness in the delivery of a public service.

c)Your own statutory responsibility?
My statutory responsibility as a Chief Executive was laid down in the Orders which established Trust status for Health and Personal Social Services in Northern Ireland. HPSS Establishment Order [1996] Each Trust Chief Executive had similar accountability in 2001 to deliver efficient and effective services within the available resources.

5) Who bore ultimate responsibility for the quality of care delivered by AHHSST?
I did.
Each member of staff employed in post as a Registered Nurse, Doctor or person who was a Professional Allied to Medicine [PAMS] practitioner was accountable for their individual conduct in accordance with their Registration. [GMC, AHP Council or UKCC]

I was the Chief Executive responsible for the management and leadership of the services provided by the organisation and I bore ultimate responsibility for the overall quality and quantity of the services which we provided.

6) Please state the identity of the individuals who had lead responsibility in AHHSST in 2001 for:

a) Clinical governance;
The Medical Director, Dr Fulton and Miss Duddy, Director of Nursing, shared responsibility for development of a Clinical Governance framework within an ethos of quality improvement and to ensure that the Trust would be ready for the enactment of the statutory duty of quality when it became law in NI.

The responsibility was delegated jointly to the Medical Director, who was part time Director and a working clinician, and the Nursing Director who was full time Executive Director.

Consistent with established professional education patterns they, along with other colleagues, were supported in their CPD to develop networks with the emerging Clinical Governance experts in other countries.

They attended Conferences, meetings, and contributed to expert peer groups, e.g. Chief Nurse Advisory Committee, Medical Directors Forum. I do not recall a specific Northern Ireland training programme or curriculum for Clinical Governance in HPSS at that time.

Each Registered Health Care Professional has a personal responsibility to ensure that they are keeping pace with developments in their respective fields of practice.

The Trust had an excellent Library and a professional Library service to support under and post graduate education, CPD and training for staff and students on placement in the Trust. Additional financial resources for the development of clinical governance education, training or structures were not, to the best of my recollection, made available at that time.

b) Risk Management;
Mrs T Brown was the responsible officer reporting to Miss Duddy, Director of Nursing. When new strategy or process was being developed training and education needs were identified and appropriate arrangements put in place to meet the particular goals. The established system of staff appraisal was the core tool to ensure that individual and organisational training needs were identified and action either for the individual's training or for more general training was agreed and organised in accordance with the established procedures.

c) Claims and Litigation;
Mrs T Brown was the Manager for claims and litigation and was experienced and expert prior to her employment in Altnagelvin Hospitals Trust.

The staff appraisal conducted across the organisation monitored the performance of individuals, measured the achievement of the set objectives and identified learning and development needs of individuals in relation to their particular post.

d) Complaints? I was Chief Executive and responded to complaints. The investigation of the complaint was undertaken, on behalf of the patient or next of kin, by the Patient Advocate.

The Complaints Procedure followed the prescribed guidance and my experience was gained over many years and was regarded as an important source of learning for the organisation.

During my time in Foyle Community Unit I had developed a system for handling complaints. I found that it was often helpful to offer to meet with complainants and to be open about the

issues.

I formed a Patient Council [Chaired by Non Executive Director of Trust Board] and recruited some members from those who had made complaints to the Trust.

The Trust Board received regular reports on Complaints.

Please also indicate what training and guidance was given to these individuals in respect of good practice and what steps were taken to monitor their procedures.

7)"The Trust strategy for clinical governance had been developed under the leadership of Nursing Director, Miss Duddy alongside the Medical Director, Dr. Fulton and had been coordinated by Mrs. Brown" **(Ref: WS-046/1 p.3). Please describe any involvement you may have had with this work, when it was done and whether it generated any note or record (if so please provide copies of the same).**

I regarded my involvement as important to ensure that staff recognised the significance of Clinical Governance as part of the improvement of our Hospital and so would always have made sure to take part in the development opportunities where possible.

The Director of Nursing and Medical Director were leading, learning and shaping proposals appropriate to the scale and shape of Altnagelvin and which would dovetail with the existing requirements for corporate governance.

I participated in discussions, in house seminars and spoke at training and conferences for our staff as well as at external Conferences. I am unable to access documentary verification. It is now 7 years since I left my post in Altnagelvin Hospitals Trust.

8)The *"Proposed Strategy for Implementing Clinical Governance"* **is dated 7th September 1998 (Ref: 321-004g-001). Please advise:**

a) As to the extent of implementation of this Strategy as at June 2001; A framework had been developed which included Clinical Incident Reviews, encouraged reporting of all risks and Incidents as well as the proactive Risk Assessments which were enacted in keeping with Legislation and Guidance on Risk Management.

The COSHH requirements, RIDDOR , Advice from Health Estates on Medical Devices are examples of the drivers for proactive assessment of risk and some required mandatory reporting to DHSS or the Health and Safety Executive.

b) If implementation suffered delay, what were the causes thereof?
The culture of NHS and HPSS in Northern Ireland had been one of professions working alongside the Administration of the services. The Griffiths Report circa 1984 recommended that Health Services should have a General Manager and a single point of accountability. General Management was ultimately introduced into HPSS Units of Management in Northern Ireland in 1990. This required a significant cultural shift in HPSS organisations.

A more open and accountable culture was being developed through clinical governance in many parts of the world. A new statutory duty of quality was introduced in the other countries of the UK from 1998 onwards. The ethos that was being proposed was one of transparency where improvement could be pursued in a culture which accepted that, when practice was less than perfect, then the opportunity was to pursue improvement not blame. The phrase commonly used was a "no blame culture". When staff were able to recognise weakness, accept the need to learn and

acted honestly, then a "no blame" culture was the vehicle for learning and underpinned the structures of reporting of clinical incidents. A primary goal in this was to develop "an Organisation with a Memory" so that lessons could be learned from untoward events and from "near miss events".

It is my recollection that in England the National Patient Safety Agency was the mechanism whereby Trusts were to report incidents so that trends would be identified and "Safety Bulletins issued to ensure widespread dissemination of the information.

It was believed that in a more open culture staff would be able to report their concerns and admit to their own learning needs.

From 1997 developments, resources and structures happened quite rapidly and were resourced in England and Wales. In addition to NPSA were the National Institute for Clinical Excellence / Effectiveness, [NICE] and the Commission for Health Improvement. [CHI]. Individual Trusts were charged with responsibility for developing Clinical Governance frameworks.

Simultaneously Northern Ireland Health and Social Services strategies were being examined in the light of the new Administration following the Good Friday Agreement and the ensuing accountability for the management of proposed changes in the pattern of Acute Services were dominant on the HPSS agenda. There were consultative papers on development of clinical and social care governance around 2001. Following upon the consultation the HPSS Quality Improvement and Regulation Order was later than originally expected and subsequently did not become enacted in law until 2003.

I, as Chief Executive, encouraged the development of a value system appropriate to clinical governance in the interests of ensuring best modern practice of sound governance and transparency in the service of the public and to support quality improvement.

Changing a long established culture is complex in any organisation. The HPSS was staffed and largely led by a Profession which, like other established professions, was historically characterised by their exclusive body of knowledge and self regulation. The culture required change to meet the challenges of a Health Service that was more focussed on the patients increasing expectations of a modern responsive, more open and efficient and effective service. The emergence of issues from the "Bristol Inquiry" created an impetus to drive improvement and clinical governance and more open professional regulation.

The Executive Directors, [Medical and Nursing] charged with responsibility for the development of capacity for clinical governance arrangements, were proactive in challenging me and advising our Trust Board on emerging professional standards and trends in specialties, in the governance of individual professional regulation and on the international drive for quality improvement through the mechanisms of clinical governance frameworks.

(9) In 2001 did the AHHSST have in place any policies, guidance or procedures governing the following:

(a) Clinical governance;
Yes. Modelled on frameworks and practice discussed in the professional literature.

(b) **Social care governance;**
Social Care Governance framework was not specifically named in the early literature and only

emerged in Northern Ireland to suit the needs of an integrated health and social care service.

(c) Health and Safety;
Yes developed under the guidance and requirement of Health and Safety Executive, Health Estates in HPSS/HPSSPS and the Trust staff who were expert in the respective fields. Please find attached.

(d) Adverse Clinical Incident Investigation;
Yes – Based upon recommended models at that time. From my recollection as a Chief Executive the Nursing and Medical Director had substantial contact with experts to test and develop the system of Adverse Incident investigation, Please see attached copy of Policy.

(e) Audit;
Yes- modelled on the Regional Audit Committee and available literature.

(f) Complaints procedure;
Yes based upon prescribed guidance from HPSS.

(g) Performance assessment;
Performance Assessment is the phrase used by Professional Regulators in relation to an individual Registrant and most frequently referred to doctors. Where a difficulty was identified the Trust did seek the assistance of the relevant and particular Royal College or Regulator where there were concerns about an individual. The Medical Director was attentive to these matters prior to the Confidence in the Future document.

It was widely regarded that where a doctor was "under performing" it was necessary to invoke the GMC type process. [Ultimately NI developed Guidance]. Many organisations appeared shy about invoking normal employment disciplinary procedures for doctors and dentists. In 2001 the NI region consultation of the management of doctors performance [and the ensuing relationship with proposed GMC revalidation procedures] was at consultation stage. Attachment Confidence in the Future. Attachment.

This annual review, Staff Appraisal system, was conducted by line managers throughout the Trust. Where an individual had weaknesses identified then arrangements and agreements were reached to support relevant development and improvement.

Senior Managers were assessed through Individual Performance Review [IPR] NI Scheme in keeping with Human Resource Policy and Practice throughout the HPSS.

Staff Appraisal and IPR were based on HPSS Schemes and were widely used through the HPSS.

(h) Continuing medical education and professional development;

Continuing Medical Education was regarded as a requirement for Medical staff and was developed in preparation for the anticipated statutory Regulatory requirements. GMC guidelines.

UKCC had requirements for their Registrants.

The advice on these matters was provided through the Director of Nursing and the Medical Director.

(i) Preparation for Inquests and the gathering of statements therefore;

This was handled by the Risk Management Department in direct liaison and with the guidance of our contracted Legal Advisors [DLS.] and Counsel, as advised.

(j) The issue of patient consent;
GMC and UKCC issued guidelines/standards to their Registrants and those were expected standards.

Guidance on Patient Consent was issued in 1995 and put in place. Following the Inquiry into Retained Organs Altnagelvin HSST undertook further work on Consent prior to the new guidance being issued....We did undertake further review following upon the Inquiry into retained tissues and organs in NI. Attachment.

(k) Clinical record keeping?

Professional standards issued by GMC/UKCC were the expected minimum.

Audit was undertaken from time to time.

If the AHHSST did have any such policies, guidance or procedures in place, then identify the same, provide a copy and state in respect of each:

(i) Whether it was modelled on or informed by any published guidance, and if so please identify this guidance;
The Management Executive of HPSS /Guidance and Reporting Mechanisms particular to certain matters and Health and Safety Executive Reports had specific requirements. The published literature underpinned approaches to reporting for example Health Estates Bulletin. Attachment.

(ii) How the guidance, policy or procedure was distributed;
The management structure provided the formal means for running the organisation including the distribution of guidance, policy and procedure. The nature, gravity and breadth of impact determined the means of distribution. Some policy required to be issued by Trust Board e.g. Health and Safety Policy, Hospital Executive, Hospital Management Team, Team Briefing, Meetings with individual Managers, Managers Meetings with their Teams.

Team Briefing regularly included information regarding these matters.

(iii) **What training or assistance was given in respect of same;**
The Trust had a range of education and training providers who offered expertise. There were specific liaison arrangements and processes for commissioning customised programmes or generic programmes to meet training needs or developmental needs. When education or training issues were identified the appropriate programmes were organised in liaison with either University, Westcare or In Service Nursing Education. Frequently. In House Organisational Development training was carried out when change was planned or specific issues were identified. The Tr**ust had an active programme of in house development and training. Discussion Groups, Task Groups, Conference and Seminars were organised to meet particular needs within the Trust and occurred frequently.**

Post Graduate Medical Education was organised via the Post Graduate Deanery and through Royal College Advisers in the Trust.

(iv) How the AHHSST satisfied itself that the guidance, policy or procedure was being implemented and complied with;

The implementation and monitoring of change, procedure or policy was achieved through the objectives set for Managers. In turn Managers / Clinical Directors set specific objectives with their Staff and regularly reviewed progress through this individual performance review system. Directorates were held to account through their accountability reviews where the achievement of objectives was assessed.

Where an issue of compliance or implementation was identified then it is likely that an audit type analysis would be undertaken and further training, development or employment process was undertaken.

(v) How implementation and compliance was enforced;
As described at iv above.

How such guidance, policy or procedure was applied in the case of Raychel Ferguson?
The Clinical Directorate for Women and Children had the described systems in place and managed in accordance with the existing systems at that time. Ward protocols were established through custom and practice and existed only where there was a high level of trust among professional colleagues. Traditionally Medical and Nursing curricula prepared people for professional practice and Registration was regarded as a standard to be relied upon.

It was my clear understanding that the Critical Incident Review established that

Raychel's care and treatment were consistent with custom and practice for a Post Operative child of that age and did not obviously vary from the clinical care which had supported the recovery of many, many children in the preceding years in Altnagelvin.

No 18 Solution was the standard solution used widely and over many years for children and for adults. Had a different IV Fluid, with a greater concentration of sodium, been in common use then the deficit in sodium and the tragic sequel would have been improbable.

there should have been a more scientific approach to measurement of vomit staining and volume of vomit in the vomit dish [it is regarded that estimates of blood and fluid stains are unhelpful] the estimations by Nurses were at variance with that subsequently reported by Raychel's mother [or her representative] at the meeting.

The Review of policy, procedure and guidance established these issues and put an action plan in place to prevent recurrence and to learn the lessons in Altnagelvin and in Northern Ireland.

The normal balance and homeostatic mechanisms which support life may have been more effective for Raychel's recovery if the IV fluid had been different.

The danger of IV solution management in children is subject to guidance and audits throughout the UK to the present day. The Regulation and Quality Improvement Authority issued Recommendations in 2008.

There were no Guidelines or Safety warnings readily available to direct attention to the dangers of Number 18 Solution as a maintenance fluid.

It was the case that no one looking after Raychel on the ward was tuned in or focussed on the dangers of low sodium solutions. The practice was common and no Alert Bulletin had been published to disseminate the information on the potential danger. The issue that No 18 Solution had potential inherent problems when homeostasis was challenged would have become known widely throughout the British Isles.

10). Did the AHHSST seek or obtain accreditation, whether from Kings' Fund Organisational Audit or otherwise, and if so:

(a) What was the accreditation and from whom was it sought;
Investors in People – organisation wide

Specific Department HSDU

Clinical Laboratory Accreditation.

(b) On what date was accreditation applied for and received; My recollection is - CPA 2001 -Investors in People 1999 - ISO 90000 in 2001/2 HSDU.

© What were the standards/criteria set;
Criteria were set by National organisations and assessed by External Assessors

(d)What was the outcome of this process? Described above a] to d] successfully achieved.

(11). In respect of Patient Charter standards please explain what is meant by the reference *"1999-2000… Key Achievements- ongoing monitoring of Patient Charter standards Charter monitoring Achievements- Figures"* (Ref: 321-004gt-001)?
This is explained in Trust Annual Report 1999-2000. Pages 40 – 44. Attached for your information.

(12). In 2001, what arrangements did the AHHSST have in place to ensure that regular and systematic nursing/medical/clinical audits took place? If such arrangements were in place please advise: In my answers to these questions it must be understood that as a Chief Executive I was not an expert in these fields. The knowledge and expertise was invested in professional experts throughout the organisation. My answers reflect my overview of the matters in question.

(a) Was there a Clinical Audit Committee? If so, what was its remit; Yes. The committee was required to encourage and coordinate audit, to facilitate and support staff undertaking audit, to build up methodological expertise within the Audit Department and to ensure a fair use and distribution of the staff of the audit department across the hospital.

(b) Who served on the Clinical Audit Committee; ATTACHED – REMIT and Membership.

(c) Who was responsible for ensuring that nursing/medical/clinical audits were carried out; Traditionally clinical professions undertook audit as part of their professional practice to ensure self improvement and team improvement. The development of a Clinical Audit Committee and Department was designed to encourage more audit, to build up methodological expertise and to provide support to audits within the resources available.

Clinicians often took part in audits across the Region of NI and sometimes participated in National Audits organised by a College/Academy.

Additionally audits were requested when there were issues identified where evidence of effectiveness or compliance was required. These audits were designed and undertaken on

behalf of the organisation. Please find attachment.

(d) To whom were the results of nursing/medical/clinical audits sent; The findings of audits undertaken directly by practitioners were immediately available to them. In 2001 findings were reported to the Clinical Audit Chairman and Committee, published in Clinical Audit report and many were presented to the in house Hospital wide Quality Improvement Programme [HOSQIP] conference.

(e) What action could be taken on foot of the results of nursing/medical/clinical audits; Audits were conducted using recognised Standards. Where deficit was found then improvement targets were set, training needs identified, responsible persons designated to support improvement and a repeat audit as advised by experts in the field.

(f) As to whether there was any procedure or system in place in 2001 to audit the quality, clarity and completeness of clinical case notes? I am aware that following the Critical Incident Review there were audits of recording of fluid balance and observation notes. I do not have access or detail of these. Please find attachment.

(13) In 2001, had the AHHST established a Medical Records Committee or like body? If so, please address the following: I do not recall.

(a) What was the function of the Committee;

(b) Was its remit and operation governed by any policy/procedure;

(c) Who formed the membership of this Committee;

(d) Did you play a role in relation to this Committee, and if so what;

(e) Whether its deliberations were minuted;

(f) Did such a Committee engage with the audit or review of medical records?

(14) Please describe the accountability and responsibilities of the Risk Management Co-ordinator/Director and the *"Department of Nursing and Risk Management"* (Ref: 022-071-184) between 2001-2003 and if you could describe the evolution of these clinical governance offices it would be very helpful.

The evolution of the national service for health had developed along professional lines with parallel administration systems. There was a tendency towards separation of systems. This was often described as a "silo" approach to management.

From my appointment I encouraged an ethos of General Management [Griffiths Report] which would help integrate goals and systems in the hope of reducing the tendency to compartmentalisation. [The silo] Given the centrality of the Medical and Nursing workforce, and their concomitant influence on, and responsibility for, quality and the management of risk, I encouraged the approach and arrangements with shared responsibility between the two Directors in the knowledge that their respective credibility among their colleagues would enable them to lead these developments effectively. Such an arrangement was designed with a view to having a coherent, respected framework within which we would develop clinical governance.

National and international trends in healthcare and Regulation for professionals advocated

transparency in the management of risk and the systems of clinical governance. Although it had not become a requirement in NI it was good practice.

The Director of Nursing was given joint responsibility along with the Medical Director to develop the culture and design a structure which would be fit for purpose for clinical governance The respective share of the responsibility for the line management of the Department of Nursing and Risk Management reflected the balance of work commitments.

(15)Did you keep a file or record of your work in relation to the case of Raychel Ferguson, including:
Any record, notes or files were managed by my PA and furnished to the Inquiry. I did not keep separate notes or files.

(a) Correspondence;

(b) Attendance notes;

(c) Telephone memoranda;

(d) Internal communications;

(e) Emails;

(f) Reviews and opinions;

(g) Any other relevant documentation?

(16)Please describe all other systems in place in 2001 for quality assuring the safe provision of patient care?
The question asks for "all" and to answer this I think that it is useful to give a brief outline of the historical context before trying to list "all" which is reliant on my memory.
It is now almost nine years since I left my post at Altnagelvin and many changes in structure have taken place since then.

Upon taking up post in January 1993 I commenced a programme of Organisational Development to develop a shared vision for the future, plan a strategy for the future and support the goals of the hospital.
Reflective practice had always informed the work of nurses, doctors and others but audit and measurement tended to be single discipline rather than Team or outcome focused and the silo system of single lines of professional accountability was being replaced by a system of general management. Effective team work was an essential underpinning.

In 1996, in keeping with HPSS policy, Altnagelvin Hospital became a "self governing Trust".
The goals for quality improvement were encompassed into the Trust ethos and mission and were at the forefront of the accountability required by the Trust Board.

During this time I worked with my executive colleagues to encourage the development of team work [including Clinical Audit] and an "outcome based focus". To ensure that the "whole Hospital" would develop and share a vision for clinical excellence it was vital to have a Medical Director who was respected, credible and who would be trusted by the medical colleagues.

The Chairman of Medical Staff Committee was so regarded within and without the organisation.

This was an important developmental step in bring the whole of the workforce into a structure and a spirit of common purpose as we developed a team approach and a system of accountability in Clinical Directorates.

Altnagelvin Hospital [later Trust[was the largest hospital outside Belfast and at the greatest distance from the major regional hospitals, which housed the most substantial resources for health interventions. I embarked upon a programme for quality improvement which would involve staff from all departments and from all disciplines in the hospital. If the largest hospital, at greatest distance from major centres, was to drive improvement and increase its capability then it had to be able to offer recruit and retain the highest quality staff. Thus began a strategy to ensure that the north west would have a major District Hospital [DGH] which would meet the specifications and recommendations of the External standards set by Royal Colleges and educational institutions. A whole hospital approach was essential.

The Executive Team and Clinical Directorates forged an approach and the strategy driving quality improvement was put in place. Quality Circles were popular at the time and, though inclusive in their membership, tended to focus on the "soft" environmental matters. Our agreed vision was focused on Clinical and Care matters and so instead of the usual Quality Circle approach we engaged the services of the Royal College of Nursing Professional Development experts to train staff in Dynamic Standard Setting System [DySSy]. The DySsystem was amenable to clinical care as well as environmental standards for measurement and improvement targets.

Inter and cross disciplinary team work through standard setting, improvement targets and measurement was encouraged. Some one hundred staff from across the hospital were trained and became Facilitators who would lead and develop quality improvement projects in their respective departments. This project was named the Hospital wide Quality Improvement Project. [HosQIP]. Many staff presented their best projects [and occasionally, in keeping with the growing culture of openness, a worse project] within their own department and to a hospital wide HOSQIP Conference annually.

The success and sustainability of this initiative supported many other formal structures which sought to provide good care and an open approach to improving quality and nurture a learning environment.

This project was imbedded into the Trust and dovetailed with the Clinical Audit system and goals for improving quality and ultimately with the developing culture and framework for clinical governance.

Additionally a Senior Nurse facilitated the HOSQIP development and undertook additional exercises in Quality Assurance through 'Monitor' and Essence of Care projects on nursing standards.

Clinical Directors and Clinical Service Managers assimilated the drive for quality into their Directorates and tried to assure that the drives for efficiency and stress of meeting waiting list targets for in patient and out patient targets and for financial balance were informed by the quality improvement agenda. With a culture of quality improvement the traditional and the emerging frameworks combined to support the focus on best practice in the provision of patient care.

Building upon these foundations for quality improvement the early work on the framework for Clinical Governance developed and increased the focus on management of clinical and other risks to improve care

The established and traditional systems for quality assuring the safe provision of patient care were:
Registration of Medical, Dental, Nursing and PAMS staff regulated by national standards

Staff Appraisal and review to ensure individual staff engaged in the process of doing the job well and identified their personal goals as well as meeting organisational targets.

A system of Clinical Directorates where a Clinical Director and Clinical Services Manager leading, managing, being held to account and holding their staff to account.

Business Plans for provision of services to the specification of Contracts monitored by GP Fund holders and Commissioning Boards. [WHSSB and Northern HSSB]

Externally validated education programmes viz.
Management Development Training – validated coursed provided in conjunction with external institutions e.g. University. Institute of Health Services Management .
NVQ system with External Verifiers.

Undergraduate Medical Education programme with QUB
Undergraduate Medical Placements from University College Galway
Specialist Higher Professional Training for Doctors approved by respective Royal Colleges and Post Graduate Deanery Standards
Under and post graduate nursing Programme and placements QUB and U of U.

Clinical Audit Programme
Drugs and Therapeutic Committee.

Monthly morbidity and mortality meetings – the recommended pattern of Peer Review over many years in medical specialies.

Emerging Clinical Governance Framework. Attachment.
Clinical Incident Reporting mechanisms.

Whistle Blowing Policy
I am unable to source pre-2001 but I recall that Management Executive issued preliminary advice around the time of Bristol Inquiry. A number of initiatives were put in place to encourage staff to report any concern. A feature of this was that each Induction course for new staff included advice on how or whom to contact and on the fact that it was a duty of every individual to report concerns about care.

Introduction courses for new course included responsibility for reporting concerns.

(17)Was there any system of independent external scrutiny in place to review clinical performance in the AHHSST, and if so please detail the same?
The system of External Scrutiny was similar to other hospitals in Northern Ireland and was a direct reflection of the rest of the UK up to about 2000 when the new regimes for clinical governance were being instituted in England,[Commission for Health Improvement] Scotland and Wales.
Historically there were formal external review systems for long term care of care but they were not applied to the Acute Hospital sector. In particular the Mental Health Commission had inspectorial rights to Mental Health and Learning Disability Hospitals.

The Acute Hospital sector was subject to reviews of various departments through different and external mechanisms, much of it associated with education and training of professionals viz., Inspection visits for Medical and Surgical Speciality Training by the Royal Colleges and Academic Advisory Groups.
Undergraduate Medical training inspections from QUB and Galway University
University of Ulster/ Queens University inspections for Nurse training.
National Audit participation – Clinical Standards Advisory Group [eg Stroke Audit]
Peer [National] Review undertaken by some Specialists .e.g. Respiratory
External Assessment for Clinical Pathology Accredition CPA
Regional Specialists – Peer Review / Audits

If standards were found not meeting the specified standards then Training Approval was withdrawn.

Data analysis through membership of CHKS for Benchmarking.

Area Boards commissioned services and sought evidence on Standards via visits and discussion with Clinicians.

Hospital Advisory Service Inspections – Spruce House
Inspection of services for disabled children – Childrens Department.

Frequent visits to wards and departments by Chairman of the Trust Board.
Ad Hoc visits to wards and Departments by Non Executive Directors.

Peer Review and audit through the NI Cancer Networks

Area Health and Social Services Council occasional visits.

Inspection and scrutiny against External standards specified earlier .e.g. ISO, CPA and IIP
ISO 13485 April 2001 issued to Hospital Sterile Supplies Department.
Clinical Pathology Accreditation
Investors In People 1999.

(18) Please describe the steps taken to disseminate, implement/enforce compliance with the recommendations deriving from external sources including the following:
The system for implementation of change and compliance with requirements from external sources was organised and delivered through the respective Management or Clinical Directorates. I believe that among the standard methods commonly used by the Trust's Managers and purported by the academic experts were to:
appoint / designate a responsible person; cascade through ward/department leaders;
to implement as part of staff appraisal system via individual contribution; or to create a special task force or project group to complete implementation. Where a substantial change was required a Project Management approach [Prince Project Methodology would likely have been used.
Clinical Directorates had accountability reviews to monitor progress in all matters. In respect of the following :

(a) The Royal Colleges;

Recommendations from Royal Colleges were not necessarily mandatory and often required

additional resources. The College recommendations ,if adopted and resource neutral, would be introduced as described according to the magnitude of the recommendations.

When a Royal College recommendation required additional resources then that formed the basis of a business case which would be submitted to the relevant Commissioners of service. [e.g Recommendations on the provision of emergency theatre capacity to manage "out of hours" emergency surgery.]

In NI recommendations and guidance from Royal Colleges on District General Hospital capacity and specialist training requirements were the source of much debate when consultation was in progress around Acute Hospital Services.

(b) UK Central Council for Nursing, Midwifery and Health Visiting;
Recommendations tended to be directed to individual Registrants. The Director of Nursing provided guidance to the Trust on potential resource implications [and oversaw the development of Business Case where necessary] and ensured appropriate structures were in place to facilitate the implementation of the recommendation

(c) Paediatric Intensive Care Society;
There was only one Regional PICU in RBHSC

(d) Department of Health;
Refers to England and Wales not applicable as requirements in NI

(e) Audit Commission;
Implemented through the systems described above. I believe that on occasions recommendations were subject to directives from the Permanent Secretary to the Accounting Officer [Chief Executive] and required formal Report to the Permanent Secretary.

(f) General Medical Council;
Like the UKCC the recommendations may be mandatory for Registrants. The Medical Director advised the Trust on potential resource implications/Business Case and advised on structures for implementation.

(g) DHSSPSNI;

(h) HPSS;

(i) Management Executive.
[g] [h] and [I] recommendations and guidelines were implemented as described above, generally within a time frame and sometimes required formal reporting arrangements.

(19) In 2001 did the AHHSST have guidance or procedures in place governing communication with next of kin? If so please provide a copy of the guidance, policy or procedure (or if not possible, please describe its main features) and confirm:

(a) Whether the guidance, policy or procedure adopted by the AHHSST, was modelled on or informed by any published guidance, and if so please identify this guidance;
I do not recall Altnagelvin specific guidelines. The standards used were those taught in Registrants programmes and were part of the core skills expected of Registered Nurses and Doctors.

(b) How the guidance, policy or procedure was distributed to staff;

(c) How the AHHSST satisfied itself that the guidance, policy or procedure was being complied with?
Complaints revealed deficiencies in communications with patient or family. Where trends were identified then individual or group training opportunities were made available. I believe that occasionally more rigorous actions were required.

(20) Was there any discussion of Raychel's case at Trust Board level or at other hospital committee meetings? If so, please provide any record thereof.
I briefed the Chairman at the earliest opportunity and would have reported to the next Trust Board Meeting through Dr Fulton reporting on the facts and the Action Plan.
The Trust Board was committed to high quality care and to openness and was aware of my offer to meet with the family. The information would have been presented with out personal details.
It was my practice to inform the Trust Board of individual Critical or Serious Adverse Incidents.
Attachment Trust Board Missing Minutes.

(21) With reference to the assertion made in the Annual Report 2001-2002 (Ref: 321-004gk-042) *"Although the statutory responsibility for clinical and social care governance is not yet in place for Trusts, there remains a moral and professional responsibility to ensure that patients and the public can seek assurance relating to the standards within the Trust. These standards relate to the quality and outcomes of patient care as well as assurance that appropriate risk management procedures are in place"* **please explain what this means?**
It means that in the absence of a HPSSPS policy or law the Trust was encouraging best modern practice for clinical governance.

(22) In relation to your statement *"On completion of the first meeting of the Critical Incident Review which took place the following day, June 12th, Dr. Fulton and Therese Brown came to my office to discuss the meeting and advised me of the issues and the actions identified from the analysis and the further information being sought to confirm information"* **(Ref: WS-046/1 p.4) please state:**

(a)The time this meeting took place and the duration thereof;

The Western Trust has not been able to retrieve my diary and I am sorry that I am unable to accurately recall the time or duration of the meeting.

(b) Was this meeting minuted or noted, and if so please provided copy?
I recall the meeting, the issues, the anxiety and the plans for action. Notes made by Medical Director or Risk Manager were provided to the Inquiry. There was no stenographer or other minute taker.

(23) Did the AHHSST conduct any internal review of any of the following matters after Raychel's death:

(a) The procedures governing consent, and whether they were complied with; I am not aware that this was a concern.

(b) The records kept/made relating to the post operative care of Raychel;

The records were identified as an area requiring improvement..

(c) The records kept/ made of communications with Raychel's parents; Not to my knowledge.

(d) The competence and training needs of those who cared for Raychel; Yes.

(e) Urea and electrolyte testing and management; Yes.

(f) Fluid balance monitoring and recording; Yes.

