VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care, treatment and management of Mrs Elizabeth Rourke

Progress review

A report for the Minister of Health and Social Services, States of Jersey

January 2010

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1. Introduction

1.1 This report provides an independent assessment of the progress made at Jersey General Hospital in implementing the recommendations from Verita's investigation into the care, treatment and management of Mrs Elizabeth Rourke.

1.2 It follows the commitment made by the Minister of Health and Social Services to States members that Verita would conduct a progress review six months after publication of the original investigation report.

1.3 The progress review took place during the autumn of 2010 and was purposely carried out by the same Verita team that conducted the original investigation - Ed Marsden, managing director of Verita, Derek Mechen, director of client work, Lucy Scott-Moncrieff, associate and Julian Woolfson, consultant obstetrician and gynaecologist and associate.

1.4 Verita is a specialist consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations.

1.5 The full terms of reference can be seen at appendix A.

2. Overview

Background

2.1 The report of our independent investigation into the care, treatment and management of Mrs Elizabeth Rourke made thirty recommendations under eight headings.

2.2 We have kept these headings in our overview of the progress the hospital has made in implementing these recommendations.

2.3 Individual write-ups on the implementation of each individual recommendation follow this overview.

2.4 In carrying out the revisit we were mindful that the scale of change some of our recommendations needed was so big that not all of them would – or could - have been fully implemented in such a short time. This was especially true where cultural and behavioural issues needed addressing.

2.5 We were therefore looking for evidence of good progress and that generally, the organisation and the relevant individual members of staff supported what we had proposed. This extended to the recommendation itself. We saw it as an encouraging sign that in some instances recommendations were modified to fit local circumstances better and to best ensure full ownership.

2.6 We stress that change had started before we were first invited to Jersey. Our investigation into the care, treatment and management of Elizabeth Rourke undoubtedly acted as a spur to further – and perhaps – escalated action, but we recognise that the hospital has for a long time employed dedicated, talented and skilled individuals, providing high-quality and safe patient care. This remains the case.

2.7 As some of the change required will only be achieved over a much longer period, the minister will wish to ensure that processes for assuring continued progress are put in place.

The management of the hospital

2.8 We said in our original report that with a board remit covering all health and social services, the chief officer can devote only a proportion of his or her time to hospital operational matters. We suggested that the hospital was so large and complex that it deserved its own manager – and that the roles of the chief officer and the hospital director should each have a different focus.

2.9 We considered this one of our key and most urgent recommendations. A hospital director needed to focus exclusively on hospital matters leaving the chief officer to focus on the strategic health and social needs of the island and corporate issues across the breadth of the Health and Social Services Department (HSSD) agenda. Without such a separation of responsibilities, it was difficult in our view, for the organisation to establish and maintain the grip it needed over its many activities.

2.10 The top team looking after these two remits is now in post - Julie Garbutt, chief executive and Andrew McLaughlin, managing director of the hospital. Their impact on the organisation has been quickly seen and felt, both through their leadership style and through their proposals for the future structure of the HSSD. The first – and perhaps largest -managerial building block is in place. The appointments are recent, but we heard and saw evidence to justify optimism about them.

2.11 Having the right committee structure to support the management plan and priorities is clearly important. We were reassured to see that this had been reworked in light of the separation of roles between the chief executive and the managing director. The top and bottom of the organisation are now joined through the Corporate Management Executive (CMEX), which has overall responsibility for management of HSSD and the Integrated Governance Committee, which holds the two care quality groups (hospital and community) to account by means of delegated powers from CMEX.

2.12 We had made the point that the medical staff were not adequately engaged in the hospital management and we recommended that clinical directors and clinical leads be allocated sufficient protected time to discharge such important roles effectively. We were struck by the measured way the chief executive and managing director had sought to address this, allowing Andrew McLaughlin (in particular) the time to develop relationships with key clinicians before formalising how best to secure such engagement.

2.13 One positive consequence of this approach was that a number of clinicians liked the new managerial style so much that they were comfortable being part of it, resulting in healthy competition for the vacant post of medical director when it was advertised. Appointments have now been made to this position and the medical director responsibilities are in fact to be shared by two consultants.

2.14 Once these individuals are settled in post it will be important to continue strengthening the managerial role of doctors in the hospital by reviewing the roles, responsibilities and authority of clinical leads.

2.15 Formalising the remit of the Medical Staff Committee has complemented these arrangements, including a re-emphasis that the committee is the appropriate forum for the consultant body to voice opinions and to participate in hospital matters.

2.16 We consider that good progress has been made and that the hospital is subsequently well positioned to develop. Key individuals have been and continue to be appointed, the infrastructure has started to take shape and perhaps most importantly, the managerial style and behaviour necessary for the presence and maintenance of a patient safety culture have been established and are permeating the organisation.

2.17 However, we emphasise that we have reviewed work in progress. The management agenda is extensive and the managers in post are both new and few. It will be important in the months ahead to stabilise the management team and to make sure that it remains appropriately resourced. It will be worthwhile identifying appropriate professional development opportunities – such as those available from the King's Fund - for doctors with a managerial role.

Maintaining and enhancing a patient safety culture

2.18 One of the main conclusions arising from our original investigation was that despite the dedication and skill of its staff, the hospital had an under-developed culture of patient safety and governance in 2006. This showed in a relative lack of policies and procedures, unwillingness to report serious incidents and a blame-oriented environment. We described this as a latent condition which combined with the other factors and active failures we identified to create the conditions in which Elizabeth Rourke's death occurred.

2.19 We made six recommendations on this theme – some more straightforward to implement than others – and it is clear from our re-visit that several important steps have been taken by the hospital to address them.

2.20 We observed that the necessary cultural shift had started to happen through the lead of CMEX, who have set out their vision and strategic direction and the targets for the next three, six and 12 months.

2.21 The senior management team have reinforced the pace and tone of change by modelling openness. They have done this, for example, through introducing team briefings, re-launching the whistleblowing policy, developing a barometer for openness and by designating a board member – the interim HR director – to lead on the promotion of a culture of workplace openness.

2.22 The managing director has developed a reputation for going to all parts of the hospital and for discussing incidents in a challenging but non-blaming way. And we thought it symbolic and positive that his office is based on the third rather than the fourth floor, making it more readily identifiable with the hospital.

2.23 The senior management team have also introduced more order and rigour to processes in general, specifically a more systematic approach to managing and investigating patient safety incidents. Medical staff are consequently more involved, and this helps normalise this activity and make it acceptable to report and discuss incidents.

2.24 We saw a vast improvement in induction and appraisal arrangements for staff and better management of rotas. We believe the hospital now has stronger governance arrangements, so any risks are being better mitigated.

Tackling staffing

2.25 The addendum to our report raised wider issues which did not fit squarely with our terms of reference but which we considered should be brought to the attention of those responsible for the hospital and HSSD. Two of these concerned staffing; one focusing on the island's ability to attract and retain good–quality staff; the other on ensuring safe staffing levels in the hospital. Both resulted in us making recommendations in the main

report alongside a third - which advocated increasing the number of permanent staff in the obstetrics and gynaecology department by appointing a fourth consultant and a sixth middle-grade doctor.

2.26 Progress in this area has been steady, but clearly much remains to be done. This is not surprising given the size of the task.

2.27 There was considerable interest in the advertisement for the consultant position and an appointment was made on 13 December. The successful applicant will be the lead for the maternity unit and in all likelihood, the lead clinician for obstetrics and gynaecology.

2.28 Interviews for the sixth middle-grade position were held in October. No appointment was made and the post is being re-advertised. A candidate appointed in July withdrew for personal reasons. It is however pleasing that the department remains intent on filling this position.

2.29 Assuming that the interviews for these positions are concluded with two good appointments, the department can look forward in the New Year to greater stability and less reliance on locums after what has been a difficult period.

2.30 The recruitment of quality staff remains a major risk for HSSD and is logged on the corporate risk register. This is particularly true in nursing and midwifery, where funding has been approved for 50 more posts but where there continue to be many vacancies.

2.31 However, we were reassured to see a number of positive signs that HSSD is addressing a complex set of strategic issues – none of which has easy answers. This included briefing the States Employment Board in October 2009 about the recruitment and retention of nurses and recommending possible solutions in December.

2.32 Income Data Services have subsequently been commissioned to carry out an independent pay review, Omni Recruitment has been asked to review the recruitment process and the HSSD workforce planning team are considering accommodation costs for nurses. When the results of this work are brought together, HSSD and the States HR service will be well placed to decide on the details of any recruitment and retention package.

2.33 Staffing and maintaining the correct skill base for Jersey's health service – at an affordable cost while maintaining patient safety - presents an enormous challenge to the senior management team and clinicians. We think they need to be able to work with and rely on a high level of HR support with specific – and current - knowledge of health care. We would therefore support the chief executive having a substantive, HR director level equivalent with recent senior acute services experience on her team.

The operation of the obstetrics and gynaecology department

2.34 Our overwhelming view after we had conducted the original investigation was that the events of 17 October 2006 and all that flowed from them had an enormous impact on the hospital and that help was needed to repair it.

2.35 We recommended that the chief officer should bring in independent professional mediation to help the obstetrics and gynaecology department support and develop the service in the aftermath of this incident.

2.36 Professor Aidan Halligan has provided this help in recent months and this has given the department the opportunity to take stock, reflect on what happened and build bridges where necessary.

2.37 Generally, we thought that at the time of the incident and at the time of our first visit that the department had too few policies and procedures. We therefore recommended that to help with the day-to-day management, the department should review and adopt policies and protocols that take account of those produced by the Royal College of Obstetricians and Gynaecologists (RCOG). A related recommendation was that the clinical lead for O&G should use the RCOG dashboard annually to monitor the health of the department.

2.38 There has been significant progress with both these recommendations. The department now has a greater sense of organisation and so is better able to articulate what it does, how it does it, the criteria and benchmarks of quality it pursues and their outcomes. The environment is therefore more conducive to providing safe patient care.

2.39 Maintaining this momentum will be a challenge. A rigorous audit programme to test compliance and trigger discussion and action whenever compliance against standards falls short is perhaps the best way to support this.

The use of locums

2.40 We said in our original report that the use of locums to cover vacant posts had increased considerably over recent years, thereby exacerbating the difficulty in recruiting doctors to the island. The number of locum days used had risen from 2,902 days in 2006 to 4,403 in 2007 and 3,719 in 2008.

2.41 We also noted that the 'Consultant's locum policy', formally agreed between HSSD and the local negotiation committee (LNC) and to be implemented in October 2009, was intended to be effective, transparent, fair and sustainable, irrespective of rota frequency. It was intended to control locum costs while meeting service and operational needs. This policy complemented another policy dated March 2009 'For the appointment and employment of locum doctors'.

2.42 The focus during our six-month review was therefore to see what impact any initiatives aimed at tackling the underlying staffing difficulties were having on locum usage. We also wanted to find out whether the locum policies were fit for purpose and properly embedded.

2.43 We were pleased to see that a locum trend analysis - introduced in early 2010 - is now routinely reported through the managing director of the hospital to the chief executive. This provides senior managers with detailed and current usage data on locums across a number of headings such as grade of doctor, specialty, the reason for locum cover and the cost.

2.44 However, while locum data are now regularly produced and reported, they indicate that at the time of our revisit the overall level of locum usage throughout the hospital had in fact increased. The average monthly locum usage across the hospital for the first nine months of 2010 is 407 days, projecting a full-year figure of more than 4,800 days - the highest for four years.

2.45 This suggests that attempts to address the underlying medical staffing problems – by for instance, paying a 'finder's fee' to a recruitment agency for every permanent doctor recruited - has not yet reduced locum usage. However, the hospital remains confident that such a reduction will occur in time.

2.46 It is encouraging that the hospital is becoming more sophisticated in its use of the locum data. For instance it has recently started distinguishing between those locums whose usage is planned and predictable from those whose usage is not- and where the associated risks are therefore likely to be greater.

2.47 Managers need to regularly assess the hospital's compliance with the systems and processes in place for those doctors employed in a locum capacity. We acknowledge and encourage the various audits undertaken in this area because they will enable the hospital to identify gaps and take corrective action. For example, a hospital audit earlier this year of the files of four locum doctors revealed that just one contained a job description which included a "*skills required*" element; only two had any evidence of an early appraisal; and one lacked any documentation relating to personalised induction, appraisal and training. By taking positive steps however, the situation had improved considerably – with full compliance - by the time of a December audit.

2.48 We were encouraged when we spoke with two locums – one long-term and one new – employed in the obstetrics and gynaecology department at the time of our re-visit. Both complimented the hospital's role in inducting them and helping them to settle in during the early days.

Day surgery unit and theatres

2.49 We explained in our report that a number of organisational factors affected the operating theatre the day that Elizabeth Rourke died. These included a long and unbalanced operating list, changing personnel and a lack of standardised instrument trays. We did not consider that these factors directly contributed to Mrs Rourke's death, but they nonetheless provided evidence of poor theatre organisation that day.

2.50 We also said that the events of that afternoon revealed the need for the hospital to have a contingency plan for dealing with major uncontrolled bleeding and we made a recommendation to that effect.

2.51 We saw during our re-visit evidence of progress in tackling these organisational issues. A few people remained resistant to the changes, which they felt unnecessary. This is probably not surprising given the size of the cultural shift required.

2.52 Generally, the consultants now check the theatre lists and patient notes with the pre-admission nurse on the day surgery unit when the lists are completed. The pre-admission nurse is empowered to refuse to admit the patient if the lists are thought to be too long.

2.53 There are now three leads for each operating session: a theatre nurse, surgeon and anaesthetist/operating department assistant who stay on duty for the duration of the list. This ensures staffing of an operating list is more stable,

2.54 The surgeons and theatre staff have agreed what instruments are to be provided for which procedure and how individual preferences and requests are to be accommodated. Importantly, there is an understanding that the theatre nurse in charge of a case can refuse to provide an instrument – for example, a resectoscope - if she feels the surgeon is not competent to use it.

2.55 Staff in all theatres have agreed to use the World Health Organization safe surgery checklist. We were pleased to learn that the checklist had been adapted to fit local circumstances and we heard of the creative ways in which the surgical teams try to ensure that all members speak up if they feel something is not right. The hospital's own audit results demonstrated high levels of compliance with the use of this checklist.

2.56 To better ensure that any episodes of major bleeding are appropriately managed, the hospital has adopted the gynaecology guideline for major bleeding. The consultants will also call for early help and support from senior colleagues.

2.57 Overall, we have concluded that more rigorous systems and processes are in place in and around the day surgery unit and theatres, mirroring what happens generally throughout the hospital. This positive development will significantly decrease the risks to patients having a surgical procedure – of its nature a complex undertaking.

Information

2.58 One of the difficulties we encountered during our original investigation was establishing who did what during each operation on 17 October 2006. In piecing together Dr Moyano's activities we had access to four lists detailing the operations she had apparently been involved in. Some appeared on all the lists, some on two or three, some on only one.

2.59 We discovered that the medical records of private patients operated on at the hospital were taken back to the private rooms of the consultant without copies being kept at the hospital.

2.60 We thought this wrong in view of the obvious safety implications and recommended that patient records should be clearly numbered and filed sequentially under a single system. We also recommended that any records on a particular patient held elsewhere – for example, by a private consultant – should be filed in the original patient record file.

2.61 We recommended that original patient records should never be removed from hospital premises but that photocopies are sent instead.

2.62 We recommended that staff should ensure that records – including patient records and departmental rotas – are accurate and comprehensible and include last-minute amendments and changes.

2.63 We heard during our re-visit that these recommendations were generating a good deal of discussion in the hospital. We consider this positive and that it is a sign of both staff confidence and understanding that these recommendations have all been adapted in the light of those discussions. It is vital that staff take ownership of any change in order that it is meaningful to them and that the change fits the local context and circumstances.

2.64 We have subsequently satisfied ourselves that the hospital has embraced the spirit behind each of our recommendations in all three cases and that the risks we identified are being mitigated. Two of the recommendations have already been implemented sensibly. The third, concerning a unique patient identifier, can – and should - now proceed, in light of the (recently agreed) refurbishment of the medical records department.

Managing external relationships

2.65 The hospital's serious incident investigation that followed Elizabeth Rourke's death was delayed once it became clear that the police were conducting a criminal investigation.

2.66 There was no local policy between the health service and the police to cover such matters. The health management team behaved as most mainland hospitals would have in the circumstances – they deferred to the police and the legal advice they were given that the criminal investigation should have primacy. The consequence was that matters of risk and patient safety were not examined in detail in the immediate aftermath of a serious incident and the senior management team could not respond to the needs of staff, including Mr Rourke.