(g) The calculation and prescription of intravenous fluids; Yes.

(h) The allocation of responsibility for the care of patients and the prescription and administration of intravenous fluids; Yes.

(i) The conduct of Post-take ward rounds/handovers; Yes

(j) The content and updating of nursing care plans; Yes

(k) The efficacy of the bleeper summonsing system; I am not aware of this.

(l) Whether there were any broader systemic failings in the provision of the care given Raychel? This was not identified.

If so please provide full details.
These are noted in the action plan and follow up was constant.

(24) Please state whether there existed a formal approach to:

(a) Assessing and developing the competence of the staff involved in the treatment of Raychel; Yes

(b) Disseminating outcomes and lessons learned internally both before and after the Inquest?

The conduct of the Inquest caused considerable trauma to a number of staff who needed support following it.

The clinical lessons learned following the critical incident review were still being reviewed, disseminated and audited and I believe continue to be so. I left the Trust in December 2004. I believe that the Trust continued to undertake audit, training and review of the issues identified both at the time of Raychel's death and following the Inquest.

(25) Please state whether:

(a) You attended any of the pre-Inquest consultations arranged by the Risk Management Co-ordinator (memorandum Ref: 022-029-073); No.

(b) You were supplied with any of the witness statements obtained for H.M. Coroner; I never read a witness statement supplied for H.M. Coroner for any case

(c) Whether you were briefed in respect of the commissioning of expert reports from Drs. Jenkins and Warde;

The commissioning of experts was not a matter I would have been involved with. I knew that reports would be sought. I recall being briefed that HM Coroner had an expert witness who contested our findings and that the expert had been involved in previous hearing involving Hyponatraemia.

I recall that I met Dr Jenkins at HPSS meetings but would not have had a conversation related to his report.

(d) You were consulted about the release of Dr. Warde's report to the Coroner; I do not recall that I was consulted.

(e) You gave any directions in respect thereof; I left Altnagelvin at the end of November 2004 and do not recall any consultation.

(f) Dr. Warde's report was furnished to the PSNI along with the other documents held by the AHHSST? I have no knowledge of this matter.

(26) Please confirm whether or not you received a report in writing into the case of Raychel Ferguson? If so please provide the same.
The Reports I read and received were the notes of the meetings and action plans and correspondence which I have read again on the Inquiry Website. I do not know of any documents other than these.
I had frequent contact with the staff responsible for follow up and was fully aware of the issues on an almost daily basis initially then on a regular basis once I believed that the lessons related to Altnagelvin were well under way and significantly that there would be a CREST Review on the safety of IV Solutions for children.

(27) Please state when you first became aware of the content of the following:

(a) The Autopsy report provided by Dr. Herron (Ref: 014-005-006);

(b) The report of Dr. Sumner to the Coroner (Ref: 012-001-001);

(c) The report of Dr. Loughrey (Ref: 014-005-014);

(d) The reports of Dr. Jenkins (Ref: 317-009-002 and 317-009-004);

(e) The report of Dr. Warde (Ref: 317-009-006)?

Was any consideration given to sharing the content of these reports with the Ferguson family? And if not why not?
The names of the above reports which I clearly recall are those of Dr Sumner and Dr Jenkins.

I believe that it would have been around the time of HM Coroners Court. The matters would have been discussed with me only for information.

I did not then, nor would I normally, have any direct contact with the process and procedures of the law enactment of the Coroners Court.
At the September meeting I assured Mrs. Ferguson that the Coroner would be the ultimate arbiter of information and would make his findings known..

These reports [listed above] were for the Coroners Court and it is my understanding that they would be made available to family solicitor.
The Trust would have followed established protocol for such matters and I believe such protocols are established by the expert advice of the legal profession.

(28) Please provide the following information:

(a) What involvement did you have with, or contribution did you make to, the Critical Incident Review conducted in 2001? I instructed that it should be conducted by the Medical Director.

(b) How much time was devoted to the meeting on 12th June 2001, giving approximate times of commencement and conclusion? I did not attend and do not know.

(c) Please advise whether you were in attendance at the Critical Incident Review meeting? As answered in [a] above I was not there.

(d) Were the meetings and deliberations of the Review minuted, noted or recorded? If not please provide reasons as to why not; Notes and Action plan were made which were shared with me after the meeting and are on the Website of this Inquiry.

(e) Were the staff members involved interviewed and/or asked to make a statement as part of the Review? If not please provide reasons as to why not; The notes describe what occurred at the meeting. I was not at the meeting.

(f) How was the admission and death of Raychel Ferguson categorised within the AHHSST statistical data in 2001? My overview of this as a Chief Executive is that admission/discharge data was put into the computer system by expert Clinical Coders. The admission, investigations, clinical diagnoses, internal transfer to ICU and subsequent transfer to Belfast PICU would all be part of the information derived by the Clinical Coders to input into the computer system

(g) Was any consideration given to inviting internal and external specialists to review the case of Raychel Ferguson?

The death of Raychel was catastrophic. Having been alerted to Solution No18 and after examination of the literature the reality of a potential danger in routine clinical practice was quickly identified. It was with a great sense of responsibility and with some urgency that preventative actions were immediately put in place, by the Clinical Director of Anaesthetics.

When the findings of the Review were reported to me there were no indicators of persistent patterns of poor care to cause the alarm bells or to trigger an external review. The nursing care in the ward was well regarded by the various consultants who had patients there. [Surgical specialties - Urology, Trauma and Orthopaedics and General Surgeons as well as the Paediatricians. The ward did not have a pattern of complaints.

The Nursing staff had recognised the weakness of their recording of observations and the issues related to objective measurement and were open and accepted that there were lessons to be learnt. The requirements for improved practice were underway as soon as the issues were recognised.

None of the staff involved in the Critical Incident Review had ever known of such a tragedy before. I discussed the findings of the review and the action plan and was assured that all staff would engage with the learning identified. Had there been an indication of a pattern of poor performance on the ward then I would have had no hesitation in seeking further scrutiny.

The scrutiny which I was most anxious about was to ensure a regional review of the IV

solution issues to prevent such a catastrophe recurring.

I knew that despite the best efforts of my colleagues to alert other hospitals there was a need for National Guideline which was beyond the capacity of our Trust or of the helpful communications undertaken by Dr Nesbit and Dr Fulton.

The Critical Incident Review had identified an overriding causative factor which required rapid action. The areas for improvement of practice were undertaken simultaneously. An unusual or idiosyncratic physiological response had precipitated the leading to the tragic death. There was no guideline which flagged up the danger of the solution. That was my overwhelming concern. It was my understanding that staff were open and spontaneous in recognising their responsibility and accepted the issues which were identified at that time. This was in keeping with good Clinical Governance which I understood at that time. The incident was notified widely and at all levels throughout the HPSSPS. I had not considered an External Review of Professional performances. I was concerned to ensure that the issue was examined with expertise and wider authority than that commanded by Altnaglevin hence my anxiety to ensure that there would be a CREST type review.

(h) When were you informed of the outcome of the Critical Incident Review, by whom and in what terms; and what steps were expected to be taken by you to ensure that the recommendations arising from this Review were implemented?

I was informed almost immediately following the first meeting and an immediate and urgent action plan was put in place. The Critical Incident Review and Action plan were at the forefront of the agenda for many months formally and in our informal discussions. The staff and management of the hospital were deeply sorry that such an untoward event could have occurred and were anxious to prevent a recurrence any where. Hence my proactive and open approach writing to Mr and Mrs Ferguson to invite a meeting and to the reporting of the incident to the HPSSPS.

It was our informed belief that No. 18 Solution was the substantial problem. The actions of the hospital were open, honest, in good faith and good governance. In good governance we responded to and learned from an overwhelming tragic death.

(1) (i)What information did you seek in relation to the Review, what meetings did you have and what personal fact finding did you undertake/instigate?

My diary cannot be accessed so I am relying on my memory when I say that I had frequent contact and probably two or three meetings in the first few weeks. I involved other Clinical Directorates and was reassured by the commitment and determination of the Medical Director and the Clinical Director of Anaesthetics that they, supported by the Risk Management department, would be rigorous in the follow through from the Critical Incident Review findings.

My Deputy Chief Executive, Raymond Mc Cartney RIP was fully briefed on the issues as I had planned to take some leave over the months of July and August.

I would visited the ward to assess that the atmosphere was not unduly affected by the sorrow and trauma of the loss of a child who should not have died. The specialities of Paediatrics and Sick Children Nursing are very challenging and sorrow at the loss of child is difficult and painful for the staff who are involved. The work to care for other children has to continue and support for the team is important to maintain confidence and competence in these situations. Ward leadership and the collegiality and confidence of consultant colleagues was

important in sustaining the provision of the service.

My personal fact finding entailed the normal rigorous questioning of the Medical Director, Clinical Director and Risk Manager and Mrs Witherow. I assured myself that they were giving priority to the issues and follow up.

I read some articles provided to me for reference. I would have given the closest attention to my responsibility and I would have discussed my understanding with expert colleagues to inform my thinking and decision making.

(j) Please describe the extent to which you believe the Ferguson family was fully informed of the causative factors of Raychel's death? At the September meeting I clearly invited Mrs Ferguson to make contact again after she had received the clinical notes. I had the Clinical notes sent immediately to the GP as I suggested at the meeting because I was concerned that Mrs Ferguson needed support. I duly sent the notes to the GP and wrote to Mrs Ferguson once again.
I had established an open and proactive approach to patients and to next of kin and met in that spirit.
I was clear and open in the invitation at the meeting and expected to hear from Mr or Mrs Ferguson when they felt ready.
Following that I did not feel I could be more proactive than I already had been by writing to Mr and Mrs Ferguson. Our meeting had not been helpful to Mrs. Ferguson but I had to leave the choice for further contact with Mrs Ferguson.

My office was adjacent to the room where the meeting took place. I bumped into some nurses as they were leaving. They spontaneously spoke to me of how dreadful the event was and of their profound sorrow. I said that I would be writing to the parents and I would let them know that they would also like to meet to express their condolences.. I subsequently wrote to Mr and Mrs Ferguson offering the opportunity to meet. Please refer to Inquest Inquiry website page.

Subsequently in August my office was contacted on behalf of Mr and Mrs Ferguson requested the meeting. A date and time suitable to the parents was were arranged.

There was no pre meeting briefing with Altnagelvin staff. My recollection is that I spoke to the staff, as we were met on the way to the meeting room, something to the effect that our purpose was to be kind, compassionate and honest to help Raychel's parents. We were clear that Raychel's death was unnecessary and tragic.

Mrs Ferguson attended without Mr Ferguson and had others as supportive representatives. In my recollection, I have the impression that someone had some paper and questions.

Mrs Ferguson seemed to be absolutely stunned and alone surrounded by people. I was trying to offer Mrs Ferguson care and empathy but felt then, and sadly know since, that I did not manage to reach her.

The information was given and was given as gently as possible and the questions asked by the representative were answered by staff spontaneously without direction or prompt. It was an extremely painful meeting for Mrs Ferguson and I was deeply concerned for her. When Raychel's Hospital Case notes were requested I suggested that the GP [who was present] should receive them and so hoped to ensure her contact so as to help Mrs Ferguson.

The September 2001 meeting happened following my invitation. I believe that Mrs Ferguson was

given our honest understanding of the issues, informed of improvements which had already been instigated, or were in process of change. I sensed that Mrs Ferguson was not sufficiently robust to be engaged with this process at that time. I gave Mrs Ferguson a clear invitation to make further contact and reassured her that the Patient Advocate would work on her behalf. I explained that her contacts or complaint would not prevent any further path [litigation] she may wish to take in the future. I was clear that the external judgement would be made by H.M Coroner and offered that reassurance to Mrs Ferguson. I was being open and kind because that is what I believe in.

I am deeply sorry that I was not able to establish the communication link that may have helped more. Mrs Ferguson did not take up the offer to make further contact.

Among those attending the meeting with Mrs Ferguson, was a member of Western HSS Patients Council. I therefore assumed that Mrs Ferguson was supported by the AHSS Patient Council. It is only recently that I read AHSS Councils papers on the Inquiry website and learned that the Western H&SS Council had in fact advised immediate legal action rather than pursuing a complaint before moving to legal redress.

(29) In respect of your statement (Ref: 098-267-721 *et seq*) please:

(a) Provide a copy of the Trust Strategy for Clinical governance;
Please find attached Clinical Governance.

(b) State whether your discussion with Therese Brown and Dr. Fulton on 12th June 2001 was minuted;
The Critical Incident Notes and Action Plan were fully discussed with me. I did not make separate notes when there was an Action Plan . The Action Plan was the basis for future meetings and updates.

(c) State in relation to your subsequent formal and informal discussions and appraisals whether minutes were taken of these;
The relevant officers had made notes for Actions and Update for me. It was custom and practice that the person to action noted their actions and reported back as necessary or at the next meeting.

I had regular meetings with staff who reported to me.

There was not a formal minute taker at operational meetings – Minute Takers were only provided for Formal hospital meetings. It was not my habit to duplicate notes and files that were the remit and direct responsibility of others. If progress was not satisfactory I would have made a note of the agreed improvement required and the date that it was required. A date would be arranged for the follow up meeting by my PA when I would have walked out of my office and requested the arrangement.

(d) State in respect of your work to "*cultivate a value system which implicitly and explicitly was to strive after excellence in the quality of diagnosis, care and treatment*" all that you did in this regard;
I was appointed Unit General Manager in January 1993 and commenced a programme of Organisational Development to support the goals for excellence in the quality of diagnosis, care and treatment.

Professional Practitioners were managed along their respective professional line of accountability. Team work was essential for good care but the "silo" lines of management tended to make multi disciplinary practice more challenging as each was reporting up separate lines of management. The silo system of single lines of professional accountability was being replaced by a system of general management and effective team work was an essential underpinning.

I embarked upon a programme for quality improvement which would involve staff from all departments and from all disciplines in the hospital, would facilitate team development and support the development of clinical audit.
Quality Circles popular at the time and, though inclusive in their membership, they tended to focus on the "soft" environmental matters - process rather than outcomes tended to be unattractive to Doctors.
Focusing upon Clinical and Care matters and anxious to make most of the talents of the staff I engaged the services of the Royal College of Nursing Professional Development expert. Some hundred plus staff from all disciplines were trained in Dynamic Standard Setting System [DySSy]. The DySSystem was amenable to clinical, environmental and experiential matters and proved an effective tool for the development of a culture of improvement, team work and audit.
Thus the HOSQIP Programme was launched and the hospital had trained Facilitators each of whom took responsibility for developing DySSy Quality Improvement Projects in their respective departments. Many staff presented their best projects [and occasionly, in keeping with the growing culture of openess, a worse project] to a hospital wide HOSQIP Annual Conference.
The success and sustainability of this initiative supported the many formal structures which sought to provide safe care and an open approach to improving quality and nurture a learning environment.

A Senior Nurse facilitated the HOSQIP development and was Quality Coordinator for nursing audits using externally validated tools such as Monitor to make assessments of the quality of care and Essence of Care Quality initiatives to facilitate improvement of nursing standards at ward level. Each Medical and Surgical specialty continued to develop improvements specific to their area of responsibility.
In 1996, in keeping with HPSS policy, Altnagelvin Hospital became a "self governing Trust" .The goals for quality improvement were encompassed into the Trust ethos and mission and were at the forefront of the accountability required by the Trust Board.

The trend towards Clinical Governance was evident in the Clinical and Management literature. In England, Scotland and Wales new organisations were being formed and new structures created within Trusts to support Clinical Governance. This was clearly a different culture and one which our Quality Improvement Programme had laid a solid foundation for. In this context the Trust began work to be prepared for the emergence on the Northern Ireland model of Clinical Governance and the expected statutory duty of Quality which became law in 2003
Medical Audit was encompassed into Clinical Audit and a Chairman of Clinical Audit Committee and members to oversee the programme of Audit appointed.
The Individual Performance Objectives of Directorates had objectives to support an emphasis on Clinical Effectiveness, and some task group work was undertaken to examine a framework and structures to facilitate the new approach and expected accountability for the implementation of Clinical Governance.

The Trust encouraged staff to network with other jurisdictions to learn from their progress on the issues.

(e) Particularise what you identified as your "*duty of care to the parents and family*"; I believed that it was my duty to offer care, compassion and information on the death of their daughter Raychel.

(f) **With respect of your statement "*staff who had been involved in Raychel's care and who wished to meet with the family attended the meeting*" identify those members of staff who had been involved in Raychel's care who did not wish to meet with the family. Please provide a list of those staff to whom invitations to attend were extended.**

When I returned from leave I was informed that the family had been in touch and wished to meet. I instructed that the meeting should be held at the soonest convenience for the family – Dr Nesbitt should be there – because he had the closest understanding of the No.18 Solution and the actions which we had taken to prevent any further tragedy. It was my belief that meeting those involved with the care of a loved one is helpful and Dr Mc Cord had been on the ward, Dr Nesbitt had undertaken the transfer of Raychel and they

would be familiar to the parents.

There may have been others who wished to be there but it was wisdom to minimise the number so as not to intrude on the level of grief and to maintain an ease of conversation and I would have asked that the ward was aware of that.

My hope was that our condolences, sorrow and regret that it happened would be helpful to the family. It was a human to human approach with an agenda to be helpful.

That was the ethos with which I undertook our responsibility to patients and their families.

The staff were given no brief other than to be gentle and answer questions openly. There was no script or choreography of the meeting.

(30) In respect of the *"Critical Incident Protocol"* (Ref: 026-012-016) please confirm the following:

(a) Whether you were provided with a completed *"Clinical Incident Form"*;
I read and understood the notes, forms and action plans shared by Dr Fulton, Ms Brown and Dr Nesbitt

(b) Whether the Nursing Director and solicitor were contacted to attend the Review;

I did not contact or instruct for the attendance of a Solicitor.

Had the Director of Nursing been available I would have discussed the issue with her. I did not see her over those few days and must assume she was unavailable.

(c) Whether the Review indentified any *"further investigations and action required to prevent recurrence"* and if so what these were;
The further actions were detailed on the notes and action sheets and were followed through as documented. July 9th Action follow-up . Please find attached documents in relation to *The written documents Clinical Incident Review Action plans and memo to the CMO show the line of connection and recording of the sequence of actions.*.

(d) Whether you were provided with a *"written report"* by the Risk Management Co-ordinator;
Please see attachment.

(e) Whether recommendations were sent to the relevant personnel for action, and if so what were they? Please see attachment.

(31) Regarding your email to the Chief medical Officer dated 3rd June 2004 (Ref: 023-021-048) and your statement that *"Altnagelvin heard a 'rumour' from Paediatrics Intensive Care Unit that the 'wrong fluids' had been used. This 'rumour' emerged from a nurse in Paediatrics Intensive*

Care Unit responding to an enquiry from Altnagelvin's Ward Nurse on the child's state, on the Sunday." **Please detail:**

(a) The identity of the Ward Nurse;
I do not know

(b) Whether a record was made of this;
I did not write a note on this

(c) When it was brought to your attention;
Dr Nesbitt told me as part of his description of the issue he was reporting – the death of a child who should have had an uneventful recovery

(d) Whether it prompted any further communication with the Paediatrics Intensive Care Unit?
I did not have any contact with PICU. Dr Nesbit did inform me that he had spoken with Royal and subsequently had telephoned other hospitals with Childrens Units to alert them regarding No 18 solution.

(32) Please describe the structures in place in 2001, and their lines of accountability and responsibility, for:
Please see attached Trust Organisational Structure.
In general Policy was derived from Government guidance and instructions, legal requirements expert Guidance from external agents, or was generated because of local issues. The Northern Ireland Act 1998 imposed duties related to equality and all policy had to screened to assess need for Equality Impact Assessments.
When Policy was agreed and established it was approved at a defined level. This may have required Trust Board approval. The Policy implications were discussed by Hospital Management Team and Policy was then issued to Directorates. The implementation and monitoring was the responsibility within the Directorate but some policy was monitored through formal Audits undertaken on a hospital wide basis.
The development of Care Pathways and Guidance for clinical care has been emerging in recent years. It would be inaccurate to assume that there were policies for all aspects of care at that time.

(a) Clinical policy setting;
An appropriate Responsible person would be appointed to develop the policy within a given time frame. Most likely a task group would be brought together to ensure the fullest consideration and implications so that there would be widespread buy in from clinicians. There was a Policy and Procedures Manual.

(b) Clinical policy monitoring;
Clinical Directorates were responsible for all matters within their respective directorates. Sometimes Hospital wide or department audits would be conducted. When complaints or comments revealed questions of compliance then an examination of the patterns would be undertaken.

(c) The adoption of policy on clinical practice as a result of NCEPOD, NICE, GMC, UKCC, CREST and other relevant bodies.

GMC/UKCC Guidelines – issued to individual Registrants. Medical Director and Nursing Director would advise Trust Board on any policy or resource implications and ensure appropriate arrangements implemented by Directorates.

NICE Guidelines were emerging in 2001 but were not applied in NI until 2006

CREST was a task group team convened to agree guidelines where there was variation on clinical practice. The CREST Guideline would be issued to relevant Directorates which would then be responsible for dissemination and monitoring implementation and compliance.

NCEPOD recommendations were used to improve practice and where possible would be implemented. Often NCEPOD recommendations would have significant resource implications and substantial Business Cases had to be produced to attempt to secure the additional resources.

(33) With respect to the meeting with Mrs. Ferguson and others (minuted Ref: 022-084-215):

(a) State whether, before attending this meeting, you were briefed as to the outcome of the Critical Incident Review;
I was briefed immediately following the Critical Incident Review in June and was kept up to date with progress on the follow up.

(b) Do you believe that the representatives of the AHHSST answered the questions posed; I do

(c) Do you believe that the representatives of the AHHSST gave a full account of their understanding of the principle causes of Raychel's death; I do believe that each gave a full though not graphic account.

(d) Do you believe that the representatives of the AHHSST gave a full account of their understanding of the deficiencies in the care and treatment of Raychel; Yes.

(e) Why did you not tell Mrs. Ferguson of the hospital's agreed action plan (Ref: 026-008-009) and the review of procedures; I believe that Dr Nesbitt explained what had been done.

I explained to Mrs Ferguson that we were deeply sorry and that whilst the Coroner would give the independent view it was our belief that had we known about the potential danger of No. 18 Solution Raychel should have recovered. I also expressed my commitment to try to ensure it could not happen again.

(f) Why did you not direct that the consultant surgeon responsible for Raychel be in attendance at the meeting; The named Consultant had not met Raychel. He was not excluded but I did believe that we should not be overwhelming in numbers when meeting the parents.

(g) Why did you not advise Mrs. Ferguson that the Patient Advocate was an employee of the Trust and accordingly lacked independence;
I advised Mrs Ferguson that the Patient Advocate was there only to support her and act on her behalf. That was the role that the Patient Advocate was employed to do. In the circumstances of such a meeting with a grieving parent I would not regard it as helpful to be talking about the specifics of employment status. The role of the Patient Advocate was to pay attention to the needs of Mrs Ferguson and to be the familiar person with whom she could make contact in future. Mrs Ferguson was also attended by a representative of Area HSS Council which was an independent organisation.

(h) Please indicate all respects in which the minute of the meeting is inaccurate?

My view is that the notes taken by the Patient Advocate reflect her perception of the questions and answers for Mrs Ferguson.

When I met with a family in difficult circumstances or following a difficult or complex complaint the Patient Advocate attended in support of the patient or relative. All notes were kept by the Patient Advocate.

In the absence of a template and given that the spirit of the meeting was to be open with and helpful to the family I would never regard it as appropriate to minute that meeting.

If and when the process of dealing with the concerns, information needs or a complaint is complete and a family wishes to pursue legal redress then those meetings would be formally minuted and I, as Chief Executive, would not be part of that process.

(34) With reference to *"information for Trust Board on Inquest"*(Ref: 022-003-008) and the statement *"the Hospital has prepared a Press Statement for release following the Inquest"* please state whether consideration was given to the preparation of a Press Statement in the light of the evidence at Inquest and the findings of the Coroner?
I cannot add to what is quoted. I still recall my sense of harassment because of what felt like relentless headlines in local newspapers. I know that I would have wanted to avoid any defensiveness by the organisation which would have been perceived as unsympathetic to Mr and Mrs Ferguson.

(35) With reference to your letter dated 23rd November 2004 to this Inquiry (Ref: 021-009-021) assuring *"that Altnagelvin Hospital will give its fullest cooperation to the Inquiry team"* please state:

(a)Whether at that time you contemplated the withholding of two Medical Reports from Dr. Jenkins and one from Dr. Warde on the basis of a claim of privilege;
I did not.

(b)Who decided that these Medical reports should not be provided to this Inquiry? I understand that all reports were sent to the Inquiry after I left the Trust.

(36) With respect to the meeting with the WHSSC on 19th February 2003, and the minute thereof (Ref: 014-016-028), please state:

(a) Your role at this meeting;
I was Chief Executive attending at their request to represent the Trust.

(b) Whether the *"Press Statement"* provided by the Trust is the document contained at Ref: 023-003-003. If not please provide a copy of the same;
I believe so.

(c) Whether the PowerPoint presentation made by Dr. Nesbitt is that appearing at Ref: 077-005-006 *et seq*. If not please provide a copy of the same;
It appears to be as it is specifically geared towards a lay audience.

(d) **With regard to the statement *"Mrs. Burnside said in hindsight the Trust accepted the***

death could have been avoidable" **how it might have been avoided and why hindsight was necessary to accept that the death could have been avoidable;**

The note is written from the perspective of its author. From the moment when I was informed of the first findings of the Critical Incident Review in June 2001 it was clear that Raychel should not have died. That is what I believed in June 2001 and continue to do so. The sort of phrase I have so often used, is that if we had known then what we know now, [now being following the first Clinical Incident Review in June 2001] Raychel should not have died.

I reject the inference in the note that hindsight had only occurred at that meeting or around that time.

(e) The basis of the indication given that the *"outcome of the Coroner's Inquest [which] did not apportion blame to the Trust"***; On the basis of his written finding.**

(f) With regard to the statement *"there are 8 media sources all competing for stories about Altnagelvin"* **(Ref: 014-016-029) - what these stories might have been?**
I clearly recall media interest, particularly in local newspapers over a considerable period of time, was rife. I cannot remember the specifics as recorded in the notes made by the Area HSS Council Officer.

(37) In respect of the *"Update for Chief Executive Re: Critical Incident Meeting"* **(Ref: 022-097-307) please state what steps were taken by you to review the** *"further action required"* **and to ensure it was achieved. Please also state what steps were taken to address the concerns of nursing staff with respect to surgical inability to commit to children on Ward 6? The Critical Incident Update Note is dated 9th July and demonstrates the amount of activity undertaken and the responsibility accepted to ensure that any variable identified as needing attention, revision and training is already well underway.**
In relation to further action -
The Clinical Director of Surgery worked with General Surgeon colleagues to organise that General Surgical Children would be reviewed each morning.
I am not aware that this was audited.
Business plans were drawn up to provide additional General Surgical Theatre lists to prevent out of hours surgery. [This was an issue for the hospital and was not specific to this incident]
Each Clinical Director and Clinical Services Managers team met for accountability reviews with the Director of Business Services. They were held to account for the performance of the Directorate through this mechanism.

Documentation was reviewed, audited and some documentation was subsequently changed.

(38) **In respect of your Circular entitled "Information for Trust Board on Inquest" (Ref: 022-003-008) please detail all those briefings given the Trust Board in relation to the Inquest.**
I have attached a memo regarding "missing" Trust Board Minutes. I can clearly recall informing my Chairman and briefing the Trust Board at the next meeting after the death of Raychel Ferguson. My Trust Board was informed of any substantial untoward events. The practice of dealing with these substantial matters at Trust Board began following the "failed sterilations" in 1997. I did brief the Trust Board on this unprecedented tragic death and unique circumstance it is my recollection that Dr Fulton gave a clear account.

(39)In relation to the Memorandum issued to you by the Risk Management Co-ordinator dated 12th March 2002 (Ref: 022-036-097) please state:

(a) The identity of the *"Clinical Staff"* referred to; I am not sure.

(b) Whether you were informed as to what the *"factual inaccuracies"* in Dr. Sumner's report were considered to be; My recollection is not specific.

(c) Whether the Trust's Clinical Incident Review had identified these *"factual inaccuracies"*? The Trust Clinical Incident Review preceded Dr Sumner's report.

(40) Did you agree with the findings of H.M. Coroner in the case of Raychel Ferguson? Yes.

(41) When did you first hear of the death of Lucy Crawford? Around the time of the production of the TV Programme Autumn 2004

(42) Please provide such additional comment as you think relevant. It would be of very considerable assistance if you could attach any documents you may hold which may relate to procedures, strategies, policies or such issues as you think may be relevant.

I have no further details at this time.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed:

Dated: 1st July 2013

CURRICULUM VITAE – IN BRIEF

STELLA BURNSIDE

QUALIFICATIONS

• ACADEMIC and	B Phil[Hons] The Bigger Post Graduate Student Prize
• PROFESSIONAL	General Nurse, Psychiatric Nurse Clinical Teachers Diploma – with Credit Nurse Tutors Diploma – with Distinction

In June 2001 I was Chief Executive of Altnagelvin Hospitals Trust. I was a Registered Nurse for General and for Mental Health Nursing.

I retired in October 2007 having completed 40 years full time service in Health and Social Care Services in Northern Ireland.

CAREER HISTORY

1990 - 2007	Chief Executive, Regulation and Improvement Authority, I commenced this post on December1st 2004 and retired 2007
	After leading the Application for Self Governing Trust Status I was appointed by the shadow Trust Board on 1st April 1996 as Chief Executive Altnagelvin Hospitals, HSS Trust Unit General Manager Altnagelvin Area Hospital. Western Health and Social Services Board Unit General Manager, Foyle Community Unit, Western Health and Social Services Board
1980 - 1990	Nurse Tutor/ Course Director – Employed by NI Council for Nurses and Midwives - seconded to Magee College, NUU and University of Ulster [1980 -1990] Teaching Nurse Tutors Course and undergraduate nurses.
!970 - 1980	Nursing Posts Belfast City Hospital, Clinical Teaching post South Belfast , Musgrave Park Hospital Belfast City Hospital Clinical Teaching, Purdysburn Hospital,Windsor House, Holywell Hospital. NURSE TUTOR WESTERN AREA COLLEGE TEACHING GENERAL MENTAL HEALTH NURSING.
1967 - 1970	I COMMENCED NURSE TRAINING IN JULY 1967 AT BELFAST CITY HOSPITAL IMMEDIATELY UPON COMPLETION OF A LEVELS.
PROFESSIONAL MEMBERSHIPS	ROYAL COLLEGE OF NURSING INSTITUTE OF HEALTH SERVICES MANAGEMENT CHAIR NI REGION IHSM CIRCA 1993
EDITORIAL BOARD	CHURCHILL LIVINGSTONE PUBLICATIONS, 1982 -1990

CONFERENCE PRESENTATIONS	NURSING, NURSE EDUCATION, LEADERSHIP AND MANAGEMENT
Management and	Human Relations Group Training, Downshire Hospital 1973 Group Facilitator, Human Relations Training Groups, QUB Extra Mural Department 1973-1978 NI Leadership Development Programme Public Services Training Council. 1990
Leadership Courses	Federal Executive Institute,Virginia , USA: - 'Leadership for a Democratic Society' 1994 Kings Fund, London, Women as Leaders, 1998
EXTRA CURRICULAR AND VOLUNTARY	1997 – 1998 Member of University of Ulster Council 1993 - 1997 Member Broadcasting Council for Northern Ireland 1993 – 1996 Executive Committee Extern, NI, 2005 - 2012 Trustee, Ulster Orchestra 2007 2012 Member, Management Board, Foyle Haven
Previous Public appointment	1982 -1989 -Western Health and Social Services Board Member - Chairman, Social Services Committee
Current Public Service and Appointments	Commissioner on Equality Commission, Northern Ireland until -2014 Appointed Lay Member for Disciplinary Panels , Bar Council for Northern Ireland until 2015 Member Independent Monitoring Board NI June 2013 - 2016
Expert Advisory External	Member NHS Research & Development , Health Technology Assessment - Diagnostics and Screening Panel, London 1997 2003 NHS Confederation, Quality Policy Advisory Panel, London 1999 – 2005 Visiting Professor, University of Ulster 2006 - 2011
NI ADVISORY WORKING GROUPS	QUB ACADEMIC LIAISON COMMITTEE HPSS EVALUATION OF PURCHASER/ PROVIDER SYSTEM HPSS CONSULTANT APPRAISAL IN SERVICE NURSING EDUCATION
	OBE 2003 Medal [Humanitarian 2007] Russian Federation 2007 Deputy Lieutenant of the County of Londonderry 2002

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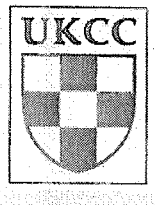

Protecting the public through professional standards

November 2003

CODE OF CONDUCT FOR HPSS MANAGERS

NOVEMBER 2003

2. I will respect and treat with dignity and fairness the public service users, relatives, carers, HPSS staff and partners in other agencies.