2.67 We subsequently recommended as a matter of urgency that the chief officer should begin discussions with the States of Jersey Police and the deputy viscount about developing a local protocol setting out working relations in the event of a patient safety incident. This should be supported by guidelines for hospital staff and senior investigating officers.

2.68 We also said with regard to external relationships generally that the chief officer should set out in a published plan a response to our report and account publicly for the actions taken.

2.69 Our re-visit leads us to believe that the SEB, LOD, HSSD and the various investigatory authorities have achieved a good deal in a short time.

2.70 The States Employment Board, LOD, HSSD and the various investigatory authorities have produced – and signed off - a memorandum of understanding (MoU) that sets out to promote liaison and effective communication. This document, which will be widely circulated, is waiting to go to the States corporate management board.

2.71 HSSD has also produced its own management guidance for staff involved in an incident, drawing heavily on the MoU from England. Our feedback on this has been positive to the extent that the MoU is already informing practice.

2.72 Nonetheless, based on our knowledge of how difficult it has proved to get frontline police and NHS staff in England to know about - and hence to act on the guidance – we urge the States, investigative bodies and HSSD to invest time and energy in informing the relevant groups about the purpose of the MoU and the existence of the guidance. We heard that the HSSD had made a good start, with training workshops scheduled for the end of October.

2.73 Our final recommendation was that the chief officer should set out in a published action plan, a response to our investigation. We were subsequently pleased to learn that the minister intends publishing a management improvement plan in due course.

3. Approach and structure

3.1 The recommendations followed the findings and conclusions in our previous report and addendum. They related not only to Mrs Rourke's care, treatment and management but also – as the terms of reference for the original investigation required of us – to further actions HSSD should take to improve the safety and quality of health services.

3.2 We made recommendations under eight headings:

- The management of the hospital
- Maintaining and enhancing a patient safety culture
- Tackling staffing
- The operation of the obstetrics and gynaecology department
- The use of locums
- Day surgery unit and theatres
- Information
- Managing external relationships.

3.3 In reporting on the progress made, we have kept to these headings.

3.4 The return visit to the hospital was first scheduled to take place in July 2010. However, at the request of the minister it was deferred until the end of October, to allow the newly appointed chief executive and interim managing director of the hospital to take up and settle into their respective positions.

3.5 Generally, we sought to work collaboratively with senior managers so that there was a shared understanding of what constituted good progress. This was both in terms of the systems and processes that we would expect to see in place during our revisit but also the range of evidence that we might look to for corroboration.

3.6 We shared the minister's view that the progress review was not a straight 'pass or fail' exercise. We knew that the action and changes that were necessary within the hospital were significant and likely to take longer than six months. What we were looking for therefore, were clear signs that the hospital was committed to the necessary change, that there were meaningful and demanding action plans and timescales in place – and that real progress and momentum was being maintained.

3.7 For these reasons, we were willing to receive and assess additional information provided to us by HSSD several weeks after we had left the island. This ensured that our report reflected the very latest situation.

3.8 The requirements of the progress review meant that our approach was quite different to the one we adopted for the original investigation. For instance, when we visited the hospital, we tended to meet with groups of staff to discuss the action taken on specific recommendations rather than with individuals. This was because the successful implementation of each recommendation was more likely to be down to a team rather than just one individual.

3.9 We have only included in the report the names of senior managers and designated leads for the various recommendations. Otherwise we have just used job titles.

4. The management of the hospital

Recommendation 1

The chief officer should appoint a hospital director to manage the hospital day to day. This person would act as the focus for all hospital matters. There should be clear separation of responsibilities between the chief officer (strategic) and the hospital director (operational). *Urgent*

Approach

4.1 We met Julie Garbutt, chief executive and Andrew McLaughlin, interim managing director of the hospital to discuss their respective positions. We also saw a range of supporting documents and over the course of the week took soundings from various HSSD staff about how they perceived – and had observed – Julie and Andrew's roles.

Documentation

4.2 We reviewed:

- the managing director's job description
- a draft organisational chart
- the managing director's work diary setting out his induction arrangements
- the managing director's goals and objectives for the early months
- the membership and terms of reference for the Corporate Management Executive, the Integrated Governance Committee and the Care Quality Group
- the minutes of various HSSD/hospital committees – including the ministerial team Meeting, the Corporate Management Executive (CMEX), the Medical Staff Committee and the Surgical Clinical Leads meeting
- outline brief for potential strategic partners – the development of a strategic roadmap.

Findings

4.3 The recommendation has been accepted. The terminology used on Jersey for the hospital director position is managing director, general hospital.

4.4 Julie Garbutt started as chief executive on 1 June 2010. She is a permanent appointment. Andrew McLaughlin began as interim managing director of the hospital on 5 May 2010 – initially for six months. At the time of our review, the Health and Social Services Department (HSSD) was in the process of negotiating an extension to his contract and we have since learned that this has been concluded.

Analysis/discussion

4.5 The job description for the managing director position is comprehensive – running to four pages. It sets out clearly the essence of the job which is to "*provide effective management of the hospital and ambulance service on a day to day basis, ensuring the provision of appropriate, effective high quality patient-centred care, which will meet the needs of patients and can be achieved within the revenues provided*". The key tasks and lines of accountability are unambiguous with the post holder reporting to the chief officer (chief executive).Similarly, it is also clear who reports to the managing director – the directorate managers, the access and capacity manager, clinical directors and leads, heads of nursing and the chief ambulance officer.

4.6 The organisation chart based on a service model sets out the envisaged structure below the managing director. At the time of our visit, the new structure had not been fully implemented and is therefore best described as a work in progress. There is no doubt however that senior staff recognised the new structure and were committed to its planned implementation.

4.7 Andrew McLaughlin's induction within the hospital was extensive - with his first six weeks largely dominated by a range of meetings and discussions across the whole range of hospital activity.

4.8 From the start, he has attended the key hospital committees, indicating a high level of personal involvement and visibility.

Assessment

4.9 The recommendation has been implemented.

4.10 This was one of our key recommendations which if implemented well, would help ensure that HSSD and the hospital had clear – and good leadership going forward.

4.11 The appointment (on an interim basis initially) of Andrew McLaughlin to focus on the running of the hospital looks to have been successful in that he has quickly established a presence, developed good working relationships – particularly with the medical staff - influenced behaviours and harnessed the skills of some capable individuals.

4.12 This has complemented Julie Garbutt well in her newly defined role of chief executive, who is concentrating specifically – and properly - on the island’s strategic and corporate health and social care issues.

4.13 However, the organisation is bedding in and we have heard from a number of individuals that their continued support and commitment is to a very great degree dependent on the current leadership team remaining in post.

4.14 The challenge moving forward therefore is to maintain the initial impetus while ensuring stability at the top. This includes pressing ahead with the proposed management structure and appointing the second tier leaders.

Recommendation 2

The chief officer should appoint a new medical director in advance of the current medical director's retirement so as to ensure a smooth transition.

Approach

4.15 We discussed with Julie Garbutt and Andrew McLaughlin the intended role of the medical director along with their plans for making a substantive appointment to this position. We also saw the paperwork supporting the interim arrangements, whereby the responsibilities of the medical director were delegated and shared between the clinical directors of surgery, medicine and mental health and the chairman of the Medical Staff Committee.

Documentation

4.16 We reviewed:

- letters from the chief executive to the clinical directors of surgery, medicine and mental health and to the chairman of the Medical Staff Committee regarding interim medical management arrangements
- the medical director job description
- the proposed medical leadership organisational structure
- job plans for the two medical directors.

Findings

4.17 The recommendation has been accepted but was modified. A new medical director would be appointed *after* the retirement of the previous medical director. This was to allow the new chief executive and interim managing director of the hospital time to determine what they wanted the role of the medical director to be – and to attract appropriate candidates for the position.

4.18 A new medical leadership structure has been developed by the chief executive and interim managing director which provides for the post of medical director to be shared by two consultants. There is in addition, a deputy medical director for the community.

4.19 The medical director(s) is supported by three associate medical directors – for governance, informatics and training & education – plus a director of infection prevention and control. Reporting to the medical director(s) are seven clinical leads – for anaesthesia, radiology, obstetrics & gynaecology, paediatrics, general surgery, emergency, and medicine.

4.20 The post of medical director has a strategic focus, is a member of the Corporate Management Executive (CMEX), the Integrated Governance Committee and Care Quality Group and the Hospital Management Board and reports to the chief executive.