   As a manager I will play my part in making sure that no one is unlawfully discriminated against because of their religion, political opinion, beliefs, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or whether or not they have dependants. I will also play my part to ensure that:

- the public are treated with respect, are taken seriously, are properly informed and given the opportunity to influence services;
- relatives and carers are, with the informed consent of service users, involved in the care of service users and their experience is valued;
- policies on equality, diversity and human rights are promoted at all times;
- partners in other agencies are valued for their contribution to improving health and social services and have their ideas and ambitions taken seriously; and
- HPSS staff are:
  - valued as individuals, colleagues and are treated with dignity and respect;
  - appropriately informed about the management of the HPSS;
  - given appropriate opportunities to take part in decision-making;
  - entitled to have their ideas and realistic ambitions taken seriously;
  - given all reasonable protection from harassment and bullying;
  - provided with a safe working environment;
  - helped to maintain and improve their knowledge and skills and developed to achieve their potential; and
  - helped to achieve a reasonable balance betweentheir working and personal lives.

3. I will be honest and I will act with integrity and probity. I will ensure that:

- I act in an unbiased manner at all times;
- the best interests of the public and service users are upheld in decision-making and that decisions are not influenced by gifts or inducements;
- I understand and act on my responsibility to protect HPSS resources from fraud and corruption and that any incident of this kind is reported to the appropriate authority;
- information about my own performance or the performance of my organisation is presented accurately, consistently and correctly irrespective of the circumstances or consequences;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbaised and include all information which affects a colleague's performance, eligibility and conduct; and
- I contribute to the creation of an open and learning organisation where concerns about individuals perceived to be breaking the Code of Conduct can be raised without fear.

4. I will accept responsibility for my own work and the proper management of the performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by explaining and justifying the use of resources and performance;
- service users, relatives and carers by answering questions and complaints in an open honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance, making sure that patients are safe and improvements to service delivery will be made, and where appropriate giving an apology; and
- HPSS staff and partners in other agencies by explaining and justifying decisions on the use of resources and responding in an open way to suggestions for improving performance, the use of resources and service delivery.

5. I will support the Accountable Officer of my organisation in his or her responsibility to answer to Parliament/the Assembly, Minister and the Department of Health, Social Services and Public Safety by explaining and justifying the use of resources and the performance of the organisation in putting Government policy into practice and delivering targets.

6. I will show my commitment to team working by working constructively with all my colleagues n the HPSS and in the wider community, contributing to the creation of an environment in which:

- teams of staff are able to work together in the best interests of service users;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the HPSS plays its full part in wider community development.

7. I will take responsibility for my own learning and development. I will:

- participate in the relevant performance management or appraisal scheme;
- take full advantage of the opportunities provided by the HPSS for my personal managerial and professional development;
- keep up to date with best practice;
- be able to provide evidence of continuous development; and
- share my learning and development with others.

Produced by:
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November 2003
Ref: 190/2003

7. REFERENCES

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Altnagelvin Hospitals
Health and Social Services Trust

Health and Safety Policy

General Statement

The Altnagelvin Hospitals Health and Social Services Trust believes that the Health, Safety and Welfare of all (staff, patients and visitors), is a managerial priority.

The Trust recognises that personal health and safety at work is fundamental to job satisfaction and performance, and therefore the application of sound risk management principles to our everyday work is essential.

We therefore wish to create a health and safety culture which motivates and involves all staff in the organisation, and aims to reduce risk.

We are committed to:

- *Promoting health and safety as a management priority throughout the organisation.*
- *Monitoring health and safety compliance.*
- *The development of organisational structures to implement our objectives.*
- *Providing a safe environment through identification and control of risks to patients staff and members of the public.*
- *Consulting with staff to maintain high standards of health and safety.*
- *Providing information, and instruction to all staff.*

All staff have a vital role to play in protecting themselves, patients, colleagues and members of the public from workplace hazards.

We will also strive to improve the health of our staff by the development and the promotion of policies which encourage a healthy lifestyle.

This statement is an expression of the Trust Board's commitment to the management of health and safety matters. Detailed information is attached to this statement. Staff should also ensure that they familiarise themselves with their departmental health and safety policies.

This safety policy will be reviewed on an annual basis by the Hospital Executive and amended when necessary.

Signed:

Mr Denis Desmond
Chairman
Altnagelvin Hospitals Health and Social Services Trust

Dated: December 1999.

Safety Policy
Health and Safety Organisation

Management Roles

The **Chief Executive** has the ultimate accountability for ensuring that the organisation and arrangements for health and safety matters are effective in providing a safe working environment.

This responsibility for such arrangements has been delegated to the **Director of Nursing** as an important element of the Trust's Risk Management Strategy. The Director of Nursing, assisted by the **Risk Management Co-ordinator** will ensure that appropriate organisational arrangements are in place throughout the Trust.

Each **Director** within the Trust is responsible for the health and safety within their Directorate and must produce a health and safety policy for their Directorate and make adequate arrangements to ensure compliance with Health & Safety Legislation. Physical areas within the Trust which do not fall within a particular Directorate will be the responsibility of the Director of Business Services as a site management responsibility. Directors should encourage feedback from all levels of staff within the Directorate.

Each **Manager** must ensure that there are detailed health and safety arrangements within their areas of control and ensure risk assessments are conducted and safe working methods employed. All health and safety information must be relevant, accessible and written in a clear unambiguous format. Proposed changes in work practices, including the introduction of new equipment must be fully risk assessed.

Each **Supervisor** must ensure that work is conducted on a day to day basis in accordance with the health and safety arrangements and rules for their area. Hazards identified by individual member of staff must be reported to the manager to ensure appropriate action is taken.

Each **Employee** must ensure that they conduct their work in accordance with the health and safety arrangements and rules and ensure that they take steps to protect themselves and others who may be affected by their acts or omissions at work.

Relevant clauses will be included in job descriptions which outline the responsibilities of individual roles for health and safety matters and performance on health and safety matters is considered to be a vital component in overall performance assessments of Directors, Managers, Supervisors and individual staff.

Specialist Roles

Risk Management Co-ordinator

The Risk Management Co-ordinator is responsible for the dissemination of information on good practice regarding health and safety. He/she will also undertake audits/risk assessments, monitor accidents, and incidents and provide advice to managers. A fuller description of the role is contained within the job description. This person is the "competent person" as required by the Management of Health and Safety at Work Regulations (N.I) 1992.

Infection Control Officer

This role is filled by the Consultant Microbiologist who will ensure that arrangements are in place to monitor and control issues relating to Infection Control within the Trust. This role is supported by the Senior Nurse- Infection Control. Further details of these roles can be found in 'Control of Infection in Provider Units'.

Radioactive Substances "Competent person"

The Director of Clinical Support Services has been nominated as the "competent person" in accordance with the legislation governing radioactive substances. This role is to ensure that proper procedures are in place to comply with the terms of the legislation. Further details are available in the Radiation Safety Policy Document.

Radiation Protection Supervisor

There are designated officers within the Pharmacy and Imaging Services Directorates who are responsible for the development of local rules in respect of radiation safety and monitoring safety standards.

Legionella - 'Authorised Officer'

The Estates Manager is the "Authorised Officer" under regulations covering Legionella. He is responsible for the regular testing etc. required by the regulations.

Clinical Waste - 'Authorised Officer'

The Director of Business Services is the authorised officer for Clinical Waste. The role is to ensure adherence to statutory standards. Each manager is responsible for proper segregation and storage of clinical waste within their areas of control in accordance with Trust Policy.

Firecode

The Director of Business Services has responsibility for fire safety within the Trust. The post holder is supported by a "nominated officer" and "deputy nominated officers" throughout the Trust.

Fire Prevention Officer

This officer will monitor arrangements in respect of Fire, provide advice to managers and carry out regular inspections of work places. He/she will also provide instruction and training in the use of related equipment and ensure it is properly maintained.

Technical Equipment Manager - A Heaney

The Technical Equipment Manager ensures proper servicing is carried out on all medical equipment.

Departmental Equipment Controllers (DEC)

DECs are responsible for ensuring that all equipment but especially medical equipment is properly used and maintained and that appropriate training is given to all staff in their Department.

High Voltage/Low Voltage Officers

The Operations and Maintenance Manager and the Technical Equipment Manager are designated under the relevant regulations.

Personnel Department

Personnel Department provides advice and support to management in relation to the impact of health and safety on employment and other related matters.

Occupational Health Department

Occupational Health service has a role in providing compliance with all relevant aspects of health and safety legislation. They also advise management and staff on all matters relating to the effect of

health on work or work on health, with the aim of preventing ill health and promoting health.

Security

Responsibility for security matters lies with the Site Management Department, Directorate of Business Services who undertake to regularly review and update security measures within the Trust. All staff must read the Trust Security Policy.

Safety Representatives

The Trust believes that Safety Representatives have an important role to play in relation to health and safety at work but fully accepts that their role does not absolve the management organisation from their responsibilities.

Safety Representatives will be accorded the rights granted within the Regulations and Code of Practice and every effort will be made to involve them in health and safety matters through the sharing of appropriate information and discussing with them appropriate issues.

Committees

Trust Health and Safety Steering Committee

The Trust Health and Safety Steering Committee will act as a focal point for promoting, implementing and monitoring Health and Safety arrangements throughout the Trust.

The Committee will report to the Clinical Governance Committee and will provide them with regular information regarding Health and Safety matters and will make recommendations for improving Health and Safety in the Trust.

Staff Safety Committees

The Trust believes that a Staff Side Safety Committee is an important component in the overall health and safety field and supports the work of the Committee within the Trust.

General Health and Safety Arrangements

Training

Health and safety training is seen as an integral part of the training of staff at all levels of the organisation to enable them to understand and fulfil their roles. Such training will be included within induction and other appropriate training programmes as well as specific training to address specific issues such as new work arrangements, new equipment or new regulations.

Accident/Incident Reporting

All accidents or dangerous incidents must be reported through the line manager immediately in accordance with Trust procedures. They must be promptly investigated by managers to identify the cause and any remedial action required. Notification of all accidents/incidents must be made on the appropriate form. Also of importance is the reporting of near misses or individual concerns, as these can act as key indicators of potential hazards.

Monitoring arrangements

Monitoring of health and safety will be carried out by the Risk Management Co-ordinator through:-

- *Risk assessments.*
- *Accident/Incident reports.*
- *Annual reports from Directorates.*
- *Training*

Fire Prevention

Monitoring of fire precautions will be carried out by the Fire Prevention Officer particularly:

- *Testing of fire alarm system.*
- *Testing of fire fighting appliances.*
- *Fire drills every 6 months.*

Departmental Safety Inspections

Monitoring of health and safety arrangements are essential to maintaining a healthy and safe working environment. All managers must include arrangements for safety inspections within their Departmental Safety Policies including the recording of results and actions. The involvement of Local Safety Representations and/or Safety Committee members is encouraged.

Important Health and Safety Information

Risk Assessments

Risk assessment is considered to be the foundation for good health and safety arrangements therefore they should be conducted within all Departments within the Trust. Details of the hazards identified and the working arrangements instituted as a result must be included in the Departmental Health and Safety Policy.

Protective Clothing

The Trust will be responsible for the provision of protective clothing and footwear identified as required in accordance with the arrangements identified within the Personal Protective Equipment at Work Regulations 1992. Where the required protective clothing, footwear or other equipment has been identified and supplied failure by staff to use it will be deemed a disciplinary offence.

Work Equipment

All work equipment in use within the Trust will be managed in accordance with the Provision and Use of Work Equipment Regulations 1992; the main requirements of which are:-

(a) *suitability for purpose for which it is used or provided.*
(b) *having regard for the conditions in which it is to be used.*
(c) *that it is used only for the purpose, and under the conditions, for which it is suitable.*
(d) *it is maintained in an efficient state, in efficient working order and in good repair.*
(e) *maintenance logs keep up to date where appropriate.*
(f) *where there is specific risk the use of equipment is restricted as is access for maintenance etc.*
(g) *adequate health and safety information, training and supervision is provided.*
(h) *proper guards and other protective measures are in place in respect of dangers associated with the equipment.*

Dangerous Substances

All dangerous substances, (including body fluids), with which staff come in contact should be assessed under the requirements of the Control of Substances Hazardous to Health Regulations (COSHH). Such assessments shall form part of each Department's Health and Safety Policy.

Violence to Staff

The Trust recognises that violence at work is a potential risk for a large number of staff within the service. Local departmental safety arrangements must include details of the protection arrangements for staff, procedures for the recording of all incidents, the training of relevant staff etc. in order to minimise the risk to staff. Further information is available in the Trust Policy and guidelines on Management of Violence in the Workplace.

Manual Handling

Manual handling forms a part of most jobs within the Trust. The Trust wishes to reduce to a minimum the risk of injury to staff undertaking manual handling operations. All employees must be conversant with The Trust's Revised Manual Handling Policy.

First Aid

Due to the nature of the facilities operated by the Trust, all staff have ready access to medical and other trained professional staff.

Contractors

All contractors coming onto Trust premises will be under the control of a designated manager who will ensure adherence to the Trust's Safety Policy and safe working practices. The relevant manager will be designated at the time of assigning the contract or placing the order for services.

Designed and Printed by Medical Illustration Department, Altnagelvin Hospitals Health and Social Services Trust

POLICY FOR THE REPORTING OF CLINICAL INCIDENTS

February 2000

Introduction

Clinical governance is defined as 'a system through which NHS Organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish'.

Clinical Risk Management is an integral part of any Clinical Governance system and a key component of this is Clinical Incident Reporting.

Definition of a Clinical Incident

A clinical incident is a situation in which a patient is involved in an event which had a potential or actual adverse clinical outcome, which would not be expected to occur in the routine course of clinical events.

Clinical Incident Reporting

Clinical incident reporting is first and foremost an opportunity to learn and to improve our practice and secondly it acts as *'an early warning'* of impending clinical negligence claims.

Clinical incident reporting will aim to:

- reduce the recurrence of preventable adverse effects;
- minimise injury to patients;
- improve the quality of care for patients.

Clinical Incident Reporting enables clinicians or any member of staff to report a clinical incident which may or may not result in an adverse reaction for the patient being treated.

In an environment where staff feel secure and valued we want to encourage a culture of honesty and openness where mistakes and untoward incidents are identified quickly and dealt with in a positive and responsive way.

Procedure for Reporting Clinical Incidents

It is extremely important that any clinical incident should be reported on the appropriate documentation. Clinical incidents must be reported immediately to the line manager and should be recorded using the relevant section in the Incident Book. All incident forms will be sent to the Risk Management Co-ordinator who will:

- Inform the Chief Executive Medical Director Director of Nursing as appropriate;
- Contact all relevant staff and obtain detailed reports;
- Provide the Trust Board with details of trends.

Duties of employees

It is clear that the success of a Clinical Incident Reporting system will be dependent on staff participation. Clinical Staff are reminded of their professional accountability under their code of conduct for the standard of care they provide and implicit in that context is the responsibility to report clinical incidents.

Quality Improvement

Reviewing incidents will enable the Trust to pay particular attention to any deficiencies in procedures or practices which may have contributed to the incidents and will formulate directions and recommendations designed to eliminate or minimise the incidence of similar occurrences.

Signed _____

Stella Burnside, Chief Executive

Policy to be reviewed in one year

Altnagelvin Hospitals
Health and Social Services Trust

Clinical Audit Report 2001/2002

CLINICAL AUDIT RESEARCH AND QUALITY SYMPOSIUM

THURSDAY 13TH SEPTEMBER 2001, LECTURE THEATRES, CLINICAL EDUCATION CENTRE

SB P4

11.00am: Welcome and Introduction,
: **Mrs Burnside, Chief Executive**

11.05am: Clinical Governance – Strategy for Altnagelvin,
: **Dr Raymond Fulton, Medical Director**
: **Dr Michael Parker, Chair Of Clinical Audit**

11.45am: Role Of HOSQIP in Altnagelvin,
: **Mrs Jean Johns, Chair of HOSQIP Committee**

12 noon: Promoting Safer Handling Practice in the Care of Non-Weight bearing Patients with Stroke
: **Staff Nurse** [redacted]

12.15am: Transferring a Ventilated Child
: **Staff Nurse Mary Mc Kenna**

12.30pm: Lunch

1.30pm: Overview of Research
: **Dr** [redacted] **Chair of Research Committee**

1.45pm: An Assessment of Pressure Risk During Prolonged Radiology Procedures
: **Mrs** [redacted]

1.55pm: Determination of a DCCT Aligned Glycated Haemoglobin Reference Range in Non-Diabetic Pregnancy
: **Dr** [redacted]

2.05pm: A Single Blind Randomised Controlled Trial Comparing Two Methods of Preparation for OPD flexible Sigmoidoscopy
: **Mr** [redacted]

2.15pm: Audit Agenda for the Trust.
: **Dr Michael Parker, Chair Of Audit Committee**

2.25pm: Audit of Wound Swabs, Knowledge and Practice
: **Mrs** [redacted]

2.35pm: Audit of analgesia for Post – Operative Caesarean Section Patients
: Dr [redacted]

2.45pm: Audit of CTG Record Keeping
: Mrs [redacted]

2.55pm: Audit of Manual Removal of Placenta
: Dr [redacted]

3.05pm: Eye Casualty Audit
: Mr [redacted]

3.15pm: Long Term Faecal Incontinence following Milligan-Morgan Haemorrhoidectomy
: Mr [redacted]

3.25pm: Laparoscopic Cholecystectomy in Altnagelvin – A Seven Year Audit
: Mr [redacted]

3.35pm: Sentinel / Stroke Audit 2
: Dr [redacted]

3.45pm: Audit of Neutropenic Sepsis
: Dr [redacted]

3.55pm: Care Pathways
: Mrs [redacted]

4.10pm: Presentation of Prizes

4.15pm: Close of Symposium
& Tea and Coffee

AUDITS GIVEN ASSISTANCE BY THE CLINICAL AUDIT DEPARMENT

REGIONAL AUDITS

TOPIC	PRESENTER	ASSISTANCE
Dermatology BCC audit	Dr [redacted]	60 notes
Thrombolysis audit	[redacted]	Admin support
National Sentinel Stroke Audit	Sister [redacted]	60 notes Data input
Regional Hepatitis C Audit	Dr [redacted]	20 notes

ANAESTHETICS

TOPIC	PRESENTER	ASSISTANCE
Acute Renal Failure	Dr [redacted]	60 notes
Epidural in major surgery	Dr [redacted]	20 notes

GENERAL SURGERY

TOPIC	PRESENTER	ASSISTANCE
Ureteric stone	Dr [redacted]	100 notes
Cholecystectomy	Mr [redacted]	600 notes
Percutaneous nephrectomy	Dr [redacted]	40 notes + x-ray's
Malignant stomach	Mr [redacted]	50 notes
Bowel Symptom Questionnaire	Mr [redacted]	Formic design (2000) 450 records on database

MEDICINE

TOPIC	PRESENTER	ASSISTANCE
PEG Tube Audit	Dr [redacted]	50 notes
Urinalysis Audit	Dr	85 notes
Barretts Oesophagus	Dr	150 notes
Paediatric Discharges	Dr	60 notes
Post ERCP	Dr	200 notes
Wd22 Admissions	Dr	40
Stroke Audit	Dr	50 notes
M.I. Audit	Dr	50 notes

OB'S & GYNAE

TOPIC	PRESENTER	ASSISTANCE
Retained placenta	Dr [redacted]	Formic questionnaire analysis
Diagnostic Laparoscopies	Dr [redacted]	40 notes
Patient counselling	Dr [redacted]	50 notes
Caesarean Section Counselling	Dr [redacted]	30 notes

OPHTHALMOLOGY

TOPIC	PRESENTER	ASSISTANCE
Ophthalmology	Mr [redacted]	Database set up
Optometry screening	Miss [redacted]	Formic Questionnaire
Ophthalmology	Dr [redacted]	50 notes
BCC Eyelids	Dr Mc [redacted]	Formic Questionnaire analysis

NURSING/PAMS

TOPIC	PRESENTER	ASSISTANCE
CTG Traces	[redacted]	Statistics/Analysis
Cardiac Arrests	[redacted]	Statistics/Analysis
Day Case Unit	Sister [redacted]	Statistics/Analysis
Ante-Natal Visits	[redacted]	Statistics/Analysis
Physio Staff	[redacted]	Statistics/Analysis
Questionnaire		
Junior Doctors Hours	[redacted]	Statistics/Analysis
Reflexology Audit		Statistics/Analysis
Diabetes Audit		60 notes

DB(NI)

BULLETIN

Management and Use of IVD Point of Care Test Devices

HEALTH ESTATES
ESTATE POLICY

An Executive Agency of the Department of Health, Social Services and Public Safety

Áisíneacht Feidhmeannach don Roinn Sláinte, Seirbhísí Sóisíalta agus Sábháilteacht Phoiblí

DB(NI)2002/03
June 2002

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

PROCEDURE FOR HANDLING COMPLAINTS, ENQUIRIES AND COMMENDATIONS

Reviewed October 1996
Reviewed April 1998
Reviewed March 2002
Reviewed February 2005

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

PROCEDURE FOR HANDLING COMPLAINTS, INQUIRIES AND COMMENDATIONS

AIM

The aim is to ensure that Altnagelvin Hospitals Health and Social Services Trust has an effective and efficient complaints procedure focusing on satisfying complainants concerns.

The purpose of the complaints procedure is to ensure that staff learn lessons from complaints and improve the quality of our services.

One officer will act as the focal point in relation to all complaints, inquiries and commendations received. This officer will be known as the Patients Advocate.

In order to standardise the processing of all complaints, inquiries and commendations the following procedure will be implemented:-

WRITTEN COMPLAINTS:

(1) **Complaints received by Officers other than Patient Advocate:**

(i) Letters of complaint must be forwarded (upon receipt) to the Patient Advocate.

(ii) The Patient Advocate will immediately issue an acknowledgement letter within two working days indicating investigations underway. (Appendix 1)

(iii) A copy should be held by the Designated Manager (Appendix II) who will be responsible for investigating the issue and advising in writing the Patient Advocate.

(iv) Relevant Managers should submit written comments to the Patients Advocate to enable an appropriate reply to be drafted.

(v) Comments and details of any remedial action taken should be forwarded to the Patient Advocate within 10 days of receipt of letter of complaint.

(vi) Correspondence will be held in the Central File in Patient Advocate's Office.

(2) **Complaints/Parliamentary Question received by Board Headquarters Charter Call:**

(i) This form of complaint/inquiry will be directed to the Chief Executive's Office or Patient Advocate Office.

(ii) Upon receipt the Patient Advocate will investigate in conjunction with relevant Manager(s) and draft the reply to the complainant - who initiated the original complaint.

(3) **Complaints received direct to the Chief Executive's Office/Patients Advocate:**

(i) The Patient Advocate will issue an acknowledgement letter within two working days.

(ii) If someone raises a complaint on behalf of a patient, the patient's consent will be obtained. Consent will be requested from NOK if the patient is deceased, or unable to consent.

(iii) The correspondence will be copied to the relevant managers highlighting the issues to be investigated.

(iv) Managers will provide written statements and/or comments to the Patient Advocate. In addition they will indicate any follow up action taken. Comments and details of any remedial action taken should be forwarded to the Patient Advocate within 10 days of receipt.

(v) The Patient Advocate will also be responsible for highlighting where any follow up action is indicated.

VERBAL COMPLAINTS IN PERSON/TELEPHONE TO THE PATIENTS ADVOCATE OFFICE:

(i) All verbal complaints should be noted on Formal Complaints Form and passed to relevant designated manager and acknowledgement letter within two working days.

(ii) Designated managers should ensure that appropriate action is taken in relation to verbal complaints.

(iii) Managers will provide written statements and/or comments to the Patient Advocate. In addition they will indicate any follow up action taken. Comments and details of any remedial action taken should be forwarded to the Patient Advocate within 10 days of receipt.

(iv) The Patient Advocate will also be responsible for highlighting where any follow up action is indicated.

(v) The Patient Advocate Office will maintain a summary of all verbal complaints with written complaints on a monthly basis.

THE LIMITS FOR ANSWERING COMPLAINTS

The current deadlines for answering complaints is two working days for an acknowledgement and 20 working days for a full response. If a full response is not completed within 20 working days time limit then a holding letter (Appendix III) is sent to the complainant informing them there is a delay and assuring them that a response is forthcoming as soon as possible.

INQUIRIES TO THE PATIENT'S ADVOCATE OFFICE

(i) All inquiries should be noted on appropriate form.

(ii) Patient Advocate should investigate and respond by telephone/letter as soon as possible

(iii) The Patient Advocate Office will maintain a summary of all inquiries.

COMMENDATIONS:

(1) Commendations received by Officers other than the Patient Advocate:

(i) Letters of commendation must be forwarded to the Patient Advocate on receipt.

(ii) The Patient's Advocate office will send a letter of acknowledgement (Appendix IV).

(iii) A copy of the original letter should be held by the Designated Manager who will be responsible for informing relevant staff.

(iv) Correspondence will be held in the Central File in Patient Advocate Office.

(2) **Commendations received direct to the Chief Executive's Office/Patient Advocate:**

(i) The Patient Advocate will send a letter of acknowledgement.

(ii) The letter commending services will be copied to the relevant Designated Manager by the Patient Advocate.

(iii) Designated managers will ensure that comments made are brought to the attention of relevant staff.

RECORDS AND MONITORING FOR COMPLAINTS/COMMENDATIONS:

(i) A central file for Complaints, Inquiries and Commendations will be established in the Patient's Advocate Office.

(ii) Written correspondence received will be filed along with any following correspondence.

(iii) Complaints are monitored under Clinical and Social Care Governance.

(iv) Complaints are identified, recorded and reported to the Equality Commission.

(v) CH8 Report Forms will be produced quarterly for the Department of Health.

VERBAL COMPLAINTS TO WARD/DEPARTMENT STAFF

1. Involved staff member remove complainant from busy area to a quiet area.

2. Listen attentively to complainant.
Remember no matter how hard we try we will not be able to meet the total expectations for every unique patient or relative so we must be ready to apologise. We do want to meet all needs.

3. Display friendly receptive attitude.

4. Remember do not meet aggression with aggression. Whilst trying to be objective and to understand the feelings of the complainant.

5. First responsibility to ensure if necessary the patient's health care needs are being met.

6. If the complaint is easily resolved action it immediately and record and complete verbal complaint form and forward to the Patient Advocate Office. (Appendix V)

7. If a complaint cannot be immediately resolved and can be resolved within a 48 hour period. Explain this to complainant and arrange a suitable time to give the information. Forward completed Verbal Complaints Form to the Patient Advocate Office.

8. If you are unable to action complaint within 48 hours then forward completed Verbal Complaints Form to the Patient Advocate Office for further investigation and resolution.

9. If complainant is unhappy with the local response refer to the Patient Advocate Office.

10. If complainant is complicated/multifaceted/multidisciplinary refer to Patient Advocate Office.

11. If complainant wishes to have their complaint dealt with more formally refer to Patient Advocate Office. Complainant can call in person, telephone or in writing.

N.B. Every member of staff has the responsibility of reassuring the general public. Complaints dealt with sensitively at this stage can often be defused.

The complaints procedure embodies the principles recommended by the 'The Wilson Report'. This entails simplicity, accessibility, responsiveness, impartiality, confidentiality and better quality, speed, cost effectiveness and accountability.

The complaints procedure will be concerned only with resolving complaints and not with disciplinary matters.

This is a two stage complaints procedure with the opportunity for the complainant to refer the matter to the Northern Ireland Commissioner for Complaints if he/she remains dissatisfied.

STAGE 1

There is a strong emphasis on rapid informal responses to complaints wherever possible and a greater emphasis on conciliation ensuring as much commonality as possible with the approach adopted for complaints against HSS Trusts and family practitioners.

One Officer will act as the focal point in relation to all complaints and commendations received. This Officer will be known as the Patient Advocate.

TIME LIMITS FOR MAKING COMPLAINTS

There will be a time limit of one year for a complaint to be made after the event being complained about, with the discretion for this time limit to be waived in appropriate cases.

TIME LIMITS FOR ANSWERING COMPLAINTS

The deadline for answering complaints is two working days for an acknowledgement, and 20 working days for a full response.

Presently if a full response is not completed at Stage 1 in the 20 day time limit then a Holding Letter is sent to the complainant informing of the delay and assuring them that a response is forthcoming as soon as possible.

STAGE 2

If complaints cannot be resolved by service providers, complainants will have the option of asking for a review which may include the establishment of a panel to reconsider the complaint. Panels will have a lay chair, a convenor and another independent person. They will have access to relevant professional advice. Health Service Boards will be responsible for screening all complaints for Stage 2 consideration.

The jurisdiction of the NI commissioner for Complaints will be extended to all complaints.

Reviewed February 2005
Mrs E. Way
Chief Executive

APPENDIX 11

List of Designated Managers

Nursing Staff	To Appropriate Clinical Services Manager and Clinical Director for each Directorate
Medical Staff	Direct to Appropriate Consultant /Clinical Services Manager and Clinical Director for each Directorate
Radiology	Consultant, Clinical Director and Clinical Services Manager
Pathology	Consultant, Clinical Director and Clinical Services Manager
Paramedical Services	Relevant Departmental Manager
Pharmacy	Pharmacy Manager
Support Services	Support Services Manager and Departmental Manager

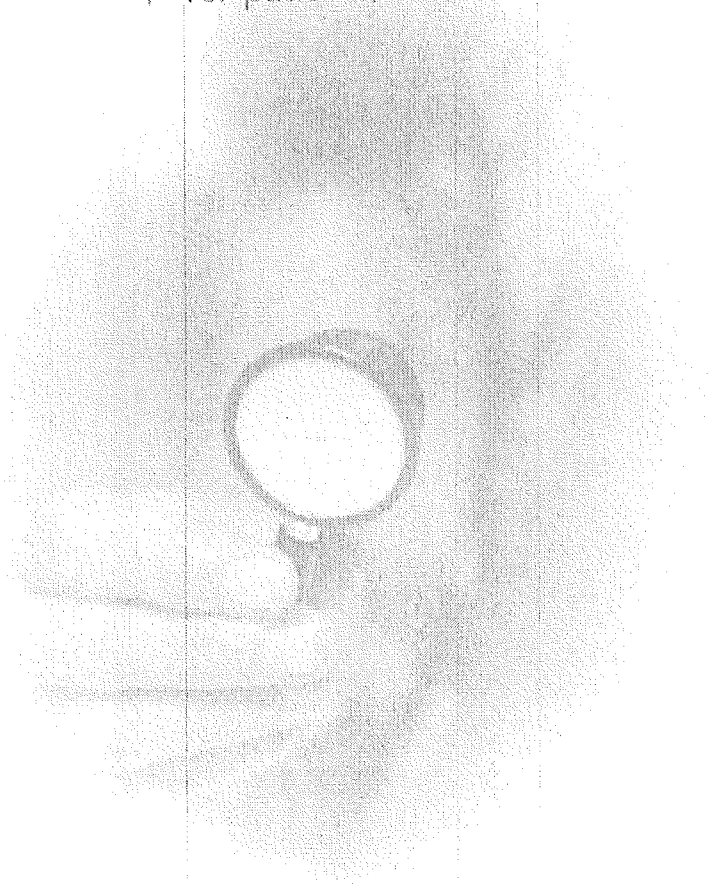
Confidence in the Future

for patients, and for doctors

A consultation document on the prevention, investigation and management of poor outcomes for patients in the Maternity Services

Confidence in the Future

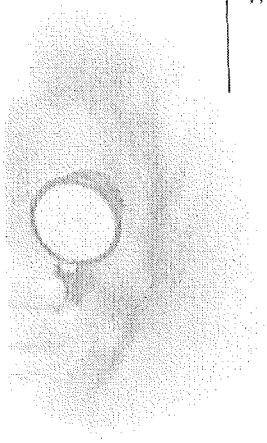
for patients, and for doctors



A consultation document on the prevention, recognition and management of poor performance of doctors in Northern Ireland

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteacht Phoiblí

Confidence in the Future



FOREWORD

We have been rightly proud of the achievements in the Health and Personal Social Services (HPSS). In particular, we acknowledge the dedication, skill and hard work of all our staff, often in very difficult and demanding circumstances.

There is little that is more important to us and to our families than our health. However, society does not stand still, nor do the developments and achievements within health care. The consequent demands and expectations placed on the health service have increased enormously in recent years.

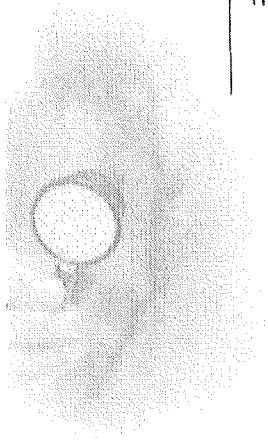
Our doctors make a significant contribution to the development of new treatments, new services and new patterns of care. Never before has their personal and professional performance come under more public scrutiny than at the present time. They are very conscious that the public reputation of the profession as a whole has been damaged by the poor performance of a few. To this end the profession have taken steps through their professional bodies, including the General Medical Council, to modernise their procedures for the prevention, detection and management of under-performance.

Although the problem is very small in Northern Ireland, it is necessary to modernise the processes in the HPSS to reduce this further. These should reflect the needs of patients and all doctors throughout their careers wherever they practice.

This document reflects similar publications which have been prepared recently to address the small minority of problem doctors working within the NHS.[1,2] It sets out proposals for the prevention, recognition and management of poor performance of doctors. Its primary aim is to ensure patient safety. In line with this aim, the Group is seeking a wide spectrum of views. I believe that this document proposes an approach in which the public, together with the medical profession, can be justifiably confident.

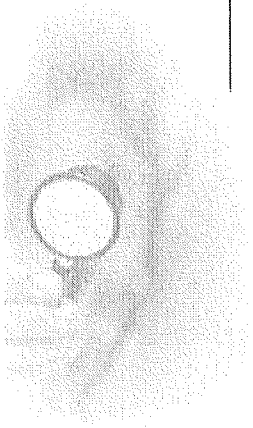
Dr. Henrietta Campbell
Chief Medical Officer

Confidence in the Future



CONTENTS

Confidence in the Future



INTRODUCTION

Recent publications have highlighted the need for modernisation in the Health Service. A key element in ensuring the quality of Health Services lies in the maintenance of the standards of performance of individual practitioners. Increasingly, doctors, together with other healthcare staff, have had to maintain their quality of practice against a background of:

- evergrowing workload;
- ongoing technological developments;
- rising public expectation; and
- ever widening range of explicit standards set by a variety of bodies.

At the same time, however, there have been a number of highly publicised instances where standards of practice have clearly fallen short of those considered acceptable. These events have given rise to public concern, undermined public confidence in the health service and damaged morale amongst staff. These incidents have exhibited some common themes:

- whilst a single incident has brought the case to light, investigation has tended to reveal a background pattern of poor practice;
- this level of performance was often known about informally; or
- formal mechanisms for addressing poor practice were not activated at an early stage.

One reason which may account for these problems is confusion about the respective roles and responsibilities of those charged with ensuring protection for patients. This requires greater clarity in the quality assurance activities undertaken by medical bodies as part of professional self-regulation and similar responsibilities discharged by the HPSS.

On the professional regulatory front, the GMC has been developing its procedures for ensuring competent clinical practice over the past decade. The initial stage was the introduction of fitness to practice procedures and the most recent is the proposed introduction of revalidation.

At the same time, it is recognised that health service arrangements for dealing with unsatisfactory performance are weak in a number of key areas: -

- in their provision of protection for patients;
- in their fairness to doctors;
- in their cumbersome, costly and legalistic nature; and
- in their inability to support the provision of high quality healthcare.

With a view to addressing these deficiencies and ensuring that medical practitioners in Northern Ireland are in a position to comply with the GMC's requirements for revalidation, the Chief Medical Officer established a working group with the following remit.

The Working Group has been established to -

- **Consider**

  procedures currently in place for the assessment of clinical performance and management of poor performance;

  proposed developments elsewhere in the UK; both within the Health Service and within the profession;

- **Advise**

  the DHSS & PS on guidance for new procedures in Northern Ireland, taking account of local administrative structures; and to

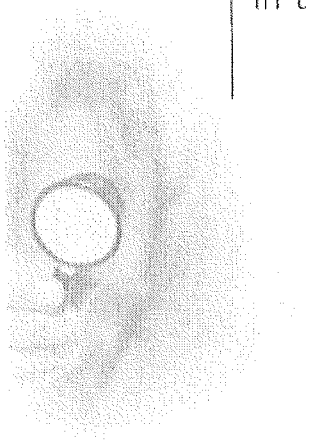
- **Consult**

  on proposed arrangements with a view to having procedures in place by April 2001.

The Working Group was established in March 2000 and the membership of the Group is included as Appendix 1.

In recognition of specific issues relevant to general practice, a sub-group representing wide interests was established. Their views are taken into account in this report.

Confidence in the Future



'WHAT WE ARE TRYING TO ACHIEVE'

The ultimate aim is that the public is assured that the doctor who treats them is well trained, highly competent and up-to-date in his or her practice.

In order to achieve this we need:

- widely accepted statements on standards of conduct, performance and ethics primarily aimed at the protection of patients;
- regulatory bodies working to explicit criteria, which are easily understood and widely publicised;
- better structures, particularly in primary care, and working environments which enable all doctors to provide a high level of care;
- a strong effective partnership between the HPSS and medical professional bodies to prevent, recognise and deal with poor clinical performance;
- well targeted continuing professional development for all doctors; and
- appropriate support systems for the small number of doctors who present with performance problems.

This should result in:

- doctors working in teams where adequate resources and support enable them to achieve and maintain a satisfactory standard of care;
- doctors with competency, conduct or ill health problems recognised at a much earlier stage than at present;
- doctors willing to report concerns about their colleagues;
- far fewer cases, than at present, of patients experiencing harm or sub-optimal outcomes of care due to poor practitioner performance;
- patients not put at risk or denied a response because the system fails to adequately resolve problems with a doctor's practice; and
- alternatives to the protracted, expensive procedures in place to address serious problems in performance.

CURRENT APPROACH TO POOR CLINICAL PERFORMANCE IN THE HPSS

Deficiencies in clinical performance may become apparent in a number of ways, such as:

- errors or delays in diagnosis,
- use of outmoded tests or treatment,
- failure to act on the results of tests,
- technical errors in the performance of a procedure,
- poor attitude in behaviour,
- inability to work as a member of a team, or
- poor communication with patients.

However, practitioners rarely work in isolation and individual problems may be a symptom of organisational deficiencies. Alternatively, an individual's performance may deteriorate as a result of health or personal problems. Information quantifying such problems is not readily available.

There are generally accepted weaknesses within the current system for managing deficient performance. These include:

- processes initiated as a result of a single serious incident which itself may only be the culmination of a pattern of deficient or deteriorating practice;
- the current system exhibits an over reliance on disciplinary action,[3] rather than prevention in the first place, early identification and remediation;
- the legalistic nature of current procedures acts as a deterrent towards early action;
- there is a lack of clarity between the roles of the GMC and the HPSS in ensuring satisfactory performance;
- processes for the identification and support of sick doctors are poor;
- there is a tendency to allow problem doctors to change employer and thus become someone else's problem; and
- the protracted timescales for dealing with problem.

Suspension of Hospital Doctors

Concern has been growing about inadequacies in the current procedures which provide for hospital doctors to be suspended[4] pending investigation of allegations of professional and personal misconduct.

Alert Letter System

A formalised system of alert notification exists within the HPSS[5], which should ensure that employers are informed of doctors or dentists who have been dismissed or suspended. The system is activated when the prospect of their continuation in practice gives rise to concerns for patients' safety. An alert letter may be issued where there is reason to believe that such

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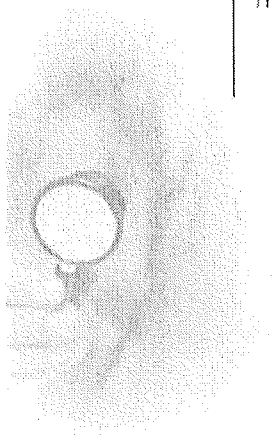

practitioners may seek work elsewhere. Although, generally, the system seems to operate effectively, it is not possible to guarantee that serious concerns are automatically shared with all parties with a legitimate interest.

Doctors in Private Practice

Given that the majority of doctors working in the private sector also practice in the HPSS, the issue of poor performance is a shared concern. As there may be more than one employer involved in these cases, problems can be exacerbated by poor communication between the two sectors.

Sick Doctors

Doctors at any stage of their career can be more prone to psychological disturbance than those in other occupations[6]. Some doctors have conditions that are unrecognised or concealed until their clinical performance is affected.

There are a number of options currently available to deal with this problem. These include:

- local HPSS procedures; including
- referral to the occupational health service, where this is available;
- a number of special national schemes [see Appendix 2]; and
- the GMC's health procedures.

In addition, the Postgraduate Dean provides a confidential counselling service for doctors in training.

HPSS Health Procedures

These procedures[7] were introduced in 1984 to assist the management of the 'sick doctor or dentist' whose clinical performance was below accepted standards. They were designed to function within the HPSS management arrangements prior to the establishment of Trusts. Often referred to as the "Three Wise Men", the procedures were not well understood, nor were they always effective. In the absence of other mechanisms, they were inappropriately used to deal with non-health related performance problems.

Summary

At present, the management of poor performance concentrates on the aftermath of serious events rather than their prevention. Currently, prevention is reliant on doctors maintaining a high standard of practice on an individual basis. There are no formal mechanisms to ensure this is effective. Available procedures are aimed at addressing serious deficiencies. They are often introduced at a relatively late stage when punitive action may be the only option. It is recognised that current procedures fail to ensure the continued maintenance of acceptable practice or address minor deficiencies that could be dealt with in a more constructive manner.

PROFESSIONAL SELF-REGULATION

The present system of professional regulation in medicine can be traced back to the mid-19th century when it was enshrined in the Medical Act of 1858. With this, came the establishment of the General Medical Council (GMC). The essential elements of self-regulation were the determination of standards of practice, the control of entry to the profession (through the medical register), and removal of a doctor from the register in specific defined circumstances. For over 100 years the Council's role changed little.

However, in recent years there has been a significant widening of that role as part of a process of modernisation. This has been supported by:

- standards for medical student education published in *Tomorrow's Doctors*[9];
- the publication of explicit standards for practicing doctors in *Good Medical Practice*[9]; and
- the establishment of new performance procedures to address a broader range of substandard practice as an extension of the GMC's traditional fitness to practice powers concerning conduct and health.

A related aspect of professional self-regulation is the management of postgraduate medical education. Following graduation, all doctors undertake a pre-registration year in designated heath service posts. They are assessed at the end of this year before they can become eligible for full registration. Doctors intending to pursue a career in general practice will spend a minimum of three further years before completing training. For those pursuing specialist practice, a further 6-10 years training can be anticipated following full registration. In all cases, assessment occurs at regular intervals particularly towards the end of the training period.

Thus, by the time doctors in training are in a position to practice independently, they have undergone a prolonged period of regular assessment. However, it is recognised that this situation is not universal.

The most recent development in medical regulation is the proposed introduction of **revalidation**. The aim of this process is the demonstration that doctors meet the standards of *Good Medical Practice* throughout their careers. Essentially, the burden of proof in future will be placed on individual practitioners who will regularly provide evidence that supports their continued registration. A consultation process on the GMC's proposals contained in *Revalidating Doctors - Ensuring Standards, Securing the Future,*[10] has been completed recently.

It is essential that all doctors have the opportunity to maintain their registration in line with the GMC's requirements. Arrangements within the HPSS must facilitate this process to ensure the quality of service.

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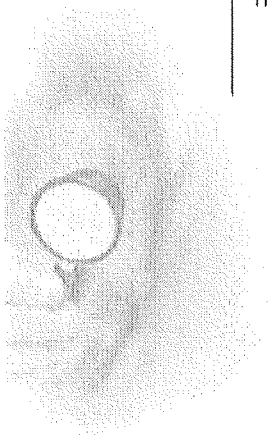

The Duties of a Doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern
- treat every patient politely and considerately
- respect patients' dignity and privacy
- listen to patients and respect their views
- give patients information in a way they can understand
- respect the rights of patients to be fully involved in decisions about their care
- keep your professional knowledge and skills up to date
- recognise the limits of your professional competence
- be honest and trustworthy
- respect and protect confidential information
- make sure that your personal beliefs do not prejudice your patients' care
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practice
- avoid abusing your position as a doctor
- work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

PREVENTION AND RECOGNITION OF POOR CLINICAL PERFORMANCE

It is evident that the current system is heavily reliant on the occurrence of serious incidents or complaints to trigger an assessment of a doctor's performance. There is an obvious need to replace this reactive approach with one that ensures maintenance of satisfactory clinical performance throughout a practitioner's career. This can only be achieved through regular assessment of all aspects of every doctor's practice. A key element of such an assessment is **appraisal.** Individual appraisal is one method whereby achievement and progress can be recognised and acknowledged, and weaknesses or shortcomings identified[11]. This, together with other assessment tools will provide a measure of individual performance and an opportunity to identify development needs. The motivation provided by annual appraisal would, in itself, be a preventative tool.

Consequently, it is recommended that:

- **a compulsory and comprehensive appraisal system which will meet the needs of the GMC for revalidation, the medical Royal Colleges for accreditation and the HPSS, be introduced for all doctors;**
- **everyone involved in the appraisal process should be adequately trained;**
- **participation in clinical audit be compulsory for all doctors;**
- **participation in programmes of continuing medical education (CME), and continuing professional development (CPD) be mandatory; and**
- **the early preparation of 'personal folders' for revalidation purposes, and to facilitate annual appraisal, be commenced.**

Further work is needed on the detail of the appraisal process:

- who will conduct appraisal;
- what information will be used to support the appraisal process; and
- what happens if the appraisal process does not lead to an agreed outcome.

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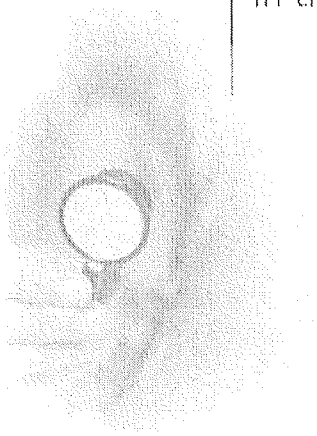


Appraisal in General Practice

Currently, there are management structures within the hospital and community sector which could provide the framework for the appraisal process. This is not the case in general practice.

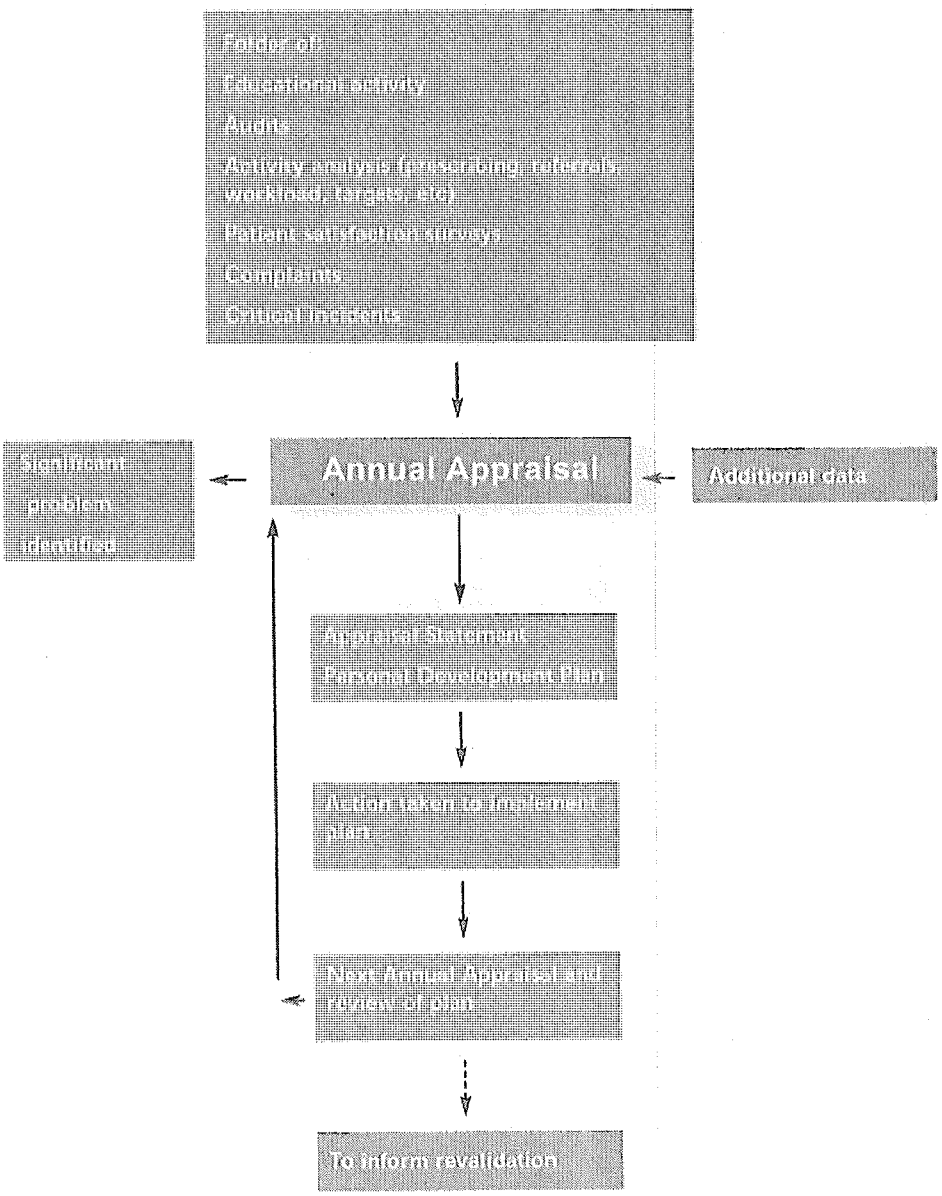
Within the current organisational framework of primary care, resources need to be identified to put suitable structures in place as a matter of urgency.

Under current arrangements, H&SS Boards have a responsibility to ensure that GPs meet their contractual obligations. However it would be inappropriate for the appraisal to be carried out solely by a H&SS Board Manager, as appraisal will address issues beyond contractual matters. Annual appraisal should be undertaken by a designated General Practitioner, with clear authority, who works within the locality.

There has been work aimed at setting standards for general practitioners[12]. This could form the basis for appraisal. There are specific issues which need to be considered to enable the introduction of appraisal in general practice. It is recommended that:

- **an independent Appraisal Body be established to co-ordinate appraisal in general practice.**

Suggested model for Annual Appraisal and Revalidation



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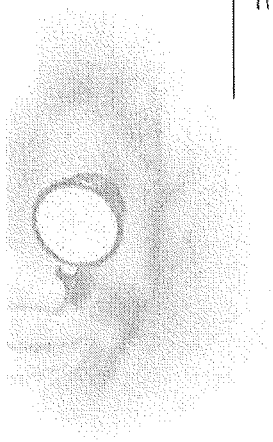


Doctors in Training

During training, junior doctors may change employer many times. Potential problems can be prevented by time spent at the beginning of each period of employment clarifying the expectations of trainer and trainee. It is recommended that:

- **thorough induction programmes should be in place, with clear explanation of departmental procedures and policies.**

This is the most effective way of ensuring satisfactory performance following a new posting.

It is important to remember that trainees' competencies will be limited. The extent of their responsibilities is dependent upon their experience which must be carefully assessed by the supervising consultant or GP. The expectations of their employer with regard to their attendance at educational meetings must also be made explicit, ideally through the training agreement.

It is recommended that:

- **clear guidance from senior doctors, along with appropriate supervision, is required when delegating clinical tasks to doctors in training.**

Locum Practitioners

Another group with specific issues relevant to good clinical practice are locum practitioners. These doctors are not in regular employment with a health service body but are frequently engaged to cover the absence of permanent staff. Good practice guidance on the employment of locums exists[17] but there is no current process to ensure the competence or continuing development of such practitioners. In recognition of the need for arrangements to remedy the current position, it is recommended that:

- **a Regional Register of all locum doctors be established.**

Doctors in training should have:-

- A written training agreement
- A full and proper induction programme
- Regular appraisal
- Regular assessment of competence and performance
- Clearly defined supervisory arrangements
- Responsibility tailored to competence
- Written policies and protocols

Health related Performance Problems

As stated earlier, health problems can underline poor clinical performance. Currently, the availability of occupational health services is limited, particularly for general practitioners. Traditionally, doctors have been reluctant to use such services, even when they are available. Consequently, it is recommended that:

- **regular health assessment be introduced for all doctors; and**
- **occupational health services be reviewed and strengthened for all doctors, particularly general practitioners.**

Organisational Problems

However, it is recognised that the finding of poor clinical performance in an individual may be a symptom of wider organisational problems. It is therefore necessary that HPSS organisations adopt procedures aimed at addressing problems and learning from them[14]. It is therefore recommended that:

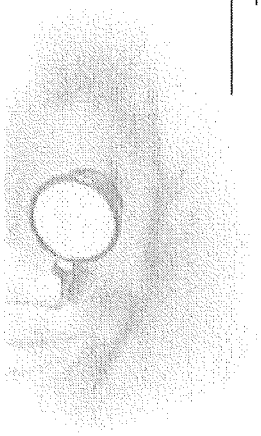
- **a framework for clinical governance in the HPSS, including primary care, be established as a matter of urgency;**
- **clinical teams with clear leadership roles and responsibilities be identified and established in every appropriate setting;**
- **methods of recording adverse events be put in place in every organisation, and a regional register established; and**
- **a regional database of performance case studies be established.**

These latter two proposals would contribute to a new basis for learning from mistakes or errors in the HPSS, either at a personal level or at a system level. The regional database of case experience would enable the HPSS to:

- monitor the incidence of underperformance;
- identify the factors which contribute to underperformance; and
- review the outcomes of investigation and resolution.

A new culture which sees the advantage of openness, rather than the current tendency towards secrecy and blame, is more likely to provide reassurance to patients and encouragement and support to doctors.

Confidence in the Future



It is recognised that there is a need to provide resources and facilities to ensure the development and maintenance of clinical skills. These would be available for all doctors, not just practitioners identified as underperforming. The following are recommended:

- **facilities for general skills training, e.g. in advanced life support, and other forms of emergency care, be established in appropriate locations; and**

- **a Regional Centre to provide advanced training in new methodologies, e.g. endoscopic interventions, be established and linked to a Regional Simulation Laboratory where competence and performance may be assessed.**

Summary

It is envisaged that the introduction of these arrangements will lead to a number of benefits:

1) Those doctors whose practice is satisfactory will have this explicitly demonstrated.

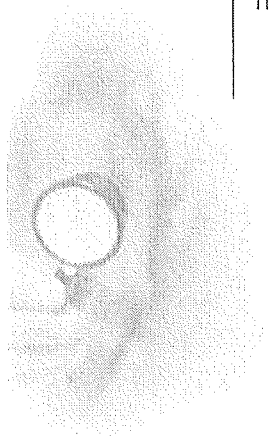
2) Professional development will be based on the results of appraisal and therefore directly related to the individual's ongoing needs.

3) Weak areas can be identified at an early stage and dealt with in a supportive manner with confidence that patient wellbeing is not compromised.

4) A register of locum practitioners should facilitate the new arrangements for revalidation in this group of doctors.

These measures are primarily preventative and will hopefully uncover problems at a much earlier stage than at present.

However, the system may still identify doctors with more serious difficulties. These may require further detailed investigation and formal steps to ensure patient safety.



on when appropriate. This is a new element and is a particularly important feature of what is proposed. It is a departure from the present where employers address professional performance using the existing disciplinary procedures.

Clinical dysfunction which is so serious as to warrant immediate referral to the regulatory body. There will be occasionally serious cases where such referral would be immediate. A decision whether to refer to the GMC would usually be taken after initial local evaluation or following receipt of external advice.

As part of this first stage, local procedures will require that the employer undertake an initial investigation to ascertain the facts relating to the situation. This should be carried out quickly, but it must also be comprehensive. The service would benefit from the development of good practice guidelines and training for clinical and medical directors and human resource staff in this important area. If this initial investigation indicates that the issues are too difficult to resolve internally, the employer should consider engaging the assistance of the appropriate medical Royal College 'rapid response team' (See Appendix 3).

Arrangements should be devised to ensure analogous procedures for primary care. Under current arrangements, these must involve the relevant H & SS Board.

Stage two:

Professional Performance Advisory Panel

If the employer is unable to resolve the difficulties following stage one, or is unclear as to what steps to follow, they may refer the case to the 'Professional Performance Advisory Panel'. This new body will be commissioned by the Chief Medical Officer to assist the service in resolving difficulties arising from the poor performance of doctors. The Panel may advise the employer to:

- continue to resolve the issues at a local level;
- refer the doctor to an appropriate 'professional assessment and support service'(see stage three below); or
- refer the doctor to the GMC.

Stage three:

Further Action

The Professional Performance Advisory Panel will have powers to commission services from an appropriate 'professional assessment and support service'. These services should be delivered within Northern Ireland, where possible. However, there will be occasions when it will be necessary for the assessment to take place in another region.

MANAGEMENT OF POOR PERFORMANCE

This section sets out arrangements for managing poor performance, once it is identified. When problems arise, it is apparent from past experience that:

- there is a variable approach to local investigation;
- there can be considerable delay in taking action when patients might be at risk; and
- there are occasions when the use of suspension is both inappropriate and unnecessarily protracted.

It is therefore recommended that:

- **Trusts and H&SS Boards adopt the following "Three Stage" approach to management of problems; and**
- **a Professional Performance Advisory Panel be established.**

Stage one:

Local Investigation and Resolution

When a problem occurs, an early view should be determined as to which category it belongs - personal misconduct, failure to fulfil contractual commitment, or concerns about clinical performance. In a hospital or community trust setting this will usually be undertaken by the Medical Director and Human Resource Director, and in primary care by the H&SS Board's Primary Care Medical Adviser.

Misconduct of a personal nature (e.g. theft, violence, deception, and sexual or racial harassment). This should be dealt with under the employer's internal disciplinary procedure or through contractor mechanisms; this is no different to the present situation.

Failure to fulfil contractual commitments (e.g. not turning up for clinics, undertaking private practice to the detriment of HPSS duties). This is also dealt with under the employer's internal disciplinary procedure or contractor mechanisms; this would simplify the present arrangements where there is often confusion about what is contractual and what is professional misconduct.

Doubts or concerns about clinical performance or professional conduct. This would lead to a new approach to investigation, with a more thorough review at a local level. In addition, external assistance or advice may be called

Referal to a 'professional assessment and support service' would provide:

- a diagnosis of the problem;
- a full impartial written assessment of its nature and seriousness; and
- recommendations for action.

This would be based on review of records, documentation, clinical audits, interviews with the doctor concerned and other staff as well as site visits. Other assessment methodologies would be used as appropriate.

The findings and recommendations following assessment would be made available to both the doctor concerned and the Trust or H & SS Board.

Doctors involved in a serious professional dispute which was jeopardising the functioning of a service could also be referred to the 'professional assessment and support service' if they were unwilling or unable to resolve their dispute.

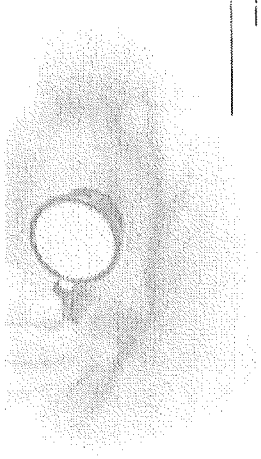
It would be for the local employer or H & SS Board to implement the findings of the 'professional assessment and support service' in each case.

Any retraining or reskilling of the doctor could be co-ordinated by the 'professional assessment and support service' in close liaison with the employer and using services designated as suitable for this purpose. The 'professional assessment and support service' would have to reassess the doctor as fit for return to practice at the end of this period. Similar liaison and reassessment could apply in cases of ill-health.

In a small number of cases there may be no prospect for remedial action within the scope of the doctor's current employment. Thus, where the report from the 'professional assessment and support service' concluded that the problem was "serious and intractable" the employer may decide to seek to terminate the doctor's contract or agree his or her retirement within its local procedures. These procedures would enable such cases to be fast tracked to deal fairly and quickly with the matter.

Where the problem is considered to have implications for the doctor's registration, parallel referral to the GMC must be made.

Confidence in the Future



Summary of possible outcomes following referral to a 'professional assessment and support service':

- The doctor could continue to practice. The report would give reassurance to the employer that there were no major problems and would give recommendations on criteria for monitoring if this is deemed appropriate.
- The doctor could continue to practice, but be monitored according to specified criteria. There were specific concerns identified but not sufficient to pose a significant risk to patients.
- A period of re-education and retraining followed by further reassessment.
- Re-skilling in another area of medical practice followed by further reassessment.
- Referral to formal GMC procedures (because the problem is so serious or complex that it could affect the doctor's registration or because there are implications for patients being treated outside the HPSS).
- Referral for medical treatment (under new procedures for sick doctors).
- Referral back to the employer with a report that assessed the problem as serious and intractable.