4.21 Interviews for the substantive appointments to the medical director position were held on the last day of our visit – Friday 15 October and we have subsequently learnt that Martyn Siodlak, ENT consultant and Dr Andrew Luksza, respiratory consultant were appointed to share the responsibilities.

Analysis/discussion

4.22 The interim medical management arrangements were entirely sensible and allowed both the new chief executive and interim managing director time to find their feet and to consider and decide upon the nature of the medical director role that will be required going forward.

4.23 Introducing a job-share arrangement for the post of medical director – with the post holders having line responsibility for the seven clinical leads - significantly strengthens medical management on site and provides further opportunity for the doctors to be fully engaged in the overall management effort. This is further enhanced by designating three associate medical director posts to lead on governance, informatics and training & education as well as the director of infection prevention and control

Assessment

4.24 The modified recommendation has been implemented.

4.25 The message behind our recommendation was that strong, stable and effective medical leadership is essential and that without it, the hospital would probably flounder.

4.26 It is a positive sign that the senior management subsequently chose to adapt – rather than adopt- the recommendation. Instead of implementing it slavishly they took an alternative – and considered view – that they should first settle on the nature of the post and where it fits before making a permanent appointment.

4.27 By putting in place robust interim arrangements they bought themselves some time to help ensure that they came up with the right solution.

4.28 Quite clearly, we are unable to comment on whether the arrangements and individuals that have been appointed are having the desired impact as they were not fully up and running at the time of our visit.

4.29 However, we are encouraged by the time and effort that has been invested in setting the medical leadership arrangements up properly and in the healthy competition for posts.

4.30 In order that the new appointees and post holders can make the maximum contribution, the chief executive will want to ensure that they receive a proper induction into their role, have job plans that reflect a managerial component, are set challenging objectives and afforded a regular opportunity to discuss their performance.

Recommendation 3

The new medical director should review the roles, responsibilities and authority of clinical directors and leads with a view to strengthening their part in running the hospital. These should be set out in job descriptions and reflected in individual job plans.

Approach

4.31 As part of our consideration of the implementation of recommendation 2, we discussed with Julie Garbutt and Andrew McLaughlin the intended role of the medical director along with their plans for making a substantive appointment – or appointments - to this position. We also saw the paperwork supporting the interim arrangements, whereby the responsibilities of the medical director were delegated and shared between the clinical directors of surgery, medicine and mental health and the chairman of the Medical Staff Committee.

4.32 Recommendation 3 is clearly inter-linked to recommendation 2 in as much as its full implementation was dependent upon the appointment of a medical director. And as we have earlier recorded a job-share appointment to this position was only made on 15 October 2010.

Documentation

4.33 We reviewed:

- letters from the chief executive to the clinical directors of surgery, medicine and mental health and to the chairman of the Medical Staff Committee regarding interim medical management arrangements
- the medical director job description
- the proposed medical leadership organisational structure.

Findings

4.34 The recommendation has been accepted but its implementation was appropriately delayed pending the appointment of the medical director.

4.35 We saw and heard a good amount of evidence to support what Julie Garbutt and Andrew McLaughlin told us about their intentions and plans for engaging the medical staff in the management of the hospital. The medical leadership structure includes seven clinical lead posts – and consultants have been appointed to five of them - anaesthesia, radiology, paediatrics, emergency, and medicine. Appointments remain outstanding for obstetrics & gynaecology and surgery.

4.36 The job description for the medical director rightly includes a large number of responsibilities and tasks which focus on the appropriate involvement of doctors.

Analysis/discussion

4.37 The two consultants sharing the medical director position have only had their new responsibilities for little over a month so they cannot realistically be expected to have yet implemented this recommendation in full.

4.38 However, perhaps the more significant issue at this stage is that the new management team have signposted their wish to engage fully with the doctors and have them central to the running of the hospital. To this end they have started to put the supporting organisational structures in place as well as some due process.

4.39 The early signs are that this approach is being embraced by the consultants who see the value and opportunity in taking such a central role.

Assessment

4.40 We subsequently consider that the message implicit in our recommendation has been firmly grasped and that the necessary work to 'skill up' the clinical leads is progressing appropriately.

Recommendation 4

The chief officer in conjunction with the committee chair should develop written terms of reference for the medical staff committee to support its role as a key part of the hospital infrastructure.

Approach

4.41 We met Andrew McLaughlin, interim managing director of the hospital and the chair of the Medical Staff Committee (MSC). We also sought the views of other members of the MSC.

Documentation

4.42 We reviewed:

- the terms of reference for the MSC
- minutes of the MSC
- minutes of the senior management team.

Findings

4.43 The recommendation has been accepted.

4.44 The managing director explained that he saw a well functioning MSC as central to the full engagement of clinicians within Jersey General. It complemented the proposed changes to the medical leadership structure (recommendations 2 and 3) and would help support his intention that the doctors play a full role in the management of the hospital.

4.45 He believed that the committee had two main roles. The first was to serve as the forum that enabled the consultant body to come together so that a consensus view could be presented to senior management. The second was to allow for a free exchange of opinions and information between the consultant staff and the senior management team.

On this later point, he described the MSC as serving a similar role to that of the Conservative Party's 1922 committee[1].

4.46 The chair of the MSC clearly saw the role and purpose of this committee in the same way and commented that "*the committee now provides a legitimate route which all doctors should use*".

4.47 The terms of reference state that MSC meetings are to be held six times a year with extraordinary meetings being held if appropriate. The committee consists of all the consultant doctors and dentists employed by Health & Social Security and the chairman – who holds the position for a two year term – is to attend the senior management meeting on a monthly basis. The MSC agenda is in two parts; Part A consists of the consultant body meeting with the senior management team; Part B of the meeting consists of the consultant body alone.

Analysis/discussion

4.48 The terms of reference that have been written for the MSC now provide the clarity that has previously been missing regarding its role and how it will function.

4.49 They cover its membership, purpose and frequency, as well as the appointment and role of the chair and secretarial arrangements.

4.50 They should fulfil their intended purpose well so long as they are kept under review from time to time – preferably annually.

Assessment

4.51 The recommendation has been implemented in full.

[1] The 1922 Committee is a Committee of Conservative Members of Parliament. Membership is limited to backbench MPs although frontbench MPs have an open invitation to attend meetings. The Committee provides a way for Conservative backbenchers to determine their views independently of frontbenchers.

5. Maintaining and enhancing a patient safety culture

Recommendation 5

Directorate management teams should ensure that staffing rotas are published at least seven days in advance so that any problems can be resolved before the rota starts. *Urgent*

Approach

5.1 We had a meeting with Angela Body, directorate manager surgery, Paul Jones, interim director of human resources, the PA to the directorate manager surgery, the head of midwifery, one of the medical secretaries, a locum middle grade doctor in general surgery, a human resources manager, two medical staffing officers and a consultant in obstetrics and gynaecology.

5.2 We considered the implementation of this recommendation alongside recommendations 6, 18 and 19.

Documentation

5.3 We reviewed:

- the report of an audit carried out in June 2010 to measure compliance with this recommendation
- copies of a variety of staffing rotas
- the draft policy setting out standards for the management of medical staff rostering dated September 2010
- the 'rota co-ordination responsibility list' for the surgical departments.

Findings

5.4 The recommendation has not only been accepted but extended so that alterations to the rota can now only be made with the agreement of the clinical lead or consultant in charge.

5.5 The audit revealed 100 per cent compliance with the recommendation that all staffing rotas must be published at least seven days in advance. These rotas show which staff will be on duty on which days and, generally, where an individual will be working during their shifts. However we were told that this does not apply with the anaesthetic rota. Anaesthetists are told when they will be on duty, but the decision about *where* they will be on duty is taken nearer the time, when the composition of the operating list is finalised. The purpose of this is to ensure that the anaesthetist is carefully matched to the needs of the operating list.

5.6 The consultant talked us through a recent example when a member of staff took compassionate leave at short notice. Another consultant in the department had a meeting with all the middle grade doctors on the same day. They had the rota in front of them, and filled in the absent doctor's slots as far as possible. It was clear that it would be necessary to arrange for a locum to be appointed. The next day a hard copy of the rota went to the department secretary who updated the electronic record, with track changes - circulating the new rota by e-mail, to all the doctors concerned and to the places where they would be working.