It is recognised that occasions will arise when the employing authority or H&SS Board will have to exercise their disciplinary powers. The current guidance is unwieldy, legalistic and slow. It is recommended that:

- **the current disciplinary procedures be abolished and replaced by fairer, quicker and more effective local procedures which integrate processes involving the HPSS and professional bodies.**

Protection of Patients by the Suspension of Doctors

The new system would retain the power of suspension for hospital doctors and it is proposed that such powers be extended to H&SS Boards in respect of general practitioners.

With the introduction of the 'Professional Performance Advisory Panel' and 'professional assessment and support services', suspension would only need to be considered when:

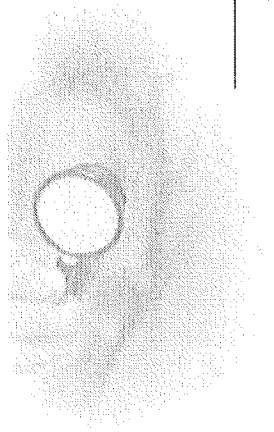
- there is an imminent danger to patients and a need to ensure that they are immediately protected;
- an employer or H&SS Board is investigating a matter of serious concern or taking action under its internal disciplinary procedures because of alleged personal misconduct or failure to fulfil contractual responsibilities;
- a doctor refused to be referred to a 'professional assessment and support service'; and
- an employer is dealing with a doctor who is referred back from the 'professional assessment and support service' with a report concluding that their problem is "serious and intractable".

Any doctor who is suspended would be required to give an undertaking not to practice in any capacity (including the private sector) until their position is resolved.

Summary

The present procedures used by the HPSS to deal with poor clinical performance need to be reformed along the lines outlined above.

They need to be simpler to utilise in practice and they need to be able to deal with the full spectrum of underperformance. This will necessitate a revision of current guidance.



ARRANGEMENTS FOR DOCTORS IN TRAINING

Doctors in training are employed by Trusts, in the main, and as such are subject to the Trust's disciplinary procedures. The Postgraduate Dean has responsibility for the doctor's education throughout the programme of training. The Dean, as the commissioner of training, has a legitimate interest in knowing that an investigation involving a doctor in training is taking place. As a general rule the Postgraduate Dean will not wish to be directly involved, but should be satisfied that matters are being handled in a fair and appropriate manner. The Dean will need to know the result of any investigation when it is completed.

Change of Employer during an Inquiry

Junior doctors are usually appointed to training programmes which involve a change of employer at frequent intervals. Often a disciplinary procedure will not be completed before it is time for the trainee to take up a new post. The trainee will be encouraged to continue to co-operate from the new post, if necessary by personal counselling from the Postgraduate Dean. It is recommended that:

- **the recipient Trust should be informed of the ongoing action and be required to facilitate the conclusion of the inquiry; and**
- **on conclusion of the inquiry the recipient trust, as the contract holder, will implement the findings.**

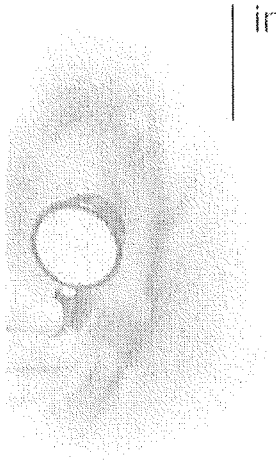
Patient safety takes precedence over an employee's right to confidentiality. The trainee has a right to know what information is being transferred and have an opportunity to challenge the accuracy, but not to prevent information being transferred. The information shared should be written and factual.

If there is no identified new employer, and the trainee does not agree to co-operate, it may be appropriate to contact the Chief Medical Officer about issuing an alert letter.

Remedial training

Where a trainee is moved for educational reasons, it is appropriate for the receiving trainer to have information about the areas of practice that gave rise to concern. This information may be necessary to protect patient safety, and is certainly necessary to ensure optimum educational supervision. This information should be transferred in writing through the Postgraduate Dean.

A distinction should be made between disciplinary procedures, which are rightly expunged from the employment record after a given time, and a training history. Subsequent trainers may have a legitimate interest in the training history, in the interests of safeguarding patient care as well as tailoring future training to the needs of the trainee.



ARRANGEMENTS FOR DOCTORS IN GENERAL PRACTICE

The proposals on management of poor performance put forward are relevant to those employed by the HPSS. These proposals do not easily translate to the contractual arrangements under which General Practitioners provide services.

Currently, H & SS Boards have responsibility to ensure:

- that there is proper adherence by all practitioners to their obligations under regulations. This includes the terms and conditions of service for GPs; and

- that adequate arrangements are put in place to ensure the probity of claims by GPs for payment through the Statement of Fees and Allowances.

In effect, however, H&SS Boards' statutory powers are very limited.

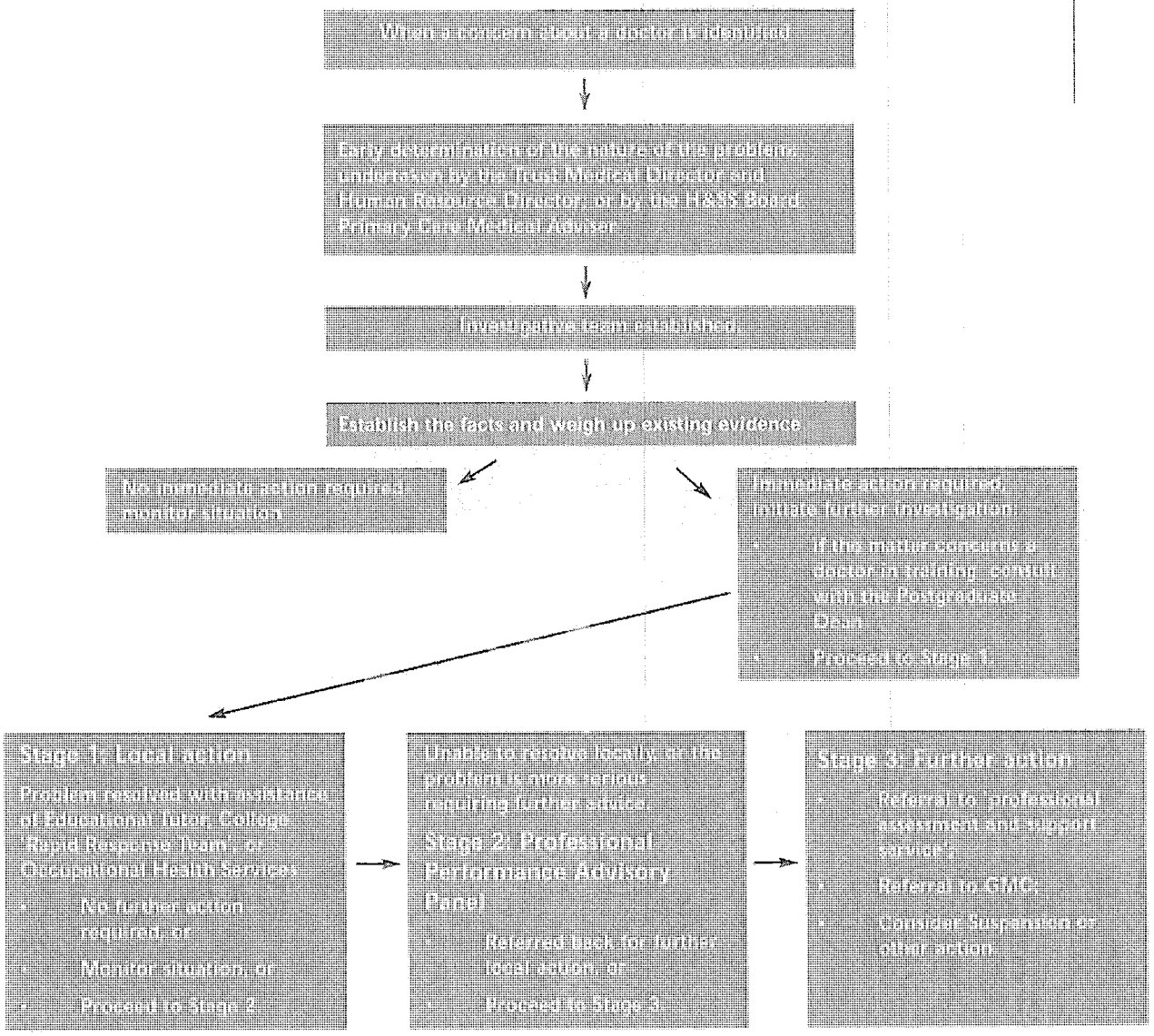
It is recommended that:

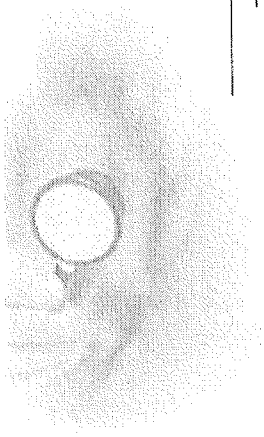
- **new powers must be granted so that concerns regarding performance of GPs can be investigated.**

Under current structures this would be facilitated by the relevant H&SS Board, and would involves setting up a small team to carry out an investigation of a GP, following the three stage approach recommended earlier. This would involve examining practice data and interviewing the practitioner and practice staff if appropriate.

Referral to this investigative process could be initiated by the appraisal process or as a consequence of complaints from patients, or other health care workers.

Model for Management of Poor Performance





SUMMARY OF RECOMMENDATIONS

Prevention and Recognition of Poor Performance

1. A compulsory and comprehensive appraisal system which meets the needs of the GMC for revalidation, the medical Royal Colleges for accreditation and the HPSS, be introduced for all doctors.

2. Everyone involved in the appraisal process should be adequately trained.

3. Participation in clinical audit be compulsory for all doctors.

4. Participation in programmes of continuing medical education (CME), and continuing professional development (CPD) be mandatory.

5. The early preparation of 'personal folders' for revalidation purposes, and to facilitate annual appraisal, be commenced.

6. An Independent Appraisal Body be established to co-ordinate appraisal in general practice.

7. Thorough induction programmes should be in place for all new staff, with clear explanation of departmental procedures and policies.

8. Clear guidance from senior doctors, along with appropriate supervision, is required when delegating clinical tasks to doctors in training.

9. A Regional Register of all locum doctors be established.

10. Regular health assessments be introduced for all doctors.

11. Review and strengthen occupational health services for all doctors, particularly general practitioners.

12. A framework for clinical governance in the HPSS, including Primary Care, be established as a matter of urgency.

13. Clinical teams, with clear leadership roles and responsibilities, be identified and established in every appropriate setting.

14. Methods of recording adverse events be put in place in every organisation, and a regional register established.

15. A regional database of performance case studies be established.

16. Facilities for general skills training, e.g. in advanced life support, and other forms of emergency care, be established in appropriate locations.

17. A Regional Centre to provide advanced training in new methodologies, e.g. endoscopic interventions, be established and linked with a Regional Simulation Laboratory where competence and performance may be assessed.

Management of Poor Performance

18. Trusts and H & SS Boards adopt the proposed 'Three Stage' approach to management of problems.

19. A Professional Performance Advisory Panel be established

20. The current disciplinary procedures be abolished and replaced by fairer, quicker and more effective local procedures which integrate processes involving the HPSS and professional bodies.

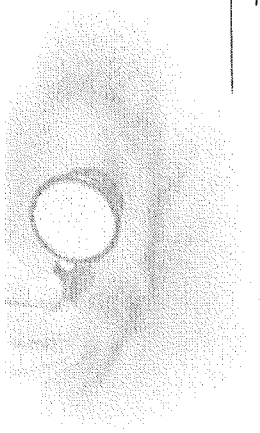
Recommendations for Doctors in Training

21. When a doctor in training transfers to a new employer before an inquiry or disciplinary process is complete, the recipient Trust should be informed of any ongoing action, and be required to facilitate the conclusion of the inquiry.

22. On conclusion of the inquiry, the recipient Trust, as the contract holder, will implement the findings.

Recommendations for General Practitioners

23. New powers be granted so that concerns regarding performance of GPs can be investigated.



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2 Department of Health. *Supporting doctors, protecting patients.* DoH: London, 1999.

3 DHSS (NI). *Disciplinary procedures for hospital and community medical and dental staff.* [HSS (TC8) 15/91]

4 DHSS (NI). *Disciplinary procedures for hospital and community medical and dental staff-suspension.* [HSS (TC8) 3/95]

5 DHSS (NI). *Issue of alert letters about hospital and community medical and dental staff under investigation by the HPSS.* [HSS (TC8) 6/98]

6 *Weinberg A, Creed F. Stress and psychiatric disorder in healthcare professionals and hospital staff. Lancet* 2000; 355: 533-37.

7 DHSS (NI). *Prevention of harm to patients resulting from physical or mental disability of hospital and community medical and dental staff.* [HSS (TC8) 1/84]

8 General Medical Council. *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education.* GMC: London, 1993.

9 General Medical Council. *Good Medical Practice.* GMC: London, 1998.

10 General Medical Council. *Revalidating Doctors – Ensuring Standards, Securing the Future.* GMC: London, 2000.

11 British Association of Medical Managers. *Appraisal in Action.* BAMM: Stockport, 1999.

12 Royal College of General Practitioners/General Practice Committee. *Good Medical Practice for General Practioners - a draft document for consultation.* RCGP/GPC: London,1999.

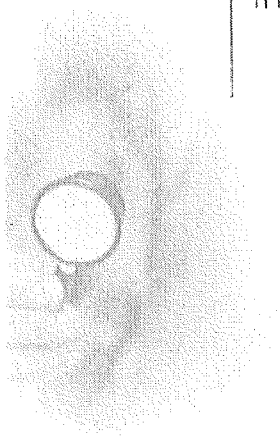
13 DHSS(NI). *A code of practice in HCHS Locum Doctors' Appointment and Employment.* (HSS (TC8) 2/98)

14 Department of Health. *An organisation with a memory – report of an expert group on learning from adverse events in the NHS.* DoH: London, 2000.

APPENDIX 1

Membership of Working Party

Dr Ian Carson (Chairman)	Special Adviser to DHSS&PS on Clinical Governance. Medical Director, Royal Group of Hospitals HSS Trust.
Mrs Stella Burnside	Chief Executive, Altnagelvin HSS Trust.
Dr John Jenkins	Chairman, Hospital Services Sub-Committee of the Central Medical Advisory Committee (CMAC). Senior lecturer in Child Health, QUB and Consultant Paediatrician, United Hospitals Trust.
Mr Seamus Magee	Chief Officer, Southern Health & Social Services Council.
Dr Jack McCluggage	Post-graduate Dean, N.I. Council for Postgraduate Medical & Dental Education.
Dr Jim McFarland	Consultant Physician, Medical Director, Ulster Hospital & Community HSS Trust.
Mr John McGrath	Director of Planning and Performance Management, DHSS&PS.
Miss Therese McKernan	Director of Human Resources, Greenpark HSS Trust.
Dr Anne Marie Telford	Director of Public Health, Southern Health & Social Services Board.
Dr Robert Thompson	General Practitioner, Chairman of the General Medical Care Sub-Committee of CMAC.
Mr Herbie Vance	Deputy Director of Human Resources, DHSS&PS.
Mrs Doreen Wilson	Chief Dental Officer, DHSS&PS.
Dr Paddy Woods	Medical Officer, DHSS&PS.



APPENDIX 2

Support Services

BMA Counselling Service:

This service is available to doctors and their families on a 24 hour basis. It provides a confidential facility for discussing personal, emotional and work related problems. Tel: 0645 200 169

The National Counselling Service for Sick Doctors:

This service is supported by the medical Royal Colleges, the Joint Consultant Committee and the BMA. It can be accessed by individual doctors or their colleagues or relatives. The service is confidential and is not linked to the GMC or any other statutory authority. Tel: 0645 200 169

Other Confidential Help Lines

The Sick Doctor Scheme, Association of Anaesthetists of Great Britain and Ireland.

Tel: 0207 631 1650

Doctors Support Network.

Tel: 01306 880 347

Sick Doctor's Trust (Helpline for addicted physicians).

Tel: 01252 345163

BMA Stress Counselling Service for Doctors.

Tel: 0645 200169

APPENDIX 3

Royal College Rapid Response or Service Review Teams

Telephone numbers for the initial contact point in the respective College or faculty:-

Royal College of Anaesthetists

The Chief Executive

Tel: 020 7813 1900

Royal College of General Practitioners

The Head of Corporate Affairs

Tel: 020 7581 3232 or 020 7584 2678

Royal College of Obstetricians & Gynaecologists

The President or a Vice-President

Tel: 020 7772 6228

Royal College of Ophthalmologists

The Chief Executive

Tel: 020 7935 0702

Royal College of Paediatrics and Child Health

The College Secretary

Tel: 020 7307 5600

Royal College of Pathologists

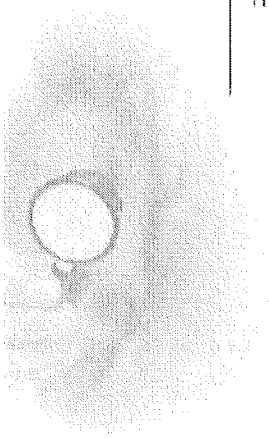
The Registrar

Tel: 020 7451 6700

The Royal College of Psychiatrists

The Vice-President

Tel: 020 7201 2601



APPENDIX 3 (continued)

Royal College of Physicians (London)
The Vice-President
Tel: 020 7935 1174

Faculty of Public Health Medicine of the Royal College of Physicians
The Vice-President
Tel: 010 7935 0243

Faculty of Occupational Medicine of the Royal College of Physicians
The President
Tel: 020 7317 5890

Royal Colleges of Radiologists
The Registrar
Tel: 020 7636 4432

Royal College of Surgeons of England (RCSE)
The College Secretary or Assistant Secretary
Tel: 020 7405 3474

Faculty of Dental Surgeons, RCSE
The Secretary to the Faculty
Tel: 020 7312 6667

APPENDIX 4

Glossary of Terms

Appraisal

A positive process to provide feedback on performance, chart continuing progress and identify development needs.

Accreditation

Formal recognition or approval of a clinical service or training programme from a recognised authority e.g. A medical royal college.

Assessment and support service

Structured service which aims to help those individuals who, for whatever reason, may need assistance in improving their performance.

BMA

British Medical Association.

Clinical Audit

A quality assessment and improvement mechanism in which health professionals peer review their practice, compare it to best practice and introduce improvements in line with their findings.

Clinical Dysfunction

A serious deviance from acceptable practice or failure to provide the service required by anyone in a clinical position.

Clinical Governance

A framework through which local organisations are accountable for the quality of service they provide.

CME

Continuing medical education

CPD

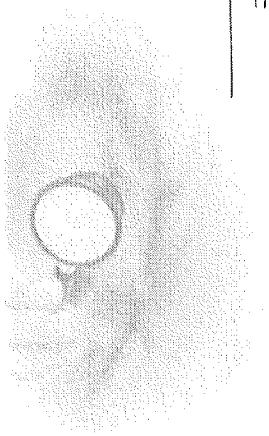
Continuing professional development.

Endoscopic Interventions

Surgical or other procedures conducted through instruments which are designed to be as minimally invasive as possible.

Fitness to practice procedures

The GMC's procedures for assessing whether a doctor's performance has fallen below the standards for registration.



APPENDIX 4 (continued)

General Medical Council (GMC)

The body responsible for maintaining a register of those suitably qualified to practice medicine.

Locum Practitioner

One who works on a temporary basis, usually taking the place of another doctor or filling a vacancy for a finite period of time.

Misconduct

Improper or unprofessional behaviour, such as theft, violence, and sexual or racial harrassment.

Personal Folder

A folder of information containing the doctor's relevant personal details; a description of what the doctor does; information on performance assessment; and evidence of continuing development.

Postgraduate Dean

A senior professional in a Region who is responsible for the organisation of doctors in training.

Primary Care

Those services, based in the community, which an individual can access on his/her own behalf. These cover a wide range of health professionals as well as social services.

Professional self-regulation

A system to control entry to and maintenance within a given profession.

Rapid response teams

Teams developed by Royal colleges to provide advice and assisstance where problems have been identified within a local service.

Revalidation

The regular demonstration by registered doctors that they remain fit to practice in their chosen field(s).

Simulation laboratory

A facility designed to replicate the working environment.

Underperformance

The repeated failure to meet acceptable standards over a period of time.

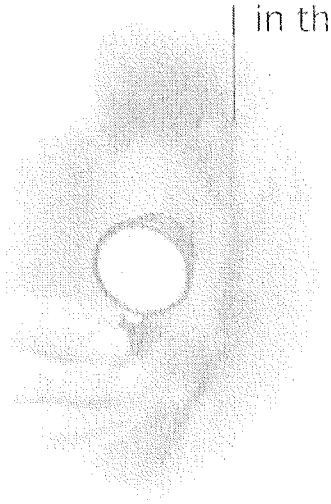
APPENDIX 5

Implications for other Clinical Professionals, including Dentists

In May 2000 the General Dental Council considered a document setting out the framework for the Council's Performance Review Scheme and Fitness to Practice. Traditionally, the General Dental Council has operated a system of reactive regulations founded on the presumption that all registered dentists are fit to practice. Performance Review will allow preventive action in the interests of public protection. It will serve this purpose through procedures for preventing, recognising and dealing with poor clinical performance.

A successful Performance Review Scheme will protect patients from poorly performing dentists by restricting or suspending their right to practice when necessary.

It will also provide a framework for their re-education and restoration to safe and acceptable practice.



HOW TO RESPOND

The consultation period will end on 12th January 2001. Written responses may be sent by post or by electronic mail to the addresses shown below.

Mrs I Wilkinson
DHSS & PS
Room C4.22
Castle Buildings
Belfast BT4 3SJ

confidence@dhsspsni.gov.uk

If you have a query about any of the issues raised in this document you may telephone 028 9052 0723 or write to / e-mail the above addresses.

In keeping with policy on openness, responses to this document may be made available to the public on request. If you do not wish your response to be used in this way, or if you would prefer it used anonymously, please let us know when responding.

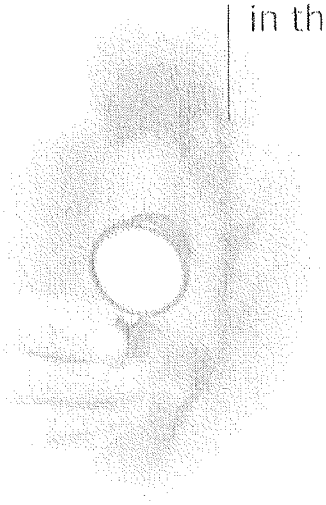
Further copies of this paper can be obtained by writing to the address above, or by telephoning 028 9052 2820, or through the e-mail address shown.

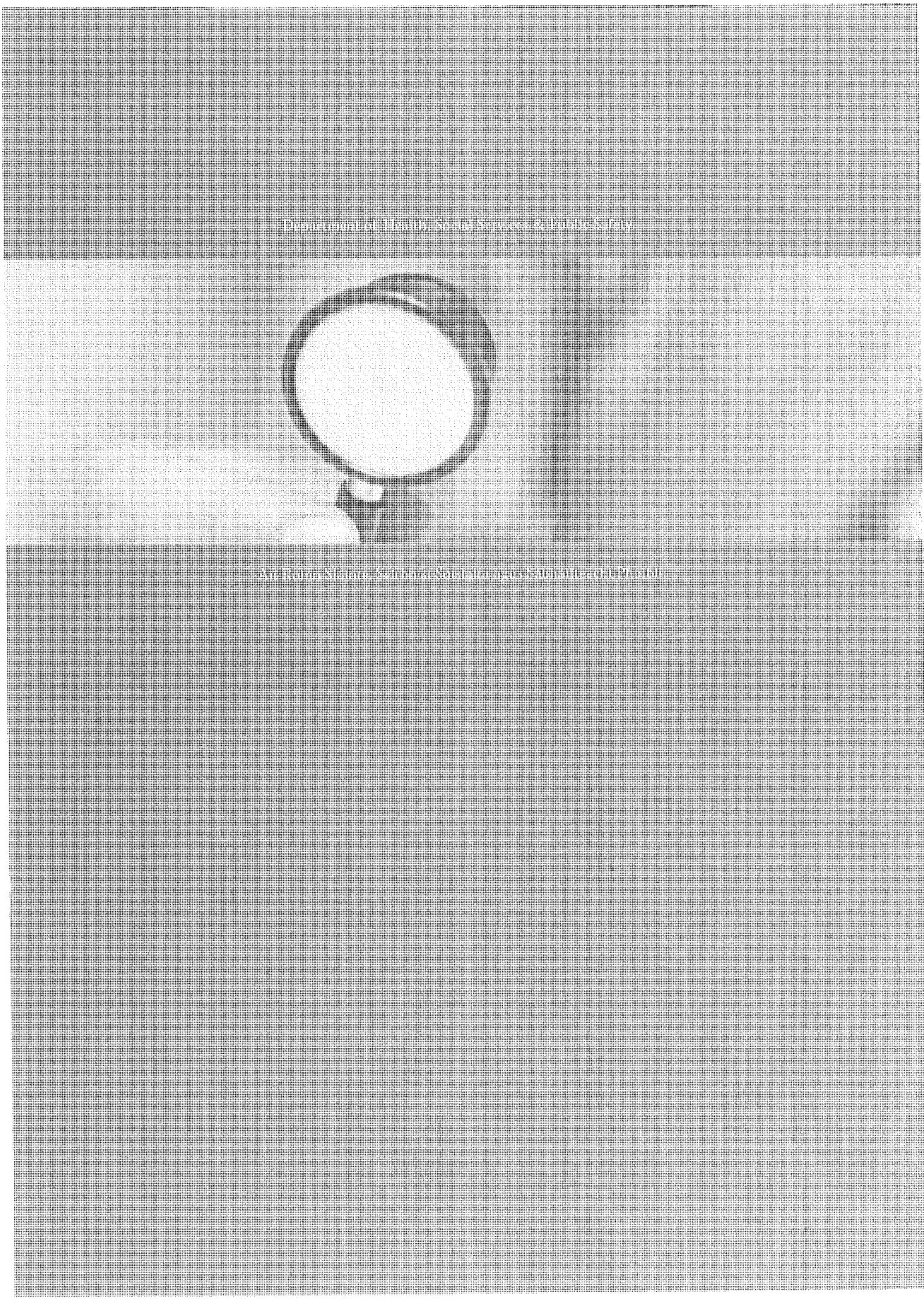
An electronic version is available at:

http://www.dhssni.gov.uk

Versions of the paper in Chinese, large type, Braille and audio cassette may be obtained through the contact points listed above.

Confidence in the Future





The NAWCH Charter

1. Children shall be admitted to hospital only if the care they require cannot be equally well provided at home or on a day basis.

2. Children in hospital shall have the right to have their parents with them at all times provided this is in the best interest of the child. Accommodation shall therefore be offered to all parents, and they should be helped and encouraged to stay. In order to share in the care of their child, parents should be fully informed about ward routine and their active participation encouraged.

3. Children and/or their parents shall have the right to information appropriate to age and understanding.

4. Children and / or their parents shall have the right to informed participation in all decisions involving their health care. Every child shall be protected from unnecessary medical treatment and steps taken to mitigate physical and emotional distress.

5. Children shall be treated with tact and understanding and at all times their privacy shall be respected.

6. Children shall enjoy the care of appropriately trained staff, fully aware of the physical and emotional needs of each age group.

7. Children shall be able to wear their own clothes and have their own personal possessions.

8. Children shall be cared for with other children of the same age group.

9. Children shall be in an environment furnished and equipped to meet their requirements, and which conforms to recognised standards of safety and supervision.

10. Children shall have full opportunity for play, recreation and education suited to their age and condition.

file in ring binder manual

ALTNAGELVIN HOSPITALS
HEALTH & SOCIAL SERVICES TRUST

POLICY ON CONSENT TO EXAMINATION OR TREATMENT

November 1996

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

POLICY ON CONSENT TO EXAMINATION OR TREATMENT

Background

i. Guidance issued by ME in 1995 which reflects common law rights of patients.

ii. Trust may face an action for damages if a patient is treated without consent.

Policy Statement

The Trust accepts that the patient has a fundamental right to grant or withhold consent prior to examination or treatment.

The Trust will ensure that patients will be provided with sufficient information about his or her medical condition, the proposed treatments, the possible alternatives and any substantial risks, in a way he or she can understand, so that he or she can make a balanced judgement.

The patient must be allowed to decide whether he or she will agree to the treatment, and may refuse treatment or withdraw consent to treatment at any time.

The principle of consent extends to the training of medical and other professional students. It should be made clear to the patient that he or she may decline to be observed, examined or attended by those in training without this affecting in any way the care he or she receives.

Procedures

Explanation to Patient

Where a choice of treatment might reasonably be offered, the health professional should always advise the patient of his or her recommendations together with the reasons for selecting a particular course of action. Enough information must normally be given to ensure that the patient understands the nature, consequences and any substantial risks of the treatment proposed so that he or she is able to take a decision based on that information. Though it should be assumed that most patients will wish to be well informed, account should be taken of those who may find it distressing.

The health professional will have to exercise his or her professional skill and judgement in deciding what risks the patient should be warned of and the terms in which the warning should be given. However there is a duty to warn the patient of substantial or unusual risks inherent in any proposed treatment.

Where a patient's ability to appreciate the significance of the information is impaired through language difficulties, physical condition or impaired functionality, every effort should be made to assist the patients understanding.

Obtaining Consent

In many cases a patient does not give express consent but his or her agreement may be implied by compliant actions such as offering an arm for the taking of a blood sample.

Oral consent will be sufficient for a large majority of contacts between patients and health professionals.

Written consent should be obtained for any procedure or treatment carrying any substantial risk or risk of substantial side effect. If the patient is capable, written consent should always be obtained for general anaesthesia, surgery, certain forms of drug therapy, e.g. cytotoxic therapy and therapy involving the use of ionising radiation.

Oral or written consent should be recorded in the patients notes with relevant details of the health professionals explanations. Where written consent is obtained it should be on the Trusts standard consent form which should be incorporated into the casenotes. (See appendices).

The most important element of a consent procedure is the duty to ensure that the patient understands the nature and purpose of the proposed treatment. Where a patient has not been given appropriate information then full consent may not always have been obtained despite the signature on the form.

Consent given for one procedure or episode of treatment does not give any automatic right to repeat that procedure or to undertake any other procedure. A health professional may, however, undertake further treatment if the circumstances are such that a patients consent cannot reasonably be requested and provided the treatment is immediately necessary and the patient has not previously indicated that the further treatment would be unacceptable.

Special Circumstances

Children & Young People

Under Age 16

In the majority of cases children will be accompanied by their parents during consultation and therefore parental consent can be obtained.

Where, exceptionally, a child is seen alone, efforts should be made to persuade the child that his or her parents should be informed except in circumstances where it is clearly not in the child's best interests to do so.

Where the health professional is satisfied that a child under the age of 16 has sufficient understanding of what is proposed, that child may consent to the health professional making an examination and giving treatment.

Over Age 16

The consent of the young person who has attained 16 years to any surgical, medical or dental treatment is sufficient in itself and it is not necessary to obtain a separate consent from the parent or guardian.

In cases where the child is between 16 and 18 but is not competent to give a valid consent then the consent of the parent or guardian is required.

Children in Care

The parental rights in respect of a child who is in care as a consequence of a Court Order will have been transferred to an appropriate H&SS Board or Trust.

Nevertheless where parental consent is necessary (regardless of age) consent should be sought from the parents as well as the child's social worker. In the event of the parents refusing consent, legal advice should be sought.

Where a child is a ward of court, authority to give consent rests with the Court.

Refusal of Parental Consent to Urgent or Life Saving Treatment

Where time permits, court action may be taken so that consent can be obtained from a judge. Otherwise hospital authorities should rely on the clinical judgement of the Consultants concerned after a full discussion between the Consultant and the parents in the presence of a witness. The doctor should obtain a written supporting opinion from a medical colleague that the patient's life is in danger if the treatment is withheld. Records should be kept in the clinical notes of the discussion, countersigned by the witness.

Adults or Competent Young Person Refusing Treatment

Some patients may refuse treatment including those where religious beliefs prevent them accepting a blood transfusion. Whatever the reason the patient should receive a detailed explanation of the need for treatment and the possible consequences of their refusal. Where the patient continues to refuse, their wishes must be respected. This should be recorded in the clinical notes and witnessed.

Examination or Treatment Without the Patient's Consent

The following are examples of occasions where examination or treatment may proceed without obtaining the patient's consent:-

i. For life saving procedures where the patient is unconscious and cannot indicate his or her wishes. Exceptions to this may be:-

   a. where the patient has previously indicated that he/she does not wish to have the particular treatment; or
   b. this can be reliably deduced from the patient's immediate family.

Examination or Treatment Without the Patient's Consent (Con't/d)

ii. Where there is a statutory power requiring the examination of a patient, for example, under the Public Health Act (Northern Ireland) 1967. However an explanation should be offered and the patient's co-operation should nevertheless be sought.

iii. In certain cases where a minor is a ward of court and the court decides that a specific treatment is in the child's best interests.

iv. Treatment for mental disorder of a patient liable to be detained in hospital in circumstances permitted under the Mental Health (Northern Ireland) Order 1986.

v. Treatment for physical disorder where the patient is incapable of giving consent by reason of mental disorder, and the treatment is in the patient's best interests.

Treatments Which Have Caused Concern

Maternity Services

Principles of consent are the same in maternity services as in other areas of medicine. It is important that the proposed care is discussed with the woman, preferably in the early antenatal period, when any special wishes she expresses should be recorded in the notes. Of course the woman has a right to change her mind about these at any stage, including during labour.

Decisions may have to be taken swiftly at a time when the woman's ability to give consent is impaired eg as a result of medication, including analgesics. If the safety of the woman or child/ren is at stake the obstetrician or midwife should take any reasonable action this is necessary.

If, in the judgement of the relevant doctor or other health professional, the woman is temporarily unable to make a decision, it may be advisable for the position to be explained to her husband or partner if available, but his consent (or withholding of consent) cannot legally over-ride the clinical judgement of the doctor or other health professional, as guided by the previously expressed wishes of the woman herself.

Breast Cancer

The usual principles of explaining proposed treatment and obtaining the patient's consent should be followed in treating cases of breast cancer. Breast cancer does not normally require emergency treatment. The patient needs reassurance that a mastectomy will not be performed without her consent, and that unless she has indicated otherwise the need for any further surgery will be fully discussed with her in the light of the biopsy and other results. This is a particular case of the principle that

consent to an initial treatment or investigations does not imply consent to further treatment.

Tissue and Organ Donation: Risk of Transmitted Infection

Where tissues or organs are to be transplanted, the recipient should be informed, prior to consent to the operation being obtained, of the small but unavoidable risk of the transplant being infected.

Female Sterilisation/Vasectomy

Although the legal view is that there is no obligation law to obtain consent of the spouse or partner, the Trust considers it good practice to ensure that when counselling patients they are encouraged to bring along their spouse/partner and involve them in this process. Where possible, the spouse/partner should countersign the relevant consent form.

Consent by Patients Suffering From Mental Disorder

No one may give consent on behalf of an adult and in circumstances where people lack the capacity to give consent the substantive law is that a proposed operation or treatment is lawful if it is in the best interests of the patient and unlawful if it is not. Case law provides the following guidance in cases where patients lack the capacity to give or communicate consent to treatment:

(a) treatment which is necessary to preserve the life, health or well-being of the patient may lawfully be given without consent.

(b) the doctor must act in accordance with a responsible body of relevant professional opinion.

(c) in many cases it will not only be lawful for doctors, on the grounds of necessity to operate or give other medical treatment to adult patients disabled from giving their consent, but it will also be their common law duty to do so.

(d) it is good practice to consult relatives and others who are concerned with the care of the patient. Consultation with a specialist or specialists or an inter-disciplinary team may be required

Decisions taken in accordance with his guidance should be recorded in the casenotes and a form recording that the patient is incapable of giving consent to treatment should be completed and included in the casenotes (Appendix 6)

There are some circumstances where legal advice will be required prior to treatment, particularly for sterilisation, termination's of pregnancy, organ donation and certain types of research. These treatments may require High Court approval and advice should be sought through the Chief Executive's office.

Consent for Teaching/Training Purposes

Whenever practicable, the student's/trainee's status and the reason for his/her presence must be explained to the patient and the patients prior informed consent must be obtained before the first occasion on which a student/trainee is present during the examination or treatment of a patient or interviews of examines a patient. The explanation should be given by the supervising registered medical practitioner or by a member of the nursing or midwifery staff but not by the student unless specifically authorised in advance by the supervising registered medical practitioner.

Patients should be advised that they are entitled to decline to be observed or attended by students/trainees without affecting in any way the treatment they receive.

Students/trainees should not take any part in obtaining or witnessing the signature by or on behalf of a patient on a form of consent to treatment.

He/she should not take a history from, examine or undertake a procedure on a patient unless the patient's prior informed consent has been obtained. If it is not practicable for the student/trainee to obtain specific consent from the patient, the student must seek authorisation in advance from a supervising registered practitioner. This will apply in the case of those patients unable, for whatever reason, to make a decision on consent. Exceptionally, this may include some anaesthetised patients, though normally such consent should have been sought from the patient in advance.

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

CONSENT FORM

for Medical or Dental Investigation, Treatment or Operation

Patient's Label

or Patient's Surname .....

Other Name/s.....

Date of Birth .....

Sex : *(please tick)* Male ☐ Female ☐

DOCTORS OR DENTISTS *(This part to be completed by doctor or dentist. See notes on the reverse).*

e of operation, investigation or treatment for which written evidence of consent is considered appropriate.

I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/local/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature ..... Date : .....

Name of doctor or dentist .....

PATIENT/PARENT/GUARDIAN

1. Please read this form and the notes overleaf very carefully.

2. If there is anything that you do not understand about the explanation, or if you want more information, you should ask the doctor or dentist.

3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the patient / parent / guardian *(delete as necessary)*

I agree to what is proposed which has been explained to me by the doctor/dentist named on this form.

to the use of the type of anaesthetic that I have been told about.

I understand that the procedure may not be done by the doctor/dentist who has been treating me so far.

that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I have told the doctor or dentist about the procedures listed below I would not wish to be carried out without my having the opportunity to consider them first.

.....

.....

Date ..... Signed ..... (Patient)

Witness to Patient's Signature ..... (Medical Practitioner)

Signature..... (Witness present at Interview)

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST
CONSENT FORM

for Sterilisation or Vasectomy

Patient's Label or Patient's Surname .....

Other Name/s .....

Date of Birth .....

Sex : *(please tick)* Male ☐ Female ☐

DOCTORS *(This part to be completed by doctor. See notes on the reverse).*

Type of operation : Sterilisation or Vasectomy

Complete this part of the form.

I confirm that I have explained the procedure and any anaesthetic (general/local) required, to the patient in terms which in my judgement are suited to his/her understanding.

Signature ..... Date : .....

Name of doctor .....

PATIENT

1. Please read this form and the notes overleaf very carefully.
2. If there is anything that you do not understand about the explanation, or if you want more information, you should ask the doctor.
3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the patient

I agree to have this operation, which has been explained to me by the doctor named on this form.

to the use of the type of anaesthetic that I have been told about.

I understand that the operation may not be done by the doctor who has been treating me.

that the aim of the operation is to stop me having children and it might not be possible to reverse the effects of the operation.

that sterilisation/vasectomy can sometimes fail, and that there is a very small chance that I may become fertile again after some time.

that any procedures in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I have told the doctor about the procedures listed below I would not wish to be carried out straightaway without my having the opportunity to consider them first.

.....

.....

For vasectomy

I understand that I may remain fertile or become fertile again after some time.

that I will have to use some other contraceptive method until 2 tests in a row show that I am not producing sperm, if I do not want to father any children.

Signature: .....

Appendix C

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

CONSENT FORM

FOR TREATMENT BY A HEALTH PROFESSIONAL OTHER THAN DOCTORS OR DENTISTS

Patient's Label

or

Patient's Surname .....

Other Name/s .....

Date of Birth .....

Hospital Number ..... Sex :

Sex: *(please tick)* Male ☐ Female ☐

ALTH PROFESSIONAL *(This part to be completed by health professionals. See notes on the reverse).*

ype of treatment proposed for which written evidence of consent is considered appropriate.

Complete this part of the form

I confirm that I have explained the treatment proposed and such appropriate options as are available to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature ..... Date : .....

Name of Health Professional .....

Job Title of Health Professional .....

PATIENT/PARENT/GUARDIAN

1. Please read this form and the notes overleaf very carefully.

---

2. If there is anything that you do not understand about the explanation, or if you want more information, you should ask the health professional who has explained the treatment proposed.

---

3. Please check that all the information on the form is correct. If it is, and you understand the treatment proposed, then sign the form.

I am the patient / parent / guardian *(delete as necessary)*

I agree to what is proposed which has been explained to me by the health professional named on this form.

Date ..... Signed ..... (Patient)

Witness to Patient's Signature .....(Medical Practitioner)

Signature .....(Witness Present at Interview)

NOTES TO:-

Doctors

A patient has a legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to treatment at any time. The patient's consent to treatment should be recorded on this form (further guidance is given in HSS(GSH)2/95 : A Guide to Consent for Examination or Treatment).

Patients

- The doctor or dentist is here to help you. He or she will explain the proposed procedure, which you are entitled to refuse. You can ask any questions and seek further information.
- You may ask for a relative, or friend, or a nurse to be present.
- Training doctors and other health professionals are essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor.
- You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

Total Gains and Losses Recognised in Financial Year	£5,828	£3,302

Cash Flow Statement for the year ended 31 March 2000

	1999/00 £000	1999/00 £000	1998/99 £000	1998/99 £000
Net Cash Inflow from Operating Activities		4,543		4,639
Returns on Investments and Servicing of Finance				
Interest received	107		113	
Interest paid	(1,440)		(1,500)	
Dividends paid	(1,062)		(972)	
Net Cash (Outflow) on Investments and Servicing of Finance	(2,395)	(2,395)	(2,359)	(2,359)
Capital Expenditure				
Payments to acquire fixed assets		(6,900)		(7,694)
Receipts from sale of fixed assets		6		19
Net Cash (Outflow)/Inflow before Financing		(4,746)		
Financing				
New Public Dividend Capital		5,500		
Repayment of amounts borrowed		(782)		(782)
(Decrease)/Increase in Cash and Cash Equivalents		(£28)		(£77)

Clinical Governance and Quality

Whilst clinical governance is not yet a statutory requirement in Northern Ireland, Altnagelvin Trust has decided that the imperatives implicit within clinical governance are the basis for development and implementation of the Trust's Quality and Risk Management Strategies.

A Clinical Governance Committee has been established and will provide assurance to the Trust Board that procedures relating to: Clinical Effectiveness and Quality; Risk Management; and Education and Training, are in place within the Trust and are functioning effectively.

Clinical Effectiveness

The key to successful achievement of Clinical Governance will be in the development of a system which ensures changes in clinical practice on the basis of timely identification of quality failures. The Government has stressed that we need to approach the quality agenda on two fronts:-

- by evaluating outcomes of care;
- by evaluating Patients' Experiences of Care.

Key Achievements

- Establishment of a multidisciplinary Clinical Audit Committee which takes the lead in evaluating Outcomes of Care. It aims to encompass two major activities: audit of current practice against evidence based standards; audit in response to serious clinical incident reports.
- Reorganisation of the HOSQIP (Hospital Quality Improvement Programme) committee which will concentrate on evaluating and improving patients' experiences.
- Inter-professional partnership with the University of Ulster in research continues.
- Work has commenced in collaboration with Causeway Trust and the Northern Ireland Ambulance Trust looking at the prevention of pressure sores in patients with fractured femurs.
- Establishment of a Trust multidisciplinary Research Committee.
- Work has commenced on developing Care Pathways.
- Ongoing monitoring of Patient Charter standards

Targets

- Establish the Clinical Effectiveness Committee.
- Care Pathways programme to be further developed with Directorate and Ward/ Department Staff.
- Clinical Audit and HOSQIP programmes for the coming year to be agreed.
- Nursing Monitor quality assessments on 5 wards in coming year
- Clinical Effectiveness Conference in the Autumn.
- Research Seminar – University of Ulster and Altnagelvin Hospital to jointly host in September.
- Appoint Research Nurse/s

Risk Management

Risk management involves clinicians, managers and health care provider organisations in identifying circumstances or practices which put patients, staff and visitors at risk of harm, and then acting both to prevent and control those risks.

Key Achievements

- Procedure for reporting and investigating Critical Incidents agreed.
- Establishment of a Clinical Incident Review Committee.
- Establishment of a Health and Safety Committee.
- Health and Safety Policy and Annual Report issued.
- Risk assessments in 30 Wards/Departments and 6 have had repeat assessments.
- Risk Management Newsletter to be published quarterly.
- Monitoring of accidents, complaints, untoward incidents, clinical and critical incidents and legal cases to identify trends and the required action plan.
- Establishment of a multidisciplinary committee to address incidents of verbal and physical aggression.
- Revised Infection Control Policy and Annual Report issued.
- Ongoing infection control monitoring of clinical areas and departments

Targets

- Establish Risk Management Committee.
- Development of a Clinical/Critical Incident Data Base to facilitate monitoring.
- Work with United Hospitals H&SS Trust in Falls Risk Management strategy.

Education and Training

It is important to the success of any health care organisation that clinical, as well as other staff, are given the opportunity to maintain professional skills and knowledge by way of relevant training and development opportunities.

Key Achievements

- Staff Appraisal system agreed which includes identification of individual and departmental training needs.
- Training sessions for staff on:-
  - Audit
  - D.Y.S.S.S.Y. (standard setting system)
  - Infection Control
  - Risk Assessment
  - C.O.S.H.H. Assessment
  - Health and Safety
  - Fire Safety
  - Management of Medical Devices

- C.R.E.S.T. guidelines on wound care
- Clinical Governance Workshop
- Care Pathways Workshop
- Leadership Empowerment Programme
- Pilot Appraisal for Senior Medical Staff

Targets

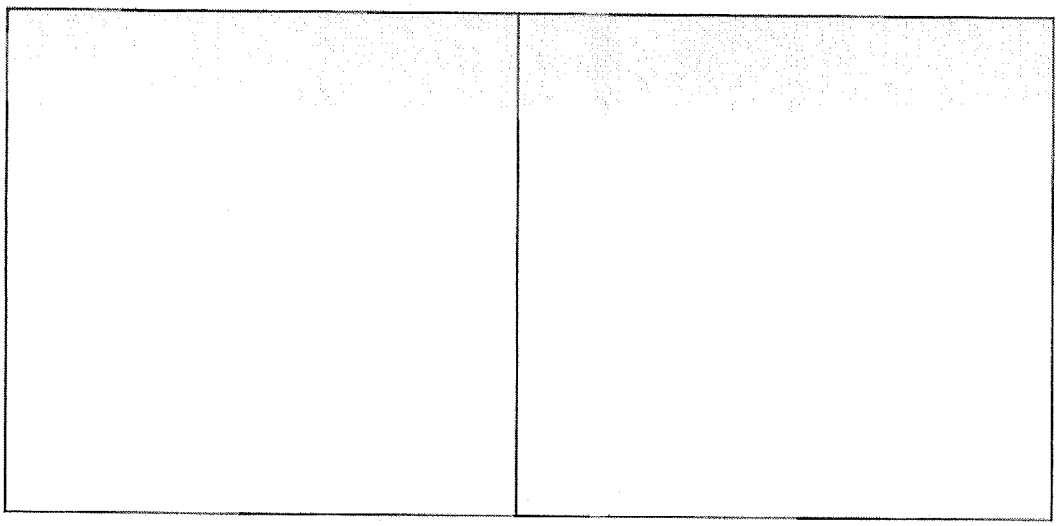
- Establish Education and Training Committee.
- Plan to structure Education and Training programmes in response to issues which arise out of the Clinical Effectiveness and Risk Management Committees.
- Development of Corporate Training Plan through the Staff Appraisal Process.
- Review of Selection and Recruitment procedures to ensure compliance with Clinical Governance requirements.
- Develop appraisal and revalidation procedures for medical staff as proposed by General Medical Council.

Charter Monitoring Achievements

- At the Professions Allied to Medicine and Nurse Led Clinics, 99.5% of patients were seen within 30 minutes of appointment time.
- In the most recent survey at the outpatients clinics, 79% of patients were seen within 30 minutes of their appointment time and 96% were seen within one hour.
- A Charter Standard was introduced in April 1998 in the Accident and Emergency Department relating to the assessment of patients and the allocation of priority categories. In 1999/00, 91% of patients were assessed within 15 minutes, 98% were given a priority category and 97% were seen within the category time.
- In the Accident and Emergency Department, from the time of decision to admit a patient to hospital, to admission being made, 85% of patients were admitted within the Charter Standard of two hours.
- The HSS Management Group commissioned a data quality audit on the above Charter Standard in February 2000. We were commended for the quality of the system operated at Altnagelvin to collect this data. This standard will be published for the first time in the Performance Tables for 1999/00.
- In 1999/00 the Patient's Advocate Office received 124 complaints from 117 complainants.
- There were 233 enquiries and 3,328 commendations in relation to services provided by the Trust.
- During the year there were 12 requests for Independent Review to the Convenor of the Western Health and Social Services Board. Ten requests were examined by the

Confidentiality	2	Treatment & Care	38
Discharge & Transfer	1	Waiting Times	14

TABLE 3: COMPLAINTS BY CATEGORY



PROMOTING HEALTH

KEY ACHIEVEMENTS

- In 1999/00, Altnagelvin was established as the Regional Co-ordinator for the European Health Promoting Hospitals Network. The Hospital is now the centre for the support and co-ordination for hospitals in Northern Ireland that have joined the Network.
- A conference, hosted by the Regional Network to encourage other hospitals to join the initiative, attracted over 90 participants and increased membership of the Network.
- The Health Promotion sub-groups have been progressive throughout the year.
- Work is underway to obtain full Baby Friendly Status for the Hospital - a UNICEF initiative.
- A Diet and Health Audit was undertaken to establish whether or not knowledge and behaviour in relation to healthy eating among staff has changed over the past five years. Training on nutrition will follow, subject to the results of the audit.
- The Women and Children's Directorate became smoke free.

CHAIRMAN'S INTRODUCTION

The Clinical Audit Committee have great pleasure in presenting the Clinical Audit F
for the period April 2001-March 2002.

Clinical Governance is defined by the Department of Health (A First Class Service Quality in the NHS. London DoH 1998) as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clearly Clinical Audit is at the centre of Clinical Governance and involves monitoring processes, outcomes and 'patient satisfaction' to maintain compliance with good practice.

CLINICAL AUDIT COMMITTEE COMPRISES:

Medical Audit Co-ordinator (Chairman)
Nursing Representative – Clinical Effectiveness Co-ordinator
PAMS Representative
Risk Management Co-ordinator
Drugs and Therapeutics Committee Chairman
HOSQIP Representative
Clinical Audit Assistants
Secretary

AUDIT TOPICS:

Topics for Clinical Audit may arise from a variety of sources:

- From within the specialty itself
- From the Clinical Audit Committee
- From Risk Management
- From Regional, National and International requests.

It is envisaged that the vast majority of audits will arise from within each discipline.

AUDIT REQUEST FORMS:

Audit request forms are available from the Clinical Audit Assistant Office.

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

DIRECTORATE OF CLINICAL SUPPORT SERVICES

PATIENT'S CASENOTES STANDARDS

The following standards were agreed by the Hospital Management Team at its meeting on 14 May 1996 and reaffirmed at its meeting in September 1997.

1. Only one set of casenotes should exist for each patient (exception - Maternity Notes)

2. The cover of all casenotes must be intact and clearly marked to identify the patient. Any known allergies must also be clearly written on the front cover.

3. Handwriting on notes should be in dark ink to facilitate legibility, photocopying and miniaturisation.

4. The date and time of <u>every</u> note must be shown.

5. The name of the person signing the notes must be printed underneath the signature. <u>(HIGHLY RECOMMENDED)</u>

6. Only approved hospital abbreviations should be used. 'Left' and 'Right' must always be written in full. Digits must be named not numbered.

7. Medical or nursing notes must never be erased, over-written or inked out. Errors must be scored out with a single line and the corrected entry written alongside with the date, time, signature and name printed. Correction fluid must not be used.

8. Any additions must be separately dated, timed and signed.

9. No personal comments must be made in the patients casenotes.

10. Typed notes and all hospital correspondence must be checked and signed by the doctor who dictates them. Any corrections to correspondence must be made on all copies or the correspondence re-typed.

11. Request forms (pathology, x-ray, etc.) must have an addressograph label attached to identify the patient and include appropriate previous history, the ward/department, and the name of the Consultant. These forms must be signed and dated by the requesting authorised practitioner.

12. All results must be reviewed and initialled by a Clinician (and appropriate action taken) before being filed in the patient's records.

13. All prescriptions must be printed in black ink, and be legible, dated and signed. Instructions regarding discontinued drugs must be dated and signed by the doctor.

S M DUNNE
May 1996
Reissued June 1998

SB

BC-0073-11

Reference Point

Hi Teresa

Please find attached a copy of the minutes of the old Altnagelvin Hospital Trust's Board Meetings as requested from January 2001 – December 2002. These meetings took place once every month, but unfortunately I have been unable to locate the minutes for some of these meetings. The month's that I have been unable to locate are as follows:

- February 2001
- July 2001
- August 2001
- August 2002
- December 2002.

I have also enclosed a copy of all the meetings from the old Altnagelvin Hospital Executive Meetings from January 2001 – December 2002.

I hope this is of help to you.

Many Thanks

Diane

Audit of Documentation of Fluid Requirements & Fluid Balance on Children following Surgery

LEAD AUDIT PERSON:

Ann Marie McGurk

STANDARDS:

'*Any child receiving Prescribed Fluids is at risk of Hyponatraemia*' Department of Health Guidelines (2002)
'*Guidelines for Record and Record Keeping*' Nursing & Midwifery Council (April 2002)

SAMPLE SIZE:

33 surgical admissions were admitted to CHW from 01/01/03 to 31/05/03, of these, 14 went to theatre and received IV fluids. The fluid balance charts of these 14 patients were used in this audit.

RESULTS:

- Patient's details are not documented on all Fluid balance charts. The February 2003 Audit was better than July 2003 Audit
- Fluid balance charts are not totalled at end of the day
- When patient goes to Theatre, fluids infused in Theatre are not documented on to the Fluid balance chart (Total infused in theatre is calculated on anaesthetic sheet)
- IV fluids management was improved in July 2003, except that, not all IV prescriptions are signed..
- July 2003 - 93% children received Maintenance Fluids in line with DOH guidelines (2002).
- Urinary output not documented for long periods, some documented in millilitres and 'PU' on same chart
- IV Fluids are not always reduced as oral fluids increased

Appendix 8

RQIA INDEPENDENT REVIEW - SEPTEMBER 2008 - RECOMMENDATIONS

Recommendation 1	All hospitals should monitor the ongoing use of No. 18 solution to enable assurance that infusions are removed from stock and general use in areas that treat children.
Recommendation 2	Where appropriate, hospitals must be able to demonstrate that an active strategy is in place for minimising risk of use in clinical areas that continue to stock No 18 solution and where children are accommodated. For example, provision of additional labelling or separate storage for those No.18 solution bags still stocked in such clinical areas.
Recommendation 3	All hospitals should continue with the ongoing work of disseminating clinical guidelines. This should be undertaken in conjunction with multidisciplinary awareness-raising and education on the use of the guidance and wall chart in all settings where children may be treated. This is particularly important in adult wards where older children are treated.
Recommendation 4	Independent hospitals must be assured that all visiting doctors who may manage patients up to 16 years old use the clinical guidelines when managing children being treated with intravenous infusions.
Recommendation 5	All hospitals should ensure that only the DHSSPS Paediatric Parenteral Fluid Therapy wall-chart *issued by DHSSPS in October 2007* is displayed in clinical areas where children may be treated, with a list of available local fluids available alongside it. All previous versions of the wall chart should be removed from clinical areas.
Recommendation 6	Hospitals should assure themselves that staff have the appropriate skill and knowledge in this clinical area. Competency assessment tools in administration of intravenous infusion to children should be developed, formalised and implemented for all relevant, multi-professional staff.
Recommendation 7	Hospitals should continue to review, collaborate and implement organisation wide policy and guidelines, in relation to intravenous infusion for children.
Recommendation 8	All hospitals should ensure that the development and provision of multidisciplinary education opportunities in administration of intravenous infusion to children and that all relevant clinical staff uptake this education.
Recommendation 9	Hospitals should develop mechanisms to identify the location of patients aged 14-16 years who are in adult wards and ensure staff who care for those children are provided with competency based, assessed education in administration of intravenous infusion to children.
Recommendation 10	All hospitals should make wider use of training sources available such as BMJ E-Learning Module on Hyponatraemia to address different learning styles and devise a mechanism to ensure 100% multi-professional uptake of such learning.
Recommendation 11	Priority must be given to the completion of a Trust-wide review, and implementation of revised paediatric intravenous fluid prescription and fluid balance charts in all settings where children may be treated including adult wards where children are treated.
Recommendation 12	All hospitals should develop a culture of incident reporting, analysis and learning generally and specifically in respect of intravenous fluids and hyponatraemia.
Recommendation 13	Plans for development of systems for reporting, analysing and monitoring incidents to assure organisations of safe practice and that actions linked to NPSA Alert 22 should be implemented and regularly audited by all hospitals to ensure adherence to the process.
Recommendation 14	The development of 'trigger lists' that have been adopted by a the Antrim Area Hospital to aid understanding of the types of incidents to be reported should be shared and taken up more widely .
Recommendation 15	The development of an audit tool which may include wider aspects but should address as a minimum aspects of NPSA Alert 22 should continue to be progressed and used at least annually.
Recommendation 16	Trusts should continue to seek approval and funding for a regional audit (GAIN proposal) on the uptake of the Paediatric Parenteral Fluid Therapy guideline and potential unexpected clinical consequences of the guideline.

AGREED ACTION FOLLOWING CRITICAL INCIDENT MEETING 12/06/01

1 Review evidence for use of routine post-operative low electrolyte IV infusion and suggest changes if evidence indicates. No change in current use of Solution 18 until review.

Action Dr Nesbitt

2 Arrange daily U&E on all post-operative children receiving IV infusion on Ward 6.

Action Sister Miller

3 Inform surgical junior staff to assess these results promptly.

Action Mr Gilliland

4 All urinary output should be measured and recorded while IV infusion ~~progress~~ in progress.

Action Sister Miller

5 A chart for IV fluid infusion rates to be displayed on Ward 6 to guide junior medical staff.

Action Dr McCord

6 Review fluid balance documentation used on Ward 6.

Action A Witherow

R A FULTON
Medical Director

13/06/01

[redacted]

026-004-005

RF – ALTNAGELVIN

PROPOSED STRATEGY FOR IMPLEMENTING CLINICAL GOVERNANCE

1.0 INTRODUCTION

1.1 Controls Assurance

From 1st April 2000 all Chief Executives will be required to sign a statement of controls assurance which will appear within the Annual Report. This statement will assure the public that the board has in place and is constantly reviewing a comprehensive risk management and control framework that is built on sound management practice. The imperatives within this wider definition of controls assurance are:

- Risk Management Policy and Strategy;
- Risk Profiling - identifying where the significant risks are;
- Risk Management Information and Communication - (e.g. Adverse Incidents, Complaints, and Claims);
- Clinical and Medical Audit;
- Human Resources (Training and Development, Recruitment, Job Roles /Definition);
- Accountability of Chief Executive.

1.2 Corporate Accountability

The concept of governance is not a new one. Good corporate governance should include effective systems to monitor; control and alter performance. This should apply to all aspects of the organisation's operation including clinical performance. However, the White Paper in 1997 "The New NHS - Modern Dependable" makes an explicit requirement on the NHS and therefore by inference the HPSS to be accountable for quality in the clinical setting. This means that there is now clear corporate accountability for clinical performance. This accountability will require both internal and external mechanisms in order to achieve its goals.

1.3 Underpinning an increasing emphasis on quality and good practice is the concept of Clinical Governance as illustrated in "Fit for the Future". This discussion paper forms the basis of the Strategy for developing Clinical Governance within Altnagelvin Hospitals Health and Social Services Trust.

1.4 What is Clinical Governance?

Clinical Governance is a new initiative to assure and improve clinical standards throughout the National Health Service (NHS). "It is a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

1.5 Clinical Governance encompasses all the processes needed to achieve the highest quality clinical practice possible within available resources. It must build on the good and effective systems already in place, and should be integrated into the way things are done in the organisation.

1.6 Clinical Governance is a framework bringing together a number of components which include:-

- ensuring that there is a comprehensive database of Evidence-based, clinically effective standards and pathways of care;
- ensuring that all clinical staff have access to this information and that they have the knowledge and skills to interpret it and use it appropriately;
- evaluating current practice against these standards by audit;
- disseminating the good practice currently in existence and continuing to build on this in order to continuously improve quality of care;
- where current practice does not meet the clinically effective standards, putting in place an action plan/s to address deficits in care resulting in quality improvement;
- in addition to improving outcomes of clinical care for patients, putting in place systems which improve their experience of the care they receive.

1.7 Clinical Governance is constituted from known systems to achieve quality improvement:-

- clinical audit;
- effective management of poorly performing clinical colleagues;
- risk management;
- evidence based clinical practice, developing guidelines and protocols;
- development of clinical leadership skills;
- continuing education for all clinical staff;
- audit of consumer feedback;
- accreditation of hospitals, community providers and primary care practices;
- continuing professional development for all staff;
- analysis of claims and complaints;

plus

- systems to ensure lessons learnt are implemented;

plus

a mechanism to ensure all systems are in place and functioning effectively.

(See Diagram 1).

CLINICAL IMPROVEMENT
Clinical Audit
Education and training
Guidelines and Standards
Incident reports
Clinical Effectiveness Info
Patient Satisfaction
Claims Information
Risk Assessment
Research

Diagram 1

1.8 Implementation of Clinical Governance has implications for organisations and for staff, requiring changes in culture and attitudes if the resultant cycle of continuous quality improvement in standards of patient care is to be achieved.

2.0 ORGANISATIONAL ISSUES

2.1 Clinical Governance is much more than a set of bureaucratic systems; far more important is the culture of the organisation and attitude of all who work in the NHS - clinical practitioners and managers alike.

2.2 It is essential that the change in culture of the organisation leads to transparency i.e. sharing and building on the good work that already exists and integrating into those systems that are already working well.

2.3 This requires systems to be put in place to disseminate good practice both within and outside of Altnagelvin Hospitals Health and Social Services Trust and by so doing quality of care is improved for a wider population of patients.

2.4 Whilst the Trust Board has corporate responsibility, and the Chief Executive has ultimate accountability for Clinical Governance, this in no way diminishes the role of accountable practitioners who have personal responsibility for delivery of high quality, clinically effective care.