5.7 We discussed the draft 'Policy on Standard for the Management of Medical Staff Rostering' dated September 2010. This makes it clear that any changes to the duty rota have to be approved by the lead clinician responsible in the department or by the doctor in charge in that person's absence. We were told that before final approval, the draft policy will be considered by the Medical Leadership Group - once the medical director position was filled - and the Medical Staff Committee.

5.8 We were also told that the Datix incident reporting system is used by some staff to alert senior management when something goes wrong with a staffing rota, that the staffing rotas have an addendum to them, showing who is not available during the relevant week (for instance because they are on study leave or on holiday) - and that the timeliness and accuracy of staffing rotas will be audited.

5.9 We learnt that the Zircadian software package which supports electronic rostering is now being rolled out across the hospital. It allows all changes to rotas to be track changed and kept in an electronic folder, so that every alteration can be seen. Therefore, in any future audit or investigation, it should be possible to know for certain who was carrying out what duty on which day.

5.10 There are now named individuals within each surgical department – with administrative support – who have responsibility for the co-ordination of specific rotas

Analysis/discussion

5.11 It is clear from what we saw and what we were told that the hospital has gone much further with this recommendation than we had proposed. Not only are the rotas published at least seven days in advance, but alterations to the rota can now only be made with the agreement of the clinical lead or the consultant in charge in the absence of the clinical lead. The action that was taken with a middle grade doctor in O&G had to leave suddenly is a good example of good practice, in that the absent doctor's work was covered as a result of discussion with all the middle grades and a consultant.

5.12 We considered the issue of the late allocation of anaesthetists to theatre lists and accept that this is in line with good patient care, in that it is entirely driven by the need of patients. We were told that in some areas, particularly ENT, it is not possible to finally complete the operation list until shortly before the day of the operations, as patients scheduled for operations may spontaneously recover at the last minute.

5.13 We accept that all grades of anaesthetists know when they will be on duty, even if they do not know exactly what their duty will be until a day or so beforehand. We consider that this sufficiently meets the purpose of our recommendation.

Assessment

5.14 This modified recommendation has been implemented well.

5.15 We consider that the hospital has properly understood the risk which our recommendation sought to reduce, and has taken effective action to reduce this risk as far as is reasonably possible. We consider that it is proper that the draft protocol should not be ratified until the newly appointed medical director has had an opportunity to consider it, but we are pleased to see that, even in the absence of a ratified protocol, the audit shows that staffing rotas comply with this recommendation.

Recommendation 6

HR and the senior management team should ensure that all new staff – permanent and locum – receive a personalised induction and training so that they can fulfil their responsibilities from the first day of their employment. Their training should be updated as appropriate. ***Urgent***

Approach

5.16 We had a meeting with Angela Body, directorate manager surgery, Paul Jones, interim director of human resources, the PA to the directorate manager surgery, the head of midwifery, one of the medical secretaries, a locum middle grade doctor in general surgery, a human resources manager, two medical staffing officers and a consultant in obstetrics and gynaecology.

5.17 We considered the implementation of this recommendation alongside recommendations 5, 18 and 19.

Documentation

5.18 We reviewed:

- the report of an audit carried out in August 2010 to measure compliance with this recommendation
- the forms used for the new model of induction checklist, locum appraisals and reference requests
- a PowerPoint presentation of the proposed on line e-induction system.

Findings

5.19 The recommendation has been accepted.

5.20 The August 2010 audit was carried out with four newly appointed locum doctors to measure compliance with the induction policy. The audit results shows compliance of between 50% and 100% with all criteria measured. It recommended a number of improvements.

5.21 An audit carried out by the hospital in December 2010, showed further improvement. The files of four recently appointed locum doctors contained all of the appropriate documentation and the audit concluded that "*a more thorough approach is evident*". Importantly, the files showed that each locum has "*the skills required for the post to which they are being appointed and that they have a comprehensive induction*".

5.22 The new model documents are clearly intended to ensure that new staff receive all the information that they need to be able to carry out their jobs properly and safely, and provide documentary evidence that every aspect of induction has been carried out. The locum appraisal form is clearly intended to ensure that useful information is obtained from supervisors with regards to the locum's performance and a reference request is intended to ensure that referees provide a reference against a detailed job description and person's specification.

5.23 The PowerPoint presentation of the e-induction process provided evidence that the hospital intends to introduce a sophisticated induction process that will allow new members of staff to start their induction before they arrive at the hospital, by giving them access to hospital policies and procedures on-line once they have been offered a job. The on-line induction process is also intended to enable new employees to provide detailed information about the nature and level of their skills and experience before they arrive at the hospital, so as to allow their supervisors to allocate them to appropriate duties.

Analysis/discussion

5.24 The audit in August showed that there was scope to improve upon the hospital's compliance standards for induction and this is seen in the progress reflected in the December audit results.

5.25 We were impressed with the work that has been done to improve recruitment and induction documentation and processes.

5.26 The reference request form is an enormous improvement on its predecessor, particularly as the request for a reference will be made in conjunction with the provision of a much more detailed job description and person specification.

5.27 The model induction document that we saw shows a sophisticated understanding of the information that needs to be provided to a new member of staff to enable them to carry out their work properly and safely.

5.28 We considered that the appraisal form that has been developed will be useful not only for the hospital, but also for the appraisee, as it will give them the opportunity to improve on identified areas of weakness. And if they have a good appraisal, this is likely to help them find further work elsewhere.

5.29 We were told that considerable interest in the e-induction package has been shown on the mainland, where there are also significant concerns about the safe employment of locums.

Assessment

5.30 The recommendation has been partly implemented.

5.31 The results of the audit in August show that there is still progress to be made. However we accept that the hospital has taken on board the need to improve induction and training of new members of staff, and that it has worked hard and imaginatively in seeking to develop a cutting edge system, using IT, that will benefit both the hospital, the people that it employs, and the patients that they treat.

5.32 The e-induction system has not yet been introduced and we recognise that this kind of project will always take a while to iron out any problems. The hospital must be careful to ensure that whilst it is perfecting the e-induction process, the traditional paper-based process, which it has also been developing, is used effectively. Regular audit, perhaps involving slightly fewer people should be undertaken to establish whether compliance with the induction process is improving.

5.33 See also recommendation 18.

Recommendation 7

The chair of the SUI panel should put in place a robust system for ensuring that recommendations arising from investigations (where accepted) are implemented. The outcome of changes should be reported to the panel and made available to hospital staff.

What have we done (evidence base)

5.34 We met Rose Naylor, director of nursing & governance, the head of risk management and a member of the governance support team.

Documentation

5.35 We reviewed:

- the policy for the management of serious or untoward incidents (January 2009 amended in September 2010)
- a summary sheet demonstrating monitoring of recommendations and actions
- the RCA proposal form
- a Dear Colleague letter
- the SUI trigger and pathway
- the B-Safe bulletin
- a copy of HSS net intranet
- the CMEX paper on SUI policy changes dated 28 September 2010
- examples of SUI reports.

Findings

5.36 The recommendation has been accepted.

5.37 HSSD now has a standardised approach to the conduct of internal investigations which includes near misses and incidents. The head of risk management produces terms of reference for all investigations which are customised as necessary and approved by the SUI panel. Investigations are conducted by two to three people. One of the team will have had RCA training. None will be from the service area concerned. External expert opinion is

sought as necessary. The investigation team meets staff from the area concerned early on in the process to establish a link. The team will provide early feedback.

5.38 More medical staff are showing an interest in investigations and want to be involved. They are interested in focusing on patient care.

5.39 A timetable is agreed for the implementation of recommendations. The integrated governance committee holds the care quality group(s) to account for implementation. The hospital managing director sits on the SUI panel so can take immediate remedial action if this is warranted.

Analysis/discussion

5.40 HSSD has a standardised and systematised approach to the investigation of incidents, directed by a revised SUI policy and led by the head of risk management who has a clinical background. More medical staff are involved in the investigation of incidents which has the potential to improve the take up of recommendations and focus on patient safety.

5.41 Implementation of recommendations is the responsibility of the care quality group. They are held to account by the integrated governance committee.

5.42 The sample RCA investigation reports available to us each contain an agreed actions section. These show the action agreed, the name of the lead person and the review date. The details for each have been completed.

Assessment

5.43 Good progress has been made with this recommendation – the focus of which was strengthening implementation of actions arising from SUI investigations.

5.44 The arrangements for the investigation of incidents now appear altogether stronger. This has been achieved by strengthening systems and processes and getting staff more involved.