2.5 A high quality service can only be delivered by a real commitment to individual professional standards where the patient and their welfare is the central focus of all activity. Staff must be encouraged to participate in reporting clinical incidents, accidents, risks etc, to ensure that these can be openly investigated and lessons learnt for the future.

2.6 The culture of the organisation must encourage individual accountability by adopting a non-punitive approach - one based on learning from mistakes and not a culture of "Name, Blame and Shame". This in no way precludes appropriate use of the disciplinary process when it is considered to be absolutely necessary.

2.7 Having the appropriate organisational structure in place which identifies clear lines of responsibility and accountability for quality of care is essential to ensuring successful implementation of Clinical Governance. At both Trust Board and Directorate levels managers and clinicians will increasingly need to work together as they share responsibility and accountability for clinical services and quality improvement.

2.8 Any proposed organisational structure must be comprised of the building blocks of multidisciplinary teams, effectively working together at every level of the organisation.

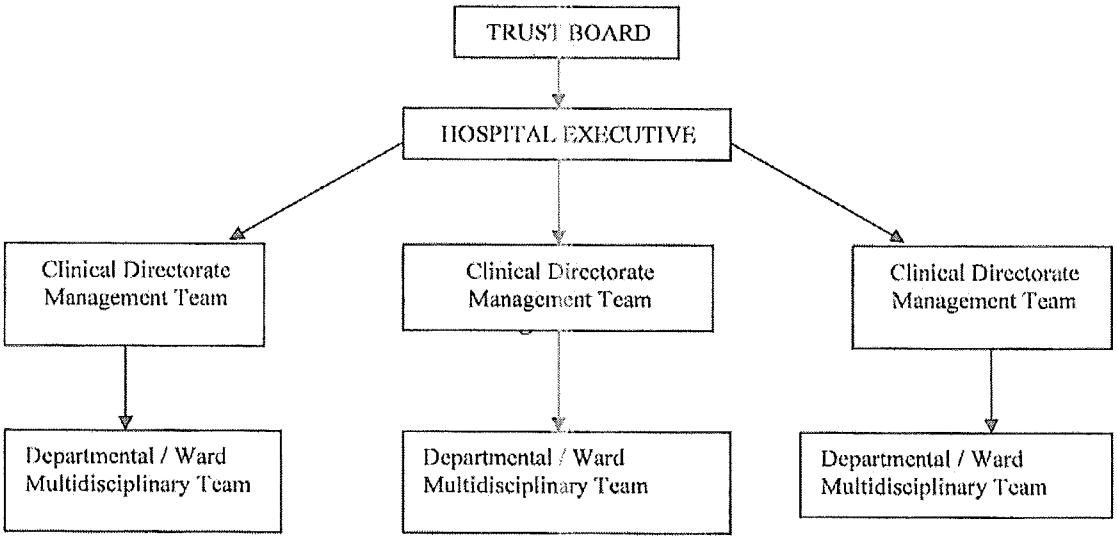


Diagram 2

As can be seen from Diagram 2 Altnagelvin Hospitals H&SS Trust has already developed a model of multidisciplinary team working.

2.9 Responsibility and Accountability for Clinical Governance must be accepted and owned at each level of the organisation structure's and systems for Clinical Governance must reflect and reinforce this accountability.

2.10 Therefore the ward multidisciplinary team is accountable to the Clinical Directorate Management Team for all resources i.e. financial, staff, equipment etc, and for the proper use of these resources to deliver a high quality of clinical practice. Key to the success of this is the commitment of individual ward sisters, consultants and department heads e.g. PAMS. In order to reinforce their individual accountability clinical governance should be a standing agenda item on ward sister meetings and directorate meetings when they will have an opportunity to review progress on issues relating to clinical governance with the clinical directorate management team.

2.11 In turn the Clinical Directorate Teams report to the Hospital Executive Team and ultimately to the Chief Executive.

2.12 Staff in the Professions Allied to Medicine report to the Director of Clinical Support Services who is a member of the Hospital Executive team. As there is no formal management reporting links to the bedded Directorates it is important that there are adequate arrangements to ensure effective communications and multidisciplinary working at ward and directorate level.

At directorate level this may be achieved through regular meetings between the Heads of PAMS and the Clinical Services Managers to discuss the services provided. More importantly, at ward level mechanisms need to be in place to ensure that the PAMS staff are recognised, and identify themselves, as an integral part of the ward team and that a sharing of information takes place. This may be through involvement in team meetings/case conferences, where appropriate, but will be mainly fostered through the daily communication on the ward.

PAMS should also be involved in multiprofessional audit at ward level, reporting back to their head of department the results of such audits and also suggesting to the ward potential audit topics.

2.13 Clinical Directorate Management Teams with the Hospital Executive Team form the Hospital Management Team. This is the forum where clinicians and managers are brought together in order to agree the major decisions and strategies of the Trust. In the future a standing agenda item for this forum must be Clinical Governance issues.

2.14 The Hospital Management Team will in turn be accountable to the Chief Executive for clinical quality standards and for ensuring that effective systems have been put in place to deliver on the Clinical Governance Agenda.

2.15 A Standing Committee of the Trust Board should be formed called the Clinical Governance Committee. The role of this committee will be to provide the Trust Board with an objective review of:-

- clinical quality monitoring and improvement systems;
- effective implementation of the lessons learnt from these systems;
- quality of the information used by those systems;
- compliance with national guidelines and protocols;
- the capacity of the organisation to deliver the required quality of service in terms of:
  - quality of clinical performance;
  - educational systems and commitment to continuing professional development;
  - leadership development of clinicians and managers;
  - commitment to organisational developments.

2.16 Membership of the Clinical Governance Committee will comprise of one of the following three options:

OPTION 1	OPTION 2	OPTION 3
1 Non-Executive Director	1 Non-Executive Director	1 Non-Executive Director
Chief Executive	Chief Executive	Chief Executive
Medical Director	Medical Director	Medical Director
Director of Nursing	Director of Nursing	Director of Nursing
Director of Personnel	Director of Personnel	Director of Personnel
Chairman of Medical Staff	Chairman of Clinical Audit Committee	Chairman of Medical Staff
?? Health & Social Services Council member or Patient Representative	?? Health & Social Services Council member or Patient Representative	Chairman of Clinical Audit Committee
?? GP Commissioner	?? GP Commissioner	?? Health & Social Services Council member or Patient Representative
		?? GP Commissioner

This Committee will be serviced by the Risk Management Co-ordinator. In relation to commissioner and patient representatives on this committee it may be prudent to await Department of Health and Social Services direction on this.

2.17 The proposed Terms of Reference for the Committee is as follows:

The Clinical Governance Committee will assure the Trust Board that there are robust systems and appropriate procedures relating to clinical effectiveness, quality, risk management, education and training in place within the Trust and that these are functioning effectively. In order to deliver on the Clinical Governance agenda there will be 3 sub-committees of the Clinical Governance Committee to address the following areas:

- Clinical Effectiveness;
- Risk Management;
- Recruitment, Education and Training.

The Clinical Governance Committee and sub-committees will ensure that the results of clinical governance reviews are addressed and acted upon at practice level. The Clinical Governance Committee will provide to the Trust Board quarterly reports and publish an Annual Report.

See Diagram 3

2.18 The link between Clinical Directorate and Ward Teams and the Clinical Governance Committee will be formalised through the above named sub committees. The Chair of each sub-committee will be a member of the Clinical

Governance Committee and should be representative of the multidisciplinary nature of Clinical Governance.

2.19 Each Directorate should nominate a lead person with a remit for the implementation of Clinical Governance.

3.0 PATIENT CARE

3.1 High quality care is a right for every patient in the NHS. The Government wants a National Health Service that is both modern and dependable. Such a National Health Service should guarantee fair access and high quality care to patients wherever they live.

3.2 Increasingly neither clinical decisions nor health policy can any longer be comfortably based on opinion alone. Accessing and appraising objective evidence of good clinical practice is becoming increasingly important and could rapidly become a core clinical competency.

3.3 Although the NHS research and development programme has helped with the production and dissemination of some of the evidence needed to inform clinical decision making and service planning, Clinical Governance will require a greater emphasis on this at local level. In the current situation infrastructures to support evidence based practice are not always in place, but where they do exist they are not always utilised to their maximum potential.

3.4 The key to successful achievement of clinical governance will be in development of a system which disseminates good practice and ensures changes in clinical practice on the basis of timely identification of quality failures.

3.5 The Government have stressed that we need to approach the quality agenda on two fronts:-

a. By evaluating Outcomes of Care;
b. By evaluating Patients Experiences of Care.

In addition to this clinical risk management contributes to the quality of care by preventing or minimising situations which place a patient at risk.

4.0 CLINICAL AUDIT

4.1 Within Altnagelvin Hospitals H&SS Trust Clinical Audit takes the lead in evaluating Outcomes of Care. However, this process needs to become more rigorous and more closely inter-related with other activities for example HOSQIP, Risk Management and Complaints.

4.2 Clinical Audit is a multidisciplinary, systematic critical analysis of the quality of clinical care including the procedures used for diagnosis, treatment and care, the associated use of resources and the resulting outcome and quality of life for the patient.

4.3 Clinical audit should encompass two major activities:-

- audit of current practice against evidence based standards
- critical incident audit

4.4 Clinical Audit is therefore not just about identifying areas for improvement, it should also provide a way of identifying and acknowledging good practice and encourage its dissemination

4.5 The Government, the NHS and the public need to know whether services really are delivering the high quality care that patients have a right to expect. A well developed and focused clinical audit strategy will support the drive for higher quality standards by ensuring there is a systematic investigation and critical inquiry into clinical practice.

4.6 Access to, appreciation and understanding of Evidence Based Practice, Clinically Effective Standards and Integrated Care Pathways are important to ensuring that practice is based on the relevant research evidence. However, understanding theoretical principles alone will not result in improved clinical standards.

4.7 Clinical audit is a process by which practice can be measured against nationally agreed standards, adjusted accordingly and re-measured to ensure clinical practice reflects the relevant evidence for a given clinical activity thus closing the audit loop.

4.8 Making clinical audit work is an organisational challenge that requires substantial numbers of people working together in new ways, doing new things and to keep on doing so even when meeting hostility.

4.9 The culture of an organisation in relation to change and the lack of sound audit methodologies can often be barriers to effective clinical audit activity. There is a need to establish the characteristics of good audit practice and methodologies and to ensure staff understand how these work.

4.10 A clinical audit steering group should be established with clear terms of reference, and a well defined strategy together with the identification of lead clinicians at all levels of service delivery is key to the success of this process. The drive to place quality at the heart of the NHS is not about ticking checklists - it is about changing thinking.

Although there is an increasing emphasis on multidisciplinary clinical audit there is still a significant contribution to be made by rigorous uni professional audit projects which can also contribute to improved outcomes of care for patients.

5.0 HOSQIP

5.1 It is well documented that the interpersonal aspects of health care are seldom evaluated although their importance is unequivocal. The views and experiences of the people who use the NHS should form an important element of any assessment of its performance.

5.2 Clinical quality improvement should start with the patient and their point of view. The patients experience of the care they received, the environment within which it was delivered and their perception of respect, courtesy and dignity they were afforded will in their opinion be equally important as the outcomes of care. Methods of learning the lessons from surveys of satisfaction should be regarded as equally as important as those lessons learnt from clinical audit or from clinical risk.

5.3 An existing system within the Trust (HOSQIP) has already begun working on evaluating the patients' experiences of care and the Trust will also continue to seek the views of patients through various channels i.e

- Complaints Procedures;
- Patient Surveys;
- Patient's Fora e.g. Maternity Services Liaison Committee and Patients Council.

5.4 Accreditation from external quality bodies e.g. Charter Mark will increase public confidence in the commitment of the Trust to achieving high standards and measurable improvements in the quality of the service it provides.

5.5 Preparing and applying for external quality awards requires a high degree of commitment and support of staff as they seek to formally describe the complexity of the services they provide. The HOSQIP programme is ideally suited to provide the necessary support to ensure staff are well prepared to compete for these awards.

5.6 The HOSQIP programme within the Trust also offers the opportunity to departments not directly involved in delivering patient care to put in place quality improvement programmes which increase their efficiency and effectiveness and therefore indirectly contribute to the improvement of services to patients.

6.0 RESEARCH

6.1 Clinical Governance demands decisions based on clinical judgement, and not just on how much care costs. However, making decisions about health care is a complicated process for everyone involved, whether professional or patient/client. The potential benefits and hazards of possible interventions have to be considered against a background of limited resources and the varying needs of patients/clients. Attention must be given not only to the outcomes of these decisions but also to the evidence on which they are based.

6.2 To be accountable therefore, for doing the right thing, in the right way, for the right patients, at the right time, necessitates the application and support of evidence-based practice in everyday practice. Health care professionals need to be "knowledgeable doers" in order to deliver the best possible care when and where it is needed.

6.3 This however, cannot be achieved without a supportive research and development programme. Evidence-based practice needs to be incorporated within the fibre of the Trust's agenda for the delivery of care. Practices which promote efficacy of care must be developed, and research must be undertaken into those practices where uncertainty exists as to their efficacy. In addition, the call for evidence-based practice must be accompanied by the application of evidence-based policy and risk management.

6.4 A multiprofessional research and development strategy is therefore an essential component for the effective operationalisation of clinical governance within Altnagelvin Hospitals Health and Social Services Trust.

7.0 CLINICAL RISK MANAGEMENT

7.1 Clinical risk management involves clinicians, managers and health care provider organisations in identifying the circumstances or practices which put patients at risk of harm, and then acting both to prevent and control those risks. It can be seen as "an approach to improving quality in health care which places special emphasis on occasions when patients are harmed by their treatment.

7.2 Clinical audit and clinical risk management programmes share common principles, particularly the use of adverse events monitoring and the development of clinical guidelines and protocols. Identification of clinical risk issues can serve as triggers for clinical audit projects.

7.3 Clinical governance demands that the systems for monitoring and improving quality - clinical audit, risk management, evidence based practice - are themselves of excellent quality, and are inter-linked and co-ordinated to form a single comprehensive system. Clinical risk management is not the role of a chosen few, it is part of the professional responsibility of every practitioner.

7.4 It is increasingly clear that non-adherence to best practice standards and failure to extend adequate supervision and training to junior staff are indicative of clinical risk.

7.5 Current thinking acknowledges that clinical risk management extends beyond medical practice alone, to the whole range of hospital staff with clinical and managerial responsibilities, and emphasises the need to recognise clinical risk management as a vital component of everyday practice.

7.6 Whilst the Risk Management Co-ordinator works closely with the Medical Director and Director of Nursing in managing all aspects of clinical risk, accountability and responsibility rests with each individual practitioner for the standards of their professional practice.

7.7 Whilst this sub-section of the report has placed emphasis on clinical risk management as it directly impacts on the quality of patient care, general risk management and health and safety principles have a major contribution to make through creating the environment in which excellence in clinical care will flourish.

8.0 STAFF ISSUES

8.1 Central to the successful implementation and maintenance of effective clinical governance will be the key policies and procedures relating to the staff of any organisation. From Altnagelvin Hospitals Trust perspective the following areas of personnel practice will be critical.

8.2 Workforce Planning

Of central importance to the effective delivery of quality care to patients is having the right balance of skills, knowledge and experience within the organisation. To this end workforce planning will play a vital role both in terms of new service developments and in the continued delivery of existing services. Workforce planning will also gain in importance as we face increasing pressures due to shortages of particular skills within the health service.

8.3 Recruitment and Retention

The Trust already has in place a set of selection and recruitment procedures which are designed to ensure best practice in the recruitment and selection of staff. It is of paramount importance that the right calibre of staff with the requisite skills, knowledge, experience and attitude are employed by the Trust. To this end the Trusts existing selection and recruitment procedures will be reviewed regularly to ensure their effectiveness. Retention of staff is becoming more difficult for a variety of reasons. It is imperative that an environment is created whereby key staff are encouraged to remain in the Trust's employment - areas such as good working environment, employment security , family friendly policies and flexible working practices, as well as fair and equitable reward systems are central to the recruitment and retention of staff.

8.4 Training and Development

Most staff employed within the Trust are professionally educated and trained. However basic skills need continuous development through experience and ongoing professional training. Most professions have a statutory minimum requirement in terms of continuous professional development. Systems need to be in place to ensure that the training and development needs for all staff are identified, delivered and evaluated. Of particular importance is the need to train clinicians in leadership skills.

8.5 Appraisal

Central to the identification of individual training needs will be the introduction of hospital wide appraisal systems, which will be tailored to the characteristics of different professional groups. These appraisal systems will be the foundation on which a corporate training plan to meet the identified training needs of all staff will be built. The training plan will be regularly reviewed to ensure relevance to meeting identified need.

8.6 The Role Of Discipline

Whilst our primary objective is to create a culture of openness where staff will be encouraged to report clinical incidents with a degree of impunity it is inevitable that in some circumstances the disciplinary process will have to be invoked. It is vitally important that discipline is used in the correct manner and is seen as a method of improving unacceptable standards of behaviour rather than as a method of punishment. Disciplinary procedures must not only be fair but must be seen to be fairly applied.

8.7 Co-ordination of education and training will ensure that the needs of the individual and the organisation are being met. Issues which are highlighted as part of the Clinical Governance process will be addressed by appropriate training.

9.0 TRAINING AND EDUCATION OF STAFF

9.1 Implicit in the principle of clinical governance is the responsibility within all Health and Social Care professionals that they accept personal responsibility and accountability for their proficiency to practice. Thus, one of the cornerstones of clinical governance is the recognition that all clinical staff engaged in care must access continuing professional development opportunities i.e. in medicine the Royal Colleges have already introduced a Continuing Medical Education (CME) Programme for all career grade staff. Similar programmes exist for Nurses and Professions Allied to Medicine.

9.2 There is therefore a need for Altnagelvin Hospitals Health and Social Services Trust to have in place frameworks and resources that support ongoing education and training, which seek out new models of support that are flexible, innovative and responsive to service needs, such as on the job training support; the expansion and enhancement of clinical and care supervision; the maximum utilisation of information technology as a tool for education training; and, the development and expansion of multidisciplinary shared training.

9.3 It would however, be fair comment to state that nurse practitioners accessing continuing professional development opportunities through Altnagelvin Hospitals Health and Social Services Trust's In-Service Education Strategy, do undertake programmes that assist them to develop their scope of practice, deliver evidence-based care, update practical skills in line with current research findings and contribute to clinical effectiveness within the context of a multiprofessional approach to the delivery of patient care.

9.4 Thus, a multiprofessional workforce support for the enhancement of in-service education for all health care professionals within the Trust requires active commitment towards the realisation that education, training and research and development are essential underpinnings for a high quality service which permits health care professionals to reliably know that they are doing the right thing, in the right way, for the right patients, at the right time.

10.0 INFORMATION / INFORMATION TECHNOLOGY / LIBRARY SERVICES

10.1 The new requirements for clinical governance mean that the quality of data collected to monitor clinical care must be of a high standard. Traditionally clinicians have viewed data collection as a requirement imposed upon them which, due to a lack of relevant feedback, they did not see as having direct benefit to their work. To achieve improvements in data quality clinicians collecting the data must have a sense of ownership brought about by their active use of it to promote local clinical improvements.

10.2 As highlighted in the new NHS Information Strategy *'Information for Health'*

"Implementing a framework for clinical governance requires a comprehensive programme of quality improvement such as clinical audit, and evidence based practice and processes for monitoring clinical care using effectiveness information and clinical records systems. To achieve this, information must be drawn from:

- local clinical audit data
- national comparative data
- local care pathways and clinical protocols
- national best practice guidelines
- National Institute for Clinical Excellence evidence
- international research evidence.

All this means statistical data must be linked with textual reference material."

10.3 Such information will be available in a number of locations and accessed in a number of ways.

a) Hospital Information Systems - currently these systems, including the departmental systems of Radiology and Pathology, provide a base of anonymised and aggregated data to support clinical audit. Ways need to be

found to make this data more accessible to the various clinical groups to support clinical audit.

b) Knowledge Bases - these are continually growing. They range from what is available in text format in libraries, through CD ROM publications to the Internet / Intranet. To encourage evidence based practice within the Trust it is necessary to provide all clinicians with easy access to these facilities.

10.4 The development of integrated care pathways brings with it a requirement to make these readily available in reference format to all professionals involved in the patients care. This again is suitable for Intranet technology. To assist these become more established within the Trust it is important to embed them into the working processes of the patients care. Information systems can be used to reinforce these pathways by including prompts at various stages and immediately highlighting actions outside of the normal pathway e.g. requesting tests through order communications. Such information can then be used to compare actual care against the planned pathway and to highlight variances.

10.5 Monitoring databases will be required to track incident and accident reporting associated with the risk management agenda.

10.6 The increased requirement for clinicians to access all the relevant information means that Trusts must enable them to acquire the skills required to analyse this information and act on their findings.

11.0 RESOURCES

Uncontrolled risks have the potential to place an increasing financial burden on Health Care organisations. The expanding costs of litigation will deflect resources away from direct patient care.

The introduction and development of a Clinical Governance Strategy has major implications for the NHS. Clinical Governance will require Trusts to develop and build on the good and effective systems already in place to deliver on the clinical governance agenda and to put in place those that are lacking. This is not without significant resource implications in terms of:-

- personnel
- training and support for staff
- information technology and management
- time
- supporting structures such as buildings and physical space.

Careful consideration and planning must be given to the realisation of the required funding necessary to support the values of clinical governance. Without this level of commitment to resources the objectives of clinical governance may be in danger of termination before life exposing our patients to a less than best service.

12.0 SUMMARY

12.1 The concept of Clinical Governance is in its infancy. It is a complex activity which seeks to co-ordinate the disparate quality activities and systems within a hospital / practice into a coherent strategy.

12.2 Clinical Governance requires the development and education of staff, an infrastructure of resources and facilities which includes information technology, and the identifying and training of clinical leaders within an organisation.

12.3 However, for the new concept of clinical governance of which clinical effectiveness is such an important part, the chief change required is probably a cultural one.

12.4 Altnagelvin Hospital is committed to the success of Clinical Governance within the Trust. Critical to that success will be the need to encourage the appropriate culture amongst all staff.

12.5 It is also of importance to continue to develop links with Purchasers, Public representatives, and Educational facilities for by doing so we will be putting quality at the top of the agenda.

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ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST
ALTNAGELVIN AREA HOSPITAL

DELIVERING QUALITY
A Clinical & Social Care Governance Strategy

BACKGROUND

Clinical Governance has been defined as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care...." (A First Class Service 1998). Under the term clinical governance NHS Trusts have had a duty, since 1998, of ensuring the clinical quality of the services they provide. In N. Ireland a consultation document was issued in April 2001 "Best Practice - Best Care". It states, "Clinical and Social Care Governance is about organisations taking corporate responsibility for performance and will provide guarantees for the standards of clinical and social care" and proposes the creation of a statutory duty of quality on Health and Social Services Trusts.

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

A Clinical Governance Steering Group was established to examine the requirements of this duty of quality. This Group's membership was drawn to reflect the various components of the clinical governance agenda. A number of workshops were held to explore the systems that the Trust needs to put in place to monitor quality and the actions required to implement the agenda.

ACCOUNTABILITY

The legislation will place a statutory responsibility on Trusts for the quality of its services. Chief Executives will be held accountable for this. Arrangements need to be put in place to enable the Chief Executive to discharge this responsibility and for the Trust Board to be assured of this.

The Steering Group believe that each Clinical Director is accountable for the quality of the services they provide and that this must be managed within the normal accountability arrangements of the Trust, both within the individual accountability system with each Clinical Director but also through the Directorate business planning and accountability meetings, where it should form a main item on the agenda.

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ASSURANCE TO TRUST BOARD

Guidance from the DHSSPS in relation to structures for Clinical Governance within individual HPSS organisations gives indications of future direction including the requirement for the following committees: -

- A Clinical Governance Committee
- A Risk Management Committee.

However, there is also a cautionary note indicating that Clinical Governance should not result in increased bureaucracy within organisations.

These requirements were shared with Hospital Executive at a recent meeting. The Chief Executive felt that there was also a need for a Standards Committee which would have a remit for Clinical Procedures and Policies / Guidelines. The Medical Director and Director of Nursing were charged with producing proposals on Structures / Remit to Hospital Executive.

STRUCTURES

Accepting that there should be no unnecessary bureaucracy and that the accountability arrangements would remain the same – the Medical Director, Director of Nursing and Risk Management Director met to discuss the Assurance aspect of the Structures for Clinical Governance. It was quickly accepted that one committee i.e. the Risk Management and Standards Committee could develop the systems for Risk Management and Clinical Procedures etc within the Trust. Proposed membership is identified in Appendix I.

The Terms of Reference included in Appendix II are clearly of a standard setting and monitoring nature i.e. not about delivery, although it is accepted that support will be needed by Directorates especially in the early stages. The role therefore of the Risk Management and Standards Committee is to assure the Clinical Governance Committee and Trust Board that systems are in place to set and monitor the standards relating to Quality of Patient Care and to Risk Management in the Trust. A number of existing committees within the Trust have a remit to address some aspects of this agenda and it is proposed that these become sub-committees of the Risk Management and Standards Committee i.e. part of the ASSURANCE SYSTEMS. The advantage of this proposal is that the accountability of these committees will be to the Risk Management and Standards Committee who will report to the Clinical Governance Committee. The Risk Management and Standards Committee will also need to link closely with Hospital Executive as there may be resource implications for the Trust in addressing deficits in quality or high risk issues and these would need to be fully explored and included in any Business Cases / Service Delivery Plans in the future.

The Trust Board considered the issue of membership of the Clinical and Social Care Governance Committee at its October and November meetings. The consensus of opinion was that for the Committee to be able to provide the assurance to Trust Board that a

rigorous system was in place for Clinical and Social Care Governance, that the Committee should be composed mainly of Non-Executive Directors. There was recognition of the complexity of the issues to be considered by the Committee so it was also agreed that the Medical Director and Director of Nursing should also be members of the Committee. In addition, the Risk Management Director was to be in attendance at each meeting and the Chief Executive could also be invited, as the accountable officer, to attend meetings as required. The membership of the Committee is contained in Appendix III and the Clinical and Social Care Governance Committee structure is in Appendix IV.

FREQUENCY OF MEETINGS

The Risk Management and Standards Committee should meet on a three-monthly cycle. The Clinical Governance Committee should meet formally four times per year, the first meeting to be held in January 2003. On a monthly basis reports from the Risk Management Department will be made available to Trust Board, Hospital Executive, Hospital Management Team and Directorates. These will be statistical reports with a brief action plan included. A standing item under Confidential Business for Trust Board should be Clinical Governance where urgent issues can be reported and discussed. A more detailed report will be available for the Clinical Governance Committee meeting, which will include quality improvements, and risk management issues addressed or to be addressed. Clinical Governance should also be a standing agenda item for each Hospital Executive and Hospital Management Team meeting as well as Directorate meetings.

USER INVOLVEMENT

The DHSSPS circular emphasises the importance of user involvement. It states "*Securing appropriate and effective user and local community involvement will be central to the success of clinical and social care governance. 'Token involvement syndrome' must be avoided.*" It refers in particular to the role of users and communities can play in the planning and delivery of services.

Within the Trust a number of initiatives are in place, which involve users of the service: -

- Patients Council
- Dermatology Users Committee
- Stroke Patient Group
- Maternity Services Liaison Committee

The Western Health and Social Services Council has regular meetings with Trust Board and their members serve on some of the internal committees: -

- Ethics Committee
- Patients Council

The Trust also works in close harmony with external agencies: -

- British Diabetic Association
- Derry Healthy Cities project
- Healthy Living Centre in Creggan
- British Heart Foundation
- Chest, Heart and Stroke Association
- Western Equalities and Human Rights Forum which is developing links with user groups for consultation on policy development, inclusive of Clinical Governance Policies

This area requires further development as part of the Clinical Governance Agenda.

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MAINSTREAMING QUALITY - ACTION PLAN FOR 2002/2003

The success in addressing the quality agenda will be in the way in which we are able to make it a part of everyone's job and not have it as a separate initiative being managed by a specially formed committee. To 'kick-start' the agenda the Clinical Governance Steering Group recommends the following actions: -

Quality:

Some years ago the Trust introduced a Hospital Quality Improvement Programme (HOSQIP). This involved a range of initiatives designed to improve the Patients' experience of care. The strength of this programme was the involvement of the entire Multi-disciplinary team/s in development of good quality initiatives. **It is recommended that each Ward/Department develop 1 or 2 HOSQIP projects to be undertaken and audited in the current year.** Directorate Management Teams should provide leadership and support to this activity through identification of a Directorate Facilitator to meet regularly with the ward/department teams and receive reports on progress and assist with problem solving.

Clinical Audit:

This is seen as an important vehicle for moving the quality agenda forward. It is already an established activity within the Trust (with variable degrees of activity). However, it is seen as a mechanism to achieve early action with the potential to see early success in achieving change that can then be built upon. **It is recommended that each specialty be charged with undertaking a clinical audit of one of the professional guidelines issued by the Royal Colleges or other professional / standards body.** It is not intended that this will replace all other audit activity within the specialty but this is the one audit that will be expected to have been through the complete audit cycle. The changes in practice that have come about as a result of the audit will be reported on by the specialty.

In addition the Clinical Governance and/or the Risk Management Committee will draw up, on behalf of the Trust Board, a list of potential audits that would be seen as a priority from a Trust perspective. The Trust Board will then commission these audits from the appropriate Directorates.

Care Pathways:

Another method to bring about change is the introduction of integrated care pathways developed from evidence-based standards of care. **It is recommended that each specialty is required to develop at least one Integrated Care Pathway, subject it to the audit cycle and to report on the outcomes.**

Baseline Assessments:

The foundation for an action plan for the Trust in this area is the assessment of where everyone currently is in terms of the issues covered by clinical governance. **It is recommended that each Directorate conducts this baseline assessment by 28th**

February 2003 and has an agreed action plan developed by 31st March 2003. The Clinical Governance Steering Group has developed the assessment tool. Support will be provided to the Directorates in the analysis of their assessment and the development of appropriate action plans (Appendix V). The assessment tool will provide information on Staff's knowledge of and participation in Clinical Governance related activities. It will be aimed specifically at senior professionals in the first instance and will provide the basis for the education and awareness training required within the Trust.

Risk Management:

Ownership of the Risk Management Agenda by Directorates and Clinical Professionals within Specialties is key to successful risk elimination and/or reduction. **It is recommended that within each Directorate lead clinician/s are identified for Risk Management.** The Risk Management Director will work with Directorates to support them in developing their knowledge and skills in improving quality through a robust Risk Management system.

Reporting Arrangements:

It is important, particularly for the assurance of the Trust Board, that there are robust arrangements for the reporting of clinical governance issues. **It is recommended that each Directorate reports on a quarterly basis the progress it is making in its action plans.** To ensure consistency and completeness of reports the Clinical Governance Steering Group have developed a reporting template to be used by all Directorates. Such reports can form the basis of reporting to the Trust Board and will input to the annual report that it is expected that the Trust will be required to produce (Appendix VI).

User Involvement:

The involvement of users in the planning and delivery of services needs to be continually reviewed. **It is recommended that the Clinical Governance Committee address this issue in the agenda of their first meeting and give guidance to the Trust staff as to how this may appropriately be achieved.**

CONCLUSION

It is important that the whole organisation sees the pursuit of quality as a priority. Ensuring ownership and accountability of individual clinicians and Directorates is critical to success and this should be actioned through existing lines of accountability. However, the Assurance aspect of Clinical Governance ensures clarity of systems and processes, which help Directorates to deliver on the Quality Agenda. Close co-operation between Directorates, Hospital Executive and Hospital Management Team and the Risk Management and Standards Committee and sub-committees will ensure a team approach to changing the culture of the organisation and improving the quality of patient care.