5.45 The head of risk management has been central to these improvements.

5.46 In the coming months the hospital should satisfy itself that the overall SUI process is working well. This should include ensuring that any recommendations arising from SUI investigations are implemented and that any lessons are learnt. This may present an opportunity to expand the role of the head of risk management.

5.47 The care quality group responsibilities for implementation need to be tried and tested. The real challenge will be whether recommendations are adopted and result in sustained changes/improvements in practise. Appropriate involvement of the medical staff – particularly the new medical directors – will help with this task.

5.48 The revised SUI policy makes reference to the MoU and guidance featured in recommendation 29.

Recommendation 8

The chief officer and the consultant body should continue to encourage openness about matters to do with patient safety. They should challenge any tendency for self-censorship. This will allow professionals to acknowledge their own limitations and raise concerns about the practice of colleagues. Staff who report reasonable concerns should be safeguarded and appreciated for contributing to improved patient safety. This is the sign of a strong organisation.

Approach

5.49 We met Rose Naylor, director of nursing & governance, Andrew McLaughlin, managing director, the clinical director for surgery and the head of risk management.

Documentation

5.50 We reviewed:

- the management document setting out vision/action plan with timetables and targets
- a presentation on building a culture of workplace openness
- a letter inviting staff representatives to participate in a partnership forum
- the terms of reference and agenda for the staff partnership forum
- the policy on reporting serious concerns - whistleblowing policy
- the whistleblowing procedure – a protocol for use within HSSD
- the barometer for openness.

Findings

5.51 The recommendation has been accepted.

5.52 HSSD have undertaken a wide range of actions to continue to encourage openness and these have been led by a director on the Corporate Management Executive.

Analysis/discussion

5.53 The hospital team felt that there had been an open culture in the hospital for some time.

5.54 Andrew McLaughlin, as a recent arrival, concurred and said people regularly told him about concerns and incidents.

5.55 The hospital has developed a more systematic approach to the management and investigation of incidents and is making better use of Datix - including looking at themes.

5.56 Doctors are starting to report incidents via Datix.

5.57 One consultant thought that doctors' previous reluctance to use Datix was connected to the availability of training.

5.58 Doctors are better involved in internal investigations (see recommendation 7).

5.59 Managers are using the learning from incidents to mitigate risks.

5.60 The management team is setting the tone for the health and social care by modelling openness e.g. team briefings and by posing questions about whether the culture of HSSD is shaped by the close knit island community. They have set out a vision and strategic direction with milestones to be met over three, six and 12 months.

5.61 The hospital managing director is out and about in the hospital. He receives incident reports on his Blackberry and visits departments in response to serious concerns.

5.62 The consultants reported that they think the management team 'listens' to their concerns. The hospital managing director operates an 'open door' policy and has his office on the third (rather than fourth) floor of the hospital.

5.63 Paul Jones, interim HR director, provides board level leadership for promoting a culture of workplace openness.

Assessment

5.64 The recommendation suggested that HSSD should continue to encourage openness and build an organisation where staff felt able to report concerns. Our assessment is that a good deal of progress has been made on a variety of fronts in support of this complex recommendation.

5.65 The leadership and tone set by the new management team has been important to promoting further developments in the culture. The leadership style is one of openness/support and challenge when needed.

5.66 The systematic approach to the reporting and investigation of incidents goes a long way to depersonalising untoward incidents. The greater involvement of medical staff in reporting and investigating SUIs helps normalise this activity and make it acceptable to report and discuss incidents.

5.67 Similarly, the World Health Organization (WHO) safe surgery checklist encourages discussion and interaction between team members. It provides a legitimate way of raising concerns.

5.68 The barometer provides a tool for assessing progress in a confidential, non-threatening and objective way. The whistle-blowing policy makes it clear how to raise concerns.

5.69 The management team need to continue to lead this work until such time that it is the predominant culture of the organisation. Regular sampling by means of the barometer will help assess progress.

5.70 HSSD may wish to showcase this organisational attribute to other parts of the States and to other important opinion-formers on the island e.g. the Jersey Evening Post and explain how a culture of openness helps the provision of safe patient care.

Recommendation 9

The chief officer should ensure that organisational arrangements are in place to support good corporate and clinical governance. This includes developing and implementing policies and procedures to cover significant risks, ensuring that incidents are reported, investigated (where necessary) and the changes and improvements implemented. *Urgent*

Approach

5.71 We met Rose Naylor, director of nursing & governance, Julie Garbutt, chief executive Andrew McLaughlin, managing director, Paul Jones, interim HR director, the head of risk management, the superintendent physiotherapist and the clinical director for surgery.

Documentation

5.72 We reviewed:

- CMEX minutes and papers
- integrated governance committee ToRs – discussed and agreed at CMEX on 21 and 28 September respectively
- integrated governance committee– notes/action points from 8 October 2010 meeting
- paper on policy and procedure for the development, ratification, distribution and review of policies and procedures
- care quality group ToRs
- note of committee structure and record of which have ToRs
- agenda for care quality group meeting on 5 October
- medical staff committee terms of reference
- medical staff committee minutes.

Findings

5.73 The recommendation has been accepted.

5.74 The chief executive has put in place new organisational arrangements to support the management of the hospital. In addition to appointing two managing directors, she has put in place a corporate management executive (CMEX), an integrated governance committee and care quality groups for the hospital and community.

5.75 The integrated governance committee is a subcommittee of CMEX and has delegated powers. Its overarching aim is to "*seek assurance that controls are in place and are operating efficiently and effectively to deliver the principal objectives if health and social services and minimise the exposure of the department to corporate, financial and clinical risks*". It is chaired by the chief executive.

5.76 At the inaugural meeting of the integrated governance committee a policy was endorsed entitled 'Policy and procedure for the development, ratification, distribution and review of policies and procedures'. This policy and procedure sets the framework to support the systematic development of policies and procedures through their life-cycle. The document reflects the revised organisational structure.

5.77 These new arrangements are complemented by the medical staff committee which now has written terms of reference (see recommendation 4). Among its roles are:

- disseminating information important to the safe and efficient running of the hospital
- allowing discussion of any proposals for change, where they impact on clinical activity
- providing input to the hospital governance board
- providing members for management committees to ensure appropriate senior clinical input.

Analysis/discussion

5.78 The structures are clear and understandable. CMEX has overall responsibility for the management of HSSD. The integrated governance committee holds the care quality groups to account by means of delegated powers from CMEX.

5.79 CMEX first met in July 2010. The integrated governance committee and care quality groups have only just come into being and both met for the first time in early October. To that extent the new structure is untested.

Assessment

5.80 Good progress has been made in implementing this recommendation which not surprisingly, remains work in progress.

5.81 Key individuals are in post, the new committee structure is in place and the organisation is working hard to develop the raft of policies and procedures which underpin good governance.

Recommendation 10

The commissioners should investigate what the staff in the obstetrics and gynaecology department knew or believed up to 17 October 2006 about Dr Moyano's skills and abilities. *Urgent*

Approach

5.82 We met Andrew McLaughlin, managing director and James Le Feuvre, director of strategy

Documentation

5.83 We were provided with file notes of three meetings that had taken place. These explained how the investigation had been undertaken and the results of the investigation.

Findings

5.84 The recommendation has been accepted.

5.85 We found that the commissioners had met to decide what action needed to be taken in response to this recommendation and that the action points identified at that meeting had subsequently been pursued

Analysis/discussion

5.86 We were satisfied following a discussion of the documents provided to us, that a proper investigation had been undertaken, and that the need for an open culture at the hospital had been identified and was being developed.

Assessment

5.87 We consider that the commissioners understood the thinking behind our recommendation, and have complied with it, both in carrying out the investigation and in identifying from it the need for an open culture in the hospital.

5.88 There is nothing left to be done in relation to this investigation which has now been satisfactorily concluded. The need for an open culture will be an on-going issue that should remain at the forefront of everyone's mind.

5.89 It is easier for us to say how an open culture will *not* be achieved rather than how it will. If people in the hospital believe that their being open about problems will harm either themselves or others - through it drawing down upon them unreasonable harsh criticism or hostility - then they are less likely to be open, which could have serious consequences for the safety of patients in the hospital. We consider that it is the responsibility not only of hospital management but also of opinion formers on the island to bear this in mind.

6. Tackling staffing

Recommendation 11

The chief officer should confirm the appointments of a fourth consultant to the obstetrics and gynaecology department and a sixth middle-grade doctor. *Urgent*

Approach

6.1 We met Andrew McLaughlin, managing director, Angela Body, directorate manager surgery and five doctors from the obstetrics and gynaecology department – four of whom were consultants (which included one locum) and one, a staff-grade doctor.