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APPENDIX 1

PROPOSED MEMBERSHIP OF RISK MANAGEMENT & STANDARDS COMMITTEE

Dr Geoff Nesbitt, Medical Director	**Chairperson**
Dr Raymond Fulton, Consultant	**Vice Chair**
Dr Maurice O'Kane, Head of Research	
Dr Michael Parker, Chair of Clinical Audit	
Mrs Therese Brown, Risk Management	
Mrs Anne Witherow, Clinical Effectiveness	
Miss Irene Duddy, Director of Nursing	
Mr Richard Wray, Chair of Medical Staff	
Mrs Paula Cunningham, Associate Director of Clinical Service Development	
Mr Seamus Doherty, Allied Health Professionals	

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APPENDIX II

RISK MANAGEMENT AND STANDARDS COMMITTEE

TERMS OF REFERENCE

1. To provide a systematic and strategic approach to the management of all risks within the Trust.

2. To promote the reporting of incidents or near misses in a culture of openness.

3. To monitor trends and risk management issues identified by the incident database.

4. Decide the nature and form of regular reports and advice to Executive Officers, and the Clinical Governance Committee on urgent risk management issues and make recommendations as to solutions to avoid recurrences.

5. Advise on education and training relating to risk management and standards.

6. Establish and maintain a timetable for an ongoing programme of risk assessment throughout the Trust.

7. To receive and review reports from Risk Management and Standards Committee sub-groups.

8. Maintain the Trust's Risk Register and prioritise the Trust's risk portfolio.

9. Assure the Trust Board that controls assurance mechanisms are in place and are effective.

10. Clinical policies, Guidelines, and Protocols will be submitted to the Risk Management and Standards Committee for approval. A central database of these will be kept within the Risk Management Department.

11. Clinicians (Medical and Non-medical) wishing to undertake new Clinical Procedures will submit a written proposal to the Risk Management and Standards Committee for approval. Approval will be based on presentation of the evidence base for the procedure, the Clinician being properly trained to carry out the procedure and an examination of the potential risk and capital and revenue cost for the organisation.

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST CLINICAL GOVERNANCE REPORTING TEMPLATE

The information provided by Directorates will form part of Altnagelvin Health & Social Services Trust Annual Clinical and Social Care Governance Reports. The information provided will demonstrate our commitment to the Statutory Duty of Quality for Clinical and Social Care Governance requirements.

NAME OF DIRECTORATE:

REPORT FOR PERIOD: 1 April 2004 – 30 September 2004

1. QUALITY
Details of HOSQIP Project(s) to be implemented and audited in the above period.

2. USER INVOLVEMENT
Details of involvement of service users within the Directorate within the reporting period

3. COMPLAINTS and COMMENDATIONS
Details of complaints and commendations arising during the above period and actions taken out of information received

4. RESEARCH
Details of research project(s) to be implemented for the above period

5. CLINICAL AUDIT
5.1 List of recommended audits from your Royal College
5.2 Details of a Clinical Audit of one of the professional guidelines issued by the Royal colleges or other professional standards body
5.3 Details of changes in practice implemented as a result of audit activity

6.	CARE PATHWAYS Details of Care Pathways developed within the Directorate for the reporting period

7.	RISK MANAGEMENT
	Details of work undertaken by the Risk Management Committees within the Directorate Details of recommended changes in practice by Directorate Management Committee(s) Confirmation that each ward/department with Directorate that Risk Assessments are up-to-date in compliance with the Management of Health & Safety at Work Regulations, COSHH Regulations and Manual Handling Regulations or other regulations/legislation appropriate to the department

8.	EDUCATION AND TRAINING
	Details of Directorate Training Plan based on outcome of the Staff Appraisal System. Details of continuing professional development which took place for the six-month period 1 April 2004 – 30 September 2004 Details of all other training that took place within the Directorate for the six-month reporting period.

9.	CORPORATE GOVERNANCE
	Details of progress on compliance with Controls Assurances Standards applicable to your Directorate Progress on risk management issues arising out of Directorate Performance Management Meetings Details of key risks and control measures to be put in place including treatment plans to reduce, control and eliminate risks.

10.	**Signature of Clinical/Executive Director** 10.1 Date

ALTNAGELVIN HOSPITALS H&SS TRUST
TRUST BOARD

Minutes of the Trust Board meeting held on Thursday, 11 January 2001 at 2.15 pm in the Boardroom, Trust Headquarters, 1st Floor, Altnagelvin Hospital

PRESENT: Mr D Desmond, Chairman
Mrs S Burnside, Chief Executive
Mr M Doherty, Director of Personnel
Miss I Duddy, Director of Nursing
Dr R Fulton, Medical Director
Mr C Henry, Non-Executive Director
Mrs M Jefferson, Non-Executive Director
Dame Geraldine Keegan, Non-Executive Director
Mr R McCartney, Director of Business Services
Mr A Moore, Director of Estates
Mr N Smyth, Director of Finance

IN ATTENDANCE: Mrs M McIvor, Executive Assistant

ACTION

1 **Chairman's Remarks**

1.1 [redacted]

1.2

1.3

1.4

[redacted] DD

Dame Geraldine asked about staff suggestion schemes. Mrs Burnside outlined the ways in which staff and patients are provided with the opportunity to make suggestions. However, she said that these are not frequently used and that this competition had generated a good deal of staff interest. Mrs Jefferson reported that Mrs Mary Brogan from the Patients' Council was a member of the judging panel. Mrs Brogan was very impressed with the entries. The synopsis of entries will be made available to the Council members.

1.5 Mr Desmond said that Mr Bradley, Chairman and Mr Lindsay, Chief Executive of the Western Board, will meet with Mrs Burnside and himself on 17 January 2001. Mr Desmond hoped that this would be the first of many joint meetings.

1.6 Mr Desmond advised the members that no progress has been made on the appointment of the vacant Non-Executive Director position. Mr Desmond has been in frequent correspondence with the Department of Health. A recent response has suggested that the vacancy may be advertised by the Department in March 2001.

2 Apologies – Mr N Orr.

3 **Previous Minutes for Approval**

The minutes of the Trust Board meeting held on 7 December 2000 were approved, subject to the following amendment.

Mr McCartney asked that the following sentence be inserted on page 4, fourth paragraph, second sentence, "Mr McCartney said that the initiative is being progressed in close collaboration with Sperrin Lakeland."

4 **Matters Arising from the Previous Minutes**

4.1 MRI Business Case – [redacted]

[redacted]

[redacted]

4.2 Permanent Injury Benefit – [redacted]

MD

5 **Executive Directors' Reports** – The Directors of Finance, Business Services, Nursing and Estates reports were taken as read.

5.1 Mr Desmond asked each of the Directors to highlight any major issues in their reports.

Matters Arising from Reports

Director of Finance Report – Mr Smyth reported that the financial position was close to break-even for the month. With regard to the year-end position, he said break even was still forecast but he warned that given the time of year, this position could change were any further pressures to arise.

Mr Smyth referred to the underlying deficit position and reported that Mr McCartney and himself have met with the Western Board on a number of occasions in an effort to move the matter forward. He reminded the members that the major components of the deficit are costs for the Stroke Unit, unfunded nursing posts and junior doctors' hours. Progress has been made with regard to junior doctors and nursing costs. Discussions continue regarding the Stroke Unit. Mr Smyth said that it has been agreed to jointly examine nursing numbers and skill mix and to conduct a benchmarking exercise with appropriate Trusts. Mr Smyth said he hoped for a solution to be reached to the deficit problem which was satisfactory to all parties including the Department of Health.

Mrs Burnside said that the benchmarking exercise will be conducted and positive action will be taken should the numbers prove to be in higher proportions to other places. She again spoke of the absence of any objective criteria for benchmarking in this area.

Director of Business Services Report – Mr McCartney drew attention to the overview of activity trends over the past four years, in Figures 1 and 2 of his report, provided for information. He then reported that the increases in activity referred to last month continued in October in a number of areas. Mr McCartney said it was hoped this increase will be maintained. He then referred to Figure 3 which provided information on seasonal variation activity over the past four years compared with the present year.

[redacted] RMcC

[redacted] RMcC

[redacted]

[redacted]

Director of Nursing Report – Miss Duddy referred to the first Risk Management Newsletter which had been provided for the members' information. She said the Newsletter was circulated to all staff to heighten awareness of their responsibilities with regard to risk management and health and safety. The newsletter will be produced on a regular basis and will address various relevant topics. Dame Geraldine said the Newsletter was very readable and a good method of staff communication.

Mr Henry presented to Mr Desmond a Certificate received by the Health and Safety Committee from the Health and Safety Executive. This related to the Hospital's participation in a "Working Well Together in Healthcare Competition". Mr Henry will convey the Trust Board's appreciation to the Health and Safety Committee.

Director of Estates Report – [redacted]

[redacted]

[redacted]

[redacted]

AM

6 **Reports from Statutory Committees**

There was no business to be reported from the Audit Committee or from the Remuneration and Terms of Service Committee.

7 **New Contract for Junior Doctors**

Mr Doherty referred to the presentation he made at the previous meeting regarding the implications for the Trust of the new contract for junior doctors. He informed the members of the high proportion of posts in the Hospital that are presently non-compliant and of the potential increase in costs. The cost could represent a 10% increase in the overall salary costs for junior medical staff. The information has been shared with the Western Board. He said it is not yet known whether any funding will be made available by the Department to cover additional costs.

Attention was also drawn to the added complexity of securing approval for additional training posts, where funding is available. These are controlled in number by the central approving authority and posts which are non-training grades are not attractive to candidates.

Dr Fulton said that this is a wide problem which is being examined at government level. He spoke of the increasing reliance upon overseas doctors, particularly in smaller hospitals. Under the present regulations, overseas doctors cannot be recruited to training grades.

Mrs Burnside spoke of the need for an examination and updating of the role of doctors, their duties and responsibilities in relation to other professional groups. She also spoke of the need for changes to the medical hierarchy system. In response to a query from Mr Desmond on any action the Trust could take, she suggested that within the Trust a pilot could be undertaken to look at ways in which the junior doctor's role relates to other professional groups, particularly nursing. It was agreed that Miss Duddy and Dr Fulton would examine the issue to explore the possibility of undertaking a pilot study in one of the smaller specialties. This could look at different ways of providing care that is traditionally given by junior doctors. It could enable a more effective use of their's and other staff's skills whilst having benefits for patient care.

ID/RF

8 **Any Other Business**

8.1 [redacted]

[redacted]

9 **Date of Next Meeting** – The next meeting of the Trust Board will take place on Thursday, 1 February 2001 at 2.15 pm in the Boardroom, Trust Headquarters.

10 **Any Confidential Business**

10.1 [redacted]

SIGNED _____ DATE _____
Chairman

ALTNAGELVIN HOSPITALS H&SS TRUST
TRUST BOARD

Minutes of the Trust Board meeting held on Thursday, 7 June 2001 at 9.45 am
in the Boardroom, Trust Headquarters, 1st Floor, Altnagel

Evidence
Clinical Governance
Report
Page 5. Item 10
Trust Board
7 June 2001

PRESENT:

Mr D Desmond, Chairman
Mrs S Burnside, Chief Executive
Mr M Doherty, Director of Personnel
Miss I Duddy, Director of Nursing
Dr R Fulton, Medical Director
Mr C Henry, Non-Executive Director
Mrs M Jefferson, Non-Executive Director
Dame G Keegan, Non-Executive Director
Mr R McCartney, Director of Business Servic
Mr A Moore, Director of Estates
Mr N Orr, Non-Executive Director
Mr N Smyth, Director of Finance

IN ATTENDANCE:

Mrs M McIvor, Executive Assistant

ACTION

1 Presentation by Medical and Ambulatory Care Directorate (OHPs available)

[redacted]

[redacted]

[redacted]

Chairman's Remarks

[redacted] DD

[redacted]

3 Apologies – none.

4 **Previous Minutes for Approval**

The minutes of the Trust Board meeting held on 3 May 2001 were approved and signed by the Chairman.

5 **Matters Arising from the Previous Minutes**

5.1 Haematology Services - [redacted]

[redacted]

[redacted]

[redacted] NS

7.2 Remuneration Committee – [redacted]

8 **Budgets 2001/02**

Mr Smyth referred to the Proposed Budgets 2001/02 which had been previously circulated. Mr Smyth said the Budgets were likely to change since the Service Investment Plan and Service Delivery Plans have not been approved and there is still a funding gap.

Mr Desmond asked whether the Budget could be approved by the Board until the assumptions that have been made within it and their outcome becomes clearer. Mr Smyth said that the document could be used internally as the basis of reporting to all budget holders each month but acknowledged that there were significant issues that need to be clarified.

It was agreed that the Budget could not be approved. It was suggested that the Department should also be informed of the untenable position of not yet having a resolution.

9 **Capital Equipment Purchases**

[redacted] NS

Clinical Governance Evidence

10 **Clinical Governance Report – Jan – Mar 2001**

Miss Duddy referred to the first Clinical Governance Report which she had provided for the quarter ended January to March 2001. She said that reports on quality standards from each of the directorates and committees will be included in the quarterly reports. She then drew attention to two issues: (i) on page 39 of the document information was included which shows there can be major cost implications of dealing with pressure sores. The work reported shows that good management and good nursing care can prevent pressure sores. Miss Duddy said that Altnagelvin is well within the national targets on this;

(ii) the report from the Rescusitation Committee on the Audit of Cardiopulmonary Arrest was included in full in the report and makes for interesting reading.

Miss Duddy said that future reports will look at significant trends and follow through. Miss Duddy asked for constructive comments on how the layout and detail of the report could be made more useful for the members. She said the detail will be provided on a quarterly basis in confidence and there will be an annual report made available to the public.

Mr Desmond said the document was extremely comprehensive and very useful to demonstrate learning and change by examining what is happening.

Dame Geraldine asked about a deadline for comments and about the longer term strategy on clinical governance. Miss Duddy said it would be useful to have comments one month before the next quarter's report and that the planned workshop with key members of staff has now taken place and she will report on feedback to the September Trust Board. Miss Duddy also distributed for the members' information a published article written by S/N [redacted] on "Transfer Anxiety: Preparing to Leave Intensive Care". All

ID

11 **"Best Practice – Best Care"**

Mrs Burnside made a presentation on the Minister's document, "Best Practice – Best Care". She said the proposals relate to setting standards, delivering services and improving monitoring. Mrs Burnside took the members through the Options contained in the document regarding standard setting, concentrating on Option 3, which is the stated preferred option. This proposes to make arrangements with the existing standard setting bodies eg, NICE, SCIE whereby the Department would have early warning of the standards and guidelines being produced.

The document is out for a consultation period with the deadline for responses due in mid July. Mrs Burnside asked for comments from the members as soon as possible to inform our response. All

She said that clinical governance is about creating a framework within all of the audit and assurance systems. She said she was favourably disposed to good clinical governance since a lot could be learnt. Mrs Burnside feels that Northern Ireland is not big enough to have it's own standard setting institutions. She suggested there should be links with those in the UK and that this would be more cost effective. With regard to resources she felt that additional investment will be required and cited an example of the Medical Audit department which has had no resource increases in the past 10 years yet clinical staffing numbers have risen over the same period.

Mr Desmond said there are links between quality and cost and that for proper systems to drive and implement practice there is clearly cost association. He suggested this must be included in our response.

Mrs Burnside agreed that this was a serious issue since changing a culture, when professionals may feel threatened and need support, will have to be done by properly qualified people and the resulting additional scrutiny of working practice will have associated costs also.

12 **Any Other Business**

12.1 The Department Circular entitled, "Public Access to Meetings" was distributed for information. Mrs Burnside said that it has serious resource implications for the Trust. She said that existing arrangements will be reviewed and new proposals put forward in due course. MMcI

12.2 [redacted]

12.3 [redacted] MMcI

12.4 The members agreed that the Annual General Meeting will be held on Wednesday, 26 September 2001 at 6.30 pm in the Clinical Education Centre. MMcI

13 **Date of Next Meeting** – The next meeting of the Trust Board will take place on Thursday, 5 July 2001 at 2.15 pm in the Boardroom, Trust Headquarters.

14 **Any Confidential Business**

14.1 Retention of Organs – [redacted]

[redacted] NO

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

14.2 Strategic Project – [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

SB

SIGNED _____ DATE _____

Chairman

Q30

CRITICAL INCIDENT PROTOCOL

Introduction

On occasions serious incidents involving patients may occur. These would include an event resulting in or with potential to develop into, serious damage, injury or death of a patient. They are usually termed Critical Incidents and are events, which will likely attract media attention.

This protocol details the procedure to be followed in the reporting and investigation of a Critical Incident. This protocol supplements the Trust Clinical Incident Policy dated February 2000.

Flow Chart
Critical Incident Process

⇓

Critical Incident Occurs

⇓

Clinical Notes Completed/ Clinical Incident Form Completed

⇓

Inform the Clinical Services Manager/ Clinical Director and the Risk Manager

⇓

The Risk Manager to Inform the Chief Executive, Medical Director, Director of Nursing

⇓

The Risk Manager will arrange a Critical Incident Review meeting ASAP comprising
~~In attendance will be~~ The Medical Director/ Nursing Director/ Clinical Effectiveness Co-ordinator/ Clinical Director/ CSM/ Consultant and other relevant staff.
(On occasions the Trust's Solicitors may be present.)

⇓

The Critical Incident Meeting will endeavour to clarify the circumstances surrounding the incident and identify further investigations and action required to prevent recurrence.
(Staff may be asked to complete a statement, containing factual information of their involvement, to assist in the investigation).
Note these statements may be discoverable in the event of future litigation.

⇓

The Chief Executive will be kept informed by the Risk Management Co-ordinator throughout the investigation.

⇓

The Risk Management Co-ordinator will provide the Chief Executive with a written report, with conclusions and recommendations within an agreed time-scale.

⇓

The recommendations will be sent to the relevant personnel for action.

RF – ALTNAGELVIN

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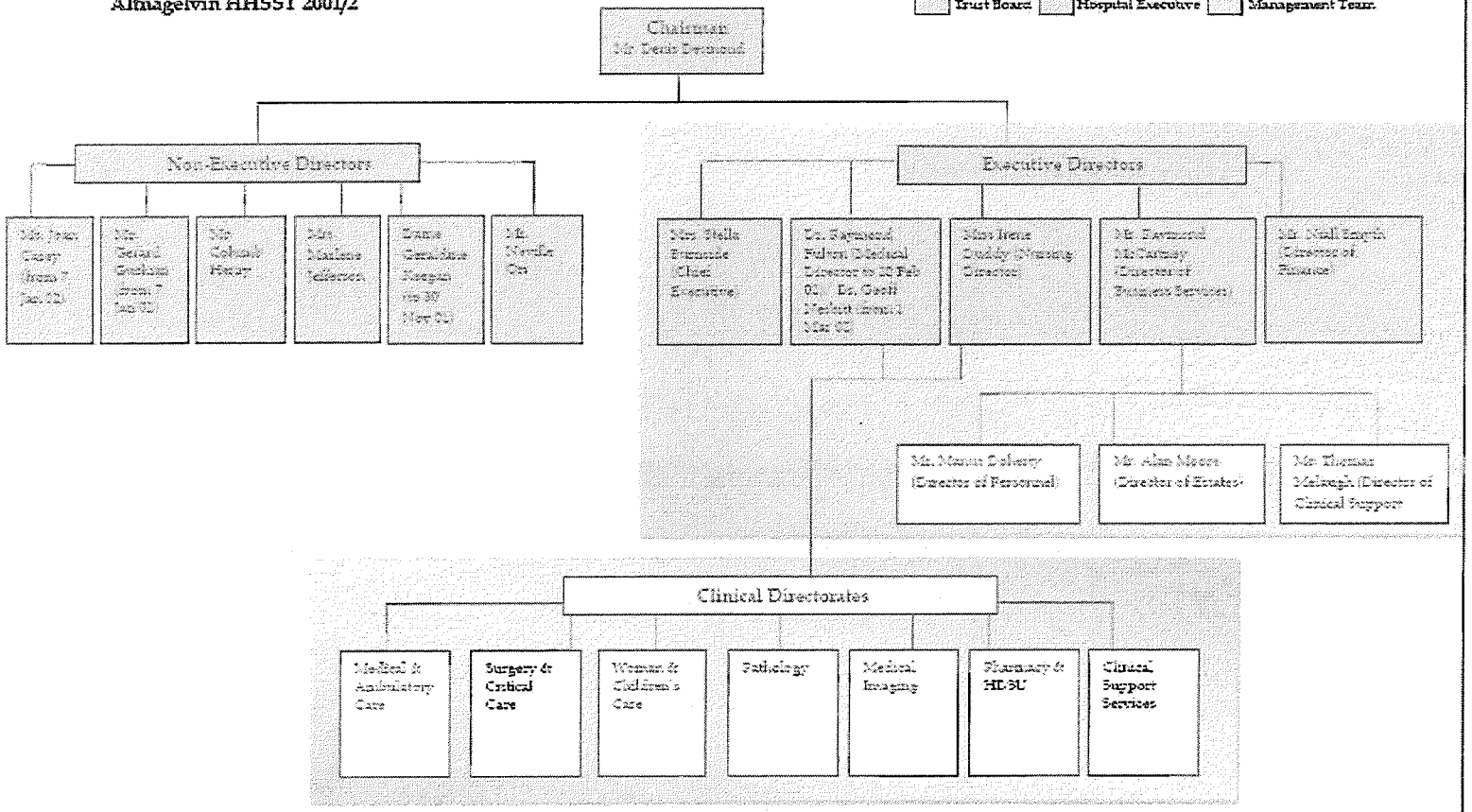
Paediatrics – M Dohert

1 / 1 74.4%

Altnagelvin HHSST 2001/2

Trust Board | Hospital Executive | Management Team



Statutory Committees of the Trust Board

Audit Committee

Mr N. Orr (Chair)
Mrs M. Jefferson

Remuneration and Terms of Service Committee

Mr D. Desmond (Chairman)
Mrs M. Jefferson

Sub-Committees of the Trust Board

Ethics Committee

Mrs M. Jefferson (Acting Chair) / Mr D. Regan (WHSSB Council) / Mrs J. Quiddy / Mr T. Mulvagh

Health & Safety Steering Committee

Mrs J. Hutchinson (Clinical Services Manager- Chair) / Mr C. Henry / Mr P. McCorkell (Support Services Contract Manager) / Mr F. Moran (Estates Services)

UPDATE FOR CHIEF EXECUTIVE
RE: CRITICAL INCIDENT MEETING 12-6-01

This is an update relating to the agreed action highlighted by Dr Fulton's note 0f 13-6-01.

1. Dr Nesbitt has had discussions with anaesthetic colleagues and has made a decision to discontinue the use of Solution 18 for Paediatric Surgical Patients. One of the Surgeons is not supporting this change. (see attached correspondence from Dr Nesbitt).

Further action required. Mrs Brown to undertake a more extensive review of the research regards the use of Solution 18.

2. Daily U&E levels will be checked on all post operative children with an IV infusion. Sr. Millar has already actioned.

3. Nursing staff advise surgical junior staff of the U&E results. Medical staff are bleeped by the nursing staff.

4. A meeting has been held with Mrs A Witherow, Mrs M Doherty, Sr Millar, Sr. Little, Nursing Staff and Nursing Auxiliary Ward 6 to discuss in detail the fluid balance management. The following has been agreed:
   a. Fluid balance sheet must be correctly completed.
   b. A record should be kept of total fluids given.
   c. Accurate recording of output. To be measured. Parents to assist.
   d. Vomit to be recorded as, small, medium or large as opposed to ++.
   e. Nursing staff to be proactive in advising medical staff regarding discontinuation of fluids.
   f. Nursing staff to be proactive in management of fluids required after 4.00 p.m. (Refill bag not just automatically put up).
   g. Sr. Millar to be involved in the training of staff in relation to e and f above.

5. Dr McCord has actioned the display of the chart detailing infusion rates.

6. The Fluid balance documentation currently in use will continue to be used The documentation will be kept under review by Mrs Witherow.

Further Action Required. Mrs Witherow to keep documentation under review.

Note: There is a concern by Nursing Staff that Surgeons are unable to give a commitment to children in Ward 6 unless they are acutely ill and are bleeped. Could Paediatricians maintain overall responsibility for surgical children in Ward 6?

Therese.
The literature need to be reviewed in relation to Adults also.

THERESE BROWN **9TH JULY 2001**

Dr Fulton → discuss with Paediatricians — Ref.

022-097-307

RF - ALTNAGELVIN

Sally Doherty

Fro Sally Doherty
Sent: 26 July 2001 11:08
To: 'Henrietta.campbell@dhsspsni.gov.uk'
Subject: electolyte balance in post operative children

I am writing further to Dr Fulton's conversation with you rgarding the above, and am concerned to ensure that an overview of the research evidence is being undertaken. I beleive that this is a regional, as opposed to local hospital issue, and would emphasise the need for a critical review of evidence.

I would be extremely grateful if you would ensure that the whole of the medical fraternity learned of the shared lesson.

I await to hear further from you.

Stella.

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST
ALTNAGELVIN AREA HOSPITAL
JOB DESCRIPTION

JOB TITLE: Chief Executive

ACCOUNTABLE TO: Chairman

AS ACCOUNTABLE OFFICER TO: The Permanent Secretary, DHSSPS

JOB PURPOSE: The Chief Executive is personally accountable to the Chairman of the Trust for the overall strategic planning, leadership, management and delivery of the quality and quantity of all services within the Trust.

The Chief Executive is responsible for ensuring that services are delivered within agreed financial budgets and that the development and monitoring of professional, statutory and other standards including the requirements under clinical and social care governance and corporate governance are met.

The Chief Executive will hold accountable officer status and operate in accordance with contract standards and within agreed financial targets.

The Chief Executive will be responsible for developing the role of the Trust in the local community with the aim of strengthening and developing strategic alliances across the whole community of Northern Ireland.

GENERAL INFORMATION: Altnagelvin Hospitals Trust is the largest acute hospital in the Western Area Board. There are 502 beds on the site covering specialities including Trauma and Orthopaedics, Oral-Maxillo Facial Surgery, Rheumatology, Haematology and Ophthalmology, Day Case, in addition to the usual DGH specialities. It is a designated Cancer Unit linking with other cancer units within the province to plan and deliver a comprehensive modern cancer care service to the population of Northern Ireland.

It provides services to a local population of 275,000.

Medical students from the Queen's University Belfast are regularly sent to Altnagelvin for part of their training.

There is a Post-Graduate Medical Education Centre attached to the hospital, and a Multi-Disciplinary Education Centre on site that includes a full library facility.

DIMENSIONS:

Facilities

- Acute Hospital Services:
  448 Inpatient Beds, 54 Day Case Beds
- Slow Stream Rehabilitation, Ward 5 Waterside Hospital
  18 Inpatient Beds
- Care of the Young Physically Disabled - Spruce House, Altnagelvin
  17 Inpatient Beds

Staffing
Over 2,200 staff in total (see Annual Report for breakdown)

Altnagelvin is the Regional Co-ordinator for the European Health Promoting Hospitals Network.

ORGANISATION CHART: (See Annual Report)

DETAILS OF THE POST:

Complexity
Managing a large multi-professional healthcare organisation with the complexities of internal and external politics that require to be handled sensitively and assertively.

Ensure the delivery of services to patients during a major capital redevelopment programme to the cost of approximately £80m

Scale
Largest acute hospital outside of the Belfast area. With a staffing complement of approximately 2,200 staff providing the widest range of medical specialities.

Whilst Acute Hospitals are described as similar - Altnagelvin is one with the widest range of acute and secondary specialties.

A capital development programme phase 1 of which has been complete with the building of new outpatients and day case departments, new theatre suite,

ICU/HDU unit, X-Ray Department and Office Suite. Phase 2 will involve a radical redesign and refurbishment of existing tower block.

Diversity
Development of a management culture that engages professionals and directorates in the debate on issues of a corporate nature.

Development of constructive collaboration with commissioners of service and the DHSSPS.

Development of relations with the media and the public and public representatives such as the Assembly, local district councils and the WHSSC.

Planning and Organising
The Chief Executive is responsible for the overall planning, management and delivery of all services within the Trust. The nature of an acute hospital is both complex in scale and time demanding. Altnagelvin Hospital is the only major hospital in a radius of 70 miles, therefore on constant 'take-in'. The hospital is busy 24 hours a day and has to meet the challenges of both urban and rural population.

The role is primarily one that sets the strategic direction for the Trust but which also recognises the need and ensures that delivery is achieved through the management structure.

Strategic Influence
Forward planning is influenced by issues such as the Commissioning intention of purchasers, the configuration of service delivery and future possible changes based on the various acute services reviews carried out or in progress and in relation to demography and morbidity.

The single most important strategic issue for which the Chief Executive is responsible is the redesign of the main hospital tower block that will have a significant impact on how services are delivered in Altnagelvin for the foreseeable future. Also of major strategic importance is the development of a culture of clinical accountability.

Partnership Working

To achieve a strong relationship between the Trust and the population it serves ensuring that patients are at the centre of decision on the delivery of health care.

The Chief Executive should maintain excellent relations with recognised social, professional and political groups in the community as well as Trust's

commissioners and other key stakeholders in order to ensure that the Trust maintains a positive image with media and opinion formers in respect of its plans and policies.

To develop an effective public relations strategy and to communicate the Trust's position sensitively to users and carers, other organisations, the public, the media and politicians.

To act as a key representative of the Trust in the public arena, setting high standards of openness, accessibility and public accountability.

FREEDOM TO ACT

The Trust Board sets strategic direction. As 'accountable officer' the Chief Executive is responsible for translating strategic direction into action with the authority to make executive decisions on expenditure and on service delivery. Obviously advice is available from clinical and management colleagues however the Chief Executive is ultimately accountable for any decision taken.

COMMUNICATIONS AND WORKING RELATIONSHIPS

The Chief Executive will develop and maintain strong relationships with key stakeholders and build a positive image of the Trust through proactive internal and external communications and programmes, as follows:

Internal

- Chairman of the Trust
- Trust Board and Non-Executive members of the Board
- Senior Management team and senior Trust staff
- Commissioners on purchasing of services
- DHSSPS on strategy and policy
- Minister on strategy and policy
- Professional bodies on standards
- Other Trusts on Service Delivery issues and collaborative working
- Acute Services Review Groups
- Trade Unions and staff organisations

External

- District Councils on local needs
- Education providers on needs of the service
- Universities - Queens & University of Ulster
- Royal Colleges

- Professional Associations
- Validating bodies eg, NVQ, CPA

(This list is not exhaustive)

PERSONAL DEVELOPMENT

The Chief Executive:

- Should agree and review personal development objectives annually with the Chairman.

- Participate as appropriate in external activities that contribute to the standing, reputation and perception of the Trust.

- Contribute to the development of the Chief Executive Role.

This Job Description is in accordance with Altnagelvin Hospitals H & SST's Equality Scheme, to ensure that equality and human rights issues are addressed within the post holder's area of responsibility.

The Trust operates a No Smoking and No Alcohol in the Workplace policy and staff are required to participate in and adhere to the implementation of these policies.

All staff must comply with the Standing Financial Instructions for the Trust.

August 2004