Documentation

6.2 We reviewed:

- the job description, job specification and advert for the fourth consultant
- the job description, job specification and advert for the sixth middle grade doctor.

Findings

6.3 The recommendation has been accepted.

6.4 We learnt that the job description for the new fourth consultant post was approved by the Royal College of Obstreticians and Gynaecologists (RCOG) and that an advert appeared in the British Medical Journal with a closing date of 12 November. There were 28 applicants - indicating a very good response – and interviews were held on 13 December for the five shortlisted candidates. A college representative sat on the interview appointments panel.

6.5 We have been told that an appointment was made and that the successful applicant will be the lead for the maternity unit and – from early in the New Year - the likely lead clinician for obstetrics and gynaecology.

6.6 We also heard that a sixth middle grade doctor had been appointed to start in July 2010 but subsequently had to withdraw for personal reasons. Further interviews were held on 25 October but no appointment was made. The post was due to be re-advertised in early November.

Analysis/discussion

6.7 The job descriptions are comprehensive and set out clearly the requirements and parameters of each position.

6.8 The early signs are that there is good competition for the fourth consultant position which is perhaps both a reflection of the 'new dawn' in the O&G department and a tougher employment market for consultants on the mainland.

6.9 While clearly disappointing that the successful applicant never took up the sixth middle grade post in July – and that no appointment was made following the October interviews - it is pleasing to learn that the department is intent on filling this position and that attempts will continue to be made to fill this position.

Assessment

6.10 The recommendation has been implemented – albeit that the middle grade post remains to be filled.

6.11 Making appointments to these two new posts will enable the O&G department to stabilise after a very difficult period and to push on with a pressing agenda.

6.12 It will obviously be important that the two appointees receive full induction, have meaningful job plans and have the opportunity to discuss their performance early on – and regularly thereafter.

Recommendation 12

The senior management team should implement the outcomes of the staffing review so as to ensure safe levels. *Urgent*

Approach

6.13 We met Rose Naylor, director of nursing & governance, Andrew McLaughlin, managing director, Paul Jones, interim HR director, the head of risk management, the superintendent physiotherapist, the project manager, workforce planning and the clinical director for surgery.

Documentation

6.14 We reviewed:

- comments on the Verita six month review document
- the HSSD nurse staffing review – summary of progress to date October 2010
- the staff grade and associate specialist contract – report to the States Employment Board 22 July 2010
- the staff grade and associate specialist contract – interim award letter from Paul Jones.
- HSSD nurses and midwives general and acute vacancy report – 6 December 2010

Findings

6.15 The recommendation has been accepted

6.16 The director of nursing briefed the States Employment Board about the recruitment and retention of nurses and midwives in October 2009. She presented a further paper recommending possible solutions in December 2009.

6.17 HSSD in conjunction with the States HR service have recruited Omni Recruitment to review the recruitment process. Income Data Services are carrying out an independent review of pay. HSSD workforce planning are reviewing accommodation costs for nurses.

6.18 The States has funded 52 WTE nursing and midwife posts in 2010. Eighteen posts were approved initially. A further 32 nursing posts were funded in January 2010 as a result of the opening of the emergency assessment unit, more beds in acute medicine and the approval of business cases for renal and endoscopy.

6.19 The States and HSSD plan to increase the nurse staffing establishment over a three year period. The managing director and director of nursing will advise about the priorities for investment. Year one is 2010.

6.20 At the time of our visit, HSSD were carrying 50 vacancies across the service. We also heard that the registered nursing workforce vacancy rate had been above six per cent for the previous 18 months.

6.21 We have subsequently received information showing that by the beginning of December 2010, this had reduced to 33 vacancies – which represents 3.1 percent of the nursing workforce.

6.22 HSSD has embarked an international nurse recruitment campaign (see recommendation 13)

6.23 HSSD are starting to anticipate vacancies

6.24 The recruitment system was described to us as being "*clunky*" and we think it could be streamlined.

6.25 HSSD has made an interim pay award to middle grades while a new contract is negotiated and finalised to help ensure the retention of a key group of doctors.

Analysis/discussion

6.26 The strategy of investing in and recruiting to these additional nursing posts has top level commitment and will clearly help the hospital maintain a safe environment for patients.

6.27 The senior managers – aided by dedicated HR support – should position themselves to react quickly and take advantage of a changing employment market. For instance,

there are likely to be many good quality nursing and medical candidates who might soon become available as a result of the public sector squeeze on the mainland.

Assessment

6.28 The nursing and midwifery establishment is now 1,060 which compares to 1,020 before the staffing review. There has been good progress, but further expansion of nursing and midwifery numbers will be required in order to meet this recommendation in full.

Recommendation 13

Simultaneously, the chief officer should commission a review of the terms, conditions - including residency rules – and prospects offered to those who come to work in HSSD and consider their impact on the staffing of the hospital and on its ability to attract and retain good-quality staff. *Urgent*

Approach

6.29 We met Rose Naylor, director of nursing & governance and Paul Jones, interim HR director.

Documentation

6.30 We reviewed:

- recruitment and retention – registered nurses and midwives – briefing paper to the States Employment Board on 30 October 2009
- feedback from Wessex foundation careers fair
- international nurse recruitment campaign working party – agenda from meeting on 5 October 2010
- terms and conditions review – undertaken by Tribal (September 2010).

Findings

6.31 The recommendation was accepted.

6.32 HSSD has commissioned a review from IDS to look at the nurses and midwives pay structure.

Analysis/discussion

6.33 Recruitment of good quality staff remains a major risk for HSSD and one that is logged on the corporate risk register. Although funding was approved for 50 more nursing posts, HSSD is still (at 6 December 2010) carrying 33 vacancies across the service. This

shows an improvement over the last three months but indicates that there is still some way to go before being fully staffed.

6.34 Nurses and midwives are the largest group of employees in HSSD. However, the focus of the review needs to cover other staff groups including consultants and middle-grades.

Assessment

6.35 The recommendation has been met although recruitment and retention of staff remains work in progress.

7. The operation of the obstetrics and gynaecology department

Recommendation 14

The chief officer should bring in independent professional mediation to help the obstetrics and gynaecology department to support and develop the service in the aftermath of this incident.

Approach

7.1 We met Andrew McLaughlin, managing director, Angela Body, directorate manager, surgery and the four consultants in the obstetrics and gynaecology department – one of whom was a locum.

Documentation

7.2 There was no particular documentation relevant to this recommendation

Findings

7.3 The hospital has amended the recommendation as follows:

> *"The Chief Officer is able to and should be encouraged to bring in independent professional mediation to help the obstetrics and gynaecology department to support and develop the service in the aftermath of this incident."*

7.4 We heard that the hospital had invited Professor Aidan Halligan to provide such mediation.

7.5 We also saw evidence of weekly consultant meetings and confirmation that on some occasions, middle-grades have attended as well.

Analysis/discussion

7.6 We had a lengthy discussion about mediation at our meeting, and those present concurred that mediation should be requested if there were any disagreements that could not be resolved between individuals.

Assessment

7.7 The amended recommendation has been accepted along with the implication that mediation will be facilitated as and when required.

7.8 The outcome of any mediation that might so far have occurred is however unclear.

7.9 In our opinion, the consultants should meet weekly to discuss potential issues – and middle grade doctors should be invited from time to time.

Recommendation 15

The department should review and adopt policies and protocols to help with day-to-day management. These should take account of the Royal College of Obstetricians and Gynaecologists (RCOG) guidance on Standards for Gynaecology, Diagnostic and Operative Hysteroscopy, Hysteroscopy Procedures, Obtaining Informed Consent, and Medical Staffing.

Approach

7.10 We met Andrew McLaughlin, managing director, Angela Body, directorate manager, surgery, two nursing sisters from Rayner Ward, four consultants from the obstetrics and gynaecology department – one of whom was a locum and a staff grade doctor.

7.11 This included a general discussion about the current position and how the department might ensure that guidelines are kept current.

Documentation

7.12 We reviewed:

- results of a compliance audit against RCOG standards
- post audit action plan
- gynaecology protocols – available on the hospital intranet
- a range of O&G policies
- a sample questionnaire – circulated by management to staff to obtain their views
- minutes of various senior level meetings
- details of the educational sessions provided.

Findings

7.13 The recommendation has been accepted.

7.14 The documents submitted as evidence for this recommendation were comprehensive and fit for purpose.

7.15 We were also pleased to note that new members of staff in the obstetrics and gynaecology department have formal inductions and performance reviews.

Analysis/discussion

7.16 The post-audit action plan is indicative of the substantial amount of work that has taken place in seeking to adopt the RCOG standards. It is a good control document which sets out the action required for which standard - by who and by when.

Assessment

7.17 The recommendation has been met.

7.18 It will obviously be important that guidelines and protocols remain current and a process established to ensure that they are brought to the attention of all the relevant staff.

Recommendation 16

The clinical lead should use the Royal College of Obstetricians and Gynaecologists (RCOG) dashboard annually to monitor the 'health' of the department.

Approach

7.19 We met Andrew McLaughlin, managing director, Angela Body, directorate manager, surgery, two nursing sisters from Rayner Ward, four consultants from the obstetrics and gynaecology department – one of whom was a locum and a staff grade doctor.

Documentation

7.20 We reviewed:

- the gynaecology dashboard
- the dashboard (monthly) results
- minutes of risk management meetings.

Findings

7.21 The recommendation has been accepted

7.22 The RCOG dashboard has been appropriately modified and adopted for local use. It is comprehensive in scope.

Analysis/discussion

7.23 Those who attended the meeting had a good understanding of the purpose and use of dashboard charts as part of risk management.

Assessment

7.24 The recommendation has been implemented and we were impressed with the progress that has been made.

7.25 It will be important to ensure through regular audit that the dashboard is in use and that the results are brought to the attention of all the relevant staff.

7.26 Also that the process is reviewed by the directorate manager of surgery and/or the managing director.

Recommendation 17

The three consultants should hold regular minuted meetings and include permanent middle-grade and junior staff. Nursing staff should also join these meetings. The three consultants should also attend departmental meetings.

Approach

7.27 We met Andrew McLaughlin, managing director, Angela Body, directorate manager, surgery, two nursing sisters from Rayner Ward, four consultants from the obstetrics and gynaecology department – one of whom was a locum and a staff grade doctor.

Documentation

7.28 We reviewed:

- minutes of the O&G management meetings
- minutes of the O&G consultants meetings
- minutes of the obstetric governance and risk management meetings.

Findings

7.29 The recommendation has been accepted.

7.30 The obstetrics and gynaecology management meetings are held monthly and include middle grade doctors and nursing staff. Minutes are taken and circulated.

7.31 The obstetrics and gynaecology consultants meeting are held on a regular basis and the Minutes shared within the department.

Analysis/discussion

7.32 Those present were supportive of the need for regular minuted meetings.

Assessment

7.33 The recommendation has been implemented.

7.34 Moving forward, the directorate manager of surgery should assure herself through regular audit that the meetings continue to be held and that they are appropriately attended by the relevant individuals.

8. The use of locums

Recommendation 18

The chief officer and the medical staff committee should ensure that locums have a detailed job description, receive a proper induction and orientation (permanent staff should be responsible for this). This should include establishing and making colleagues aware of any clinical limitations of a locum. Locums should receive an early, written appraisal from a senior member of the permanent medical staff.

Approach

8.1 We met Paul Jones, interim director of human resources, Angela Body, directorate manager surgery, the PA to the directorate manager surgery, the head of midwifery, one of the medical secretaries, a locum middle grade in general surgery, a human resources manager, two medical staffing officers, and a consultant in obstetrics and gynaecology.

8.2 We also spoke with a locum middle grade on his first day of work at the hospital, to get his views.

8.3 We considered the implementation of this recommendation alongside recommendations 5, 6, and 19.

Documentation

8.4 We reviewed:

- the policy for the recruitment and appointment of locum doctors
- the outcome of audits carried out in March, August and December 2010 to explore the work in progress in response to recommendations 18 and 19
- a 12 page document 'Rayner Ward Gynaecology Department Guidelines for F2 and GP Trainee Doctors'.

Findings

8.5 The recommendation has been accepted.

8.6 The first audit in March 2010 was a retrospective audit of ten locum doctor's employment files. These were picked at random and included those doctors employed between 4 December 2009 and 29 January 2010. Although compliance was high in some areas, for instance all files contained a CV and evidence of active GMC registration, in other areas compliance was low – for instance in only four out of ten cases was there any evidence that a consultant had seen the locum's CV, and in only two out of ten cases was there any evidence on file that a consultant had been satisfied with the CV and references before a job offer was made. In none of the files was there evidence that an interview with a consultant had been carried out, face-to-face or on the phone, before the job was offered to the individual.

8.7 The audit made a number of recommendations, including that a re-audit should be undertaken to review progress. The re-audit was undertaken in August 2010. We were not provided with detailed information about this re-audit, and were told that detailed information was not available. The conclusions of the re-audit were that:

> *"…significant progress had been made by the medical staffing department in leading on the further development of job descriptions and core clinical competencies. There are new appraisal forms, reference requests forms and induction checklists. Interviewing will be carried out wherever practicable."*

8.8 The long-term locum we met said that on arrival he had been given a good amount of information and had spent a considerable amount of time with a medical staffing officer. He had been taken through his induction by a consultant in his department, who asked him what he could and could not do. He felt that the support was good, and put this down, at least in part, to the fact that there is a closer community in a small hospital such as Jersey rather than in a large hospital. He has found that if he has problems people will listen and try to help, and that the hospital is a happy place to work.

8.9 The newly arrived locum doctor told us that he has been a locum elsewhere, and has had experience of a wide range of induction processes.

8.10 He was impressed by the fact that a consultant in his department telephoned him as part of the recruitment process and discussed his areas of competency with him. He was also impressed by the help he was given in organising his flight and accommodation. When he first arrived he was seen by medical staffing, shown around the department and

inducted into the main theatre and the DSU. He met the consultant at 6.30pm, had a detailed discussion with him, and went through the competency checklist. He thought the competency checklist was a good thing as it was very detailed and allowed him to be open about the areas in which he was not particularly experienced, rather than having to offer this information up when asked to do something during a shift. He thinks that it is helpful that any limitations are known before he started.

8.11 The consultant told us that the previous day he had gone through the competency checklist with a new locum. He said that he found it a very valuable experience, and he thinks that the locum did as well. His feeling was that the locum had been very relieved that he was able to discuss quite openly and easily what he could and could not do. The consultant also felt that the competency checklist was a powerful tool, and, particularly for those locums who are still going through training, would allow the hospital to help them develop in areas where they lacked experience.

Analysis/discussion

8.12 The March 2010 audit identified significant lack of evidence of good practice. However it is not clear whether it was merely documentary evidence of good practice that was lacking, or whether the lack of documentary evidence showed that the activities had now taken place.

8.13 It is unfortunate that the subsequent audit did not test against the same criteria, and that the detailed results were not made available to us. However, we accept the explanation given to us, which was that as the system was in a state of flux, it would not have been a fair comparison to set the second audit against the first.

8.14 Regarding the provision of proper induction and orientation, and establishing and making colleagues aware of any clinical limitations, we believe that the hospital has taken this issue on board and has treated it seriously. This is borne out by the latest audit results from December 2010.

8.15 We consider that the documents that have been developed, in particular the competency checklist documents, are a great step forward in ensuring patients' safety, and we expect that when the process is undertaken via the e-induction, it will be even more useful as it will be possible to link the competency checklist with requests for references.

Assessment

8.16 Clearly the hospital understands the need for high quality induction and orientation, and to establish any clinical limitations of a locum. The process that has been developed to ensure that these happen is a good one.

8.17 However, it is not enough to have a good process, it is also necessary to comply with the process. We think that the early audits gave rise to a certain amount of concern but hope that the results of the December 2010 audit will now be maintained. It is important that hospital staff do not feel that induction and orientation is simply, or mainly, the responsibility of the medical staffing department.

8.18 As with the audits of medical records, we believe that those responsible for providing induction in departments should undertake the audits of locum files, as this will be the best way to get them to take ownership of the process.

8.19 See also recommendation 6.

Recommendation 19

The chief officer in conjunction with the medical staff committee should ensure that policies for the recruitment of locum medical staff are fit for purpose and properly implemented. Recruitment – including reference request forms - documents should be redesigned to ensure that they capture detailed information about an applicant.

Approach

8.20 We had a meeting with Angela Body, directorate manager surgery, Paul Jones, interim director of human resources, the PA to the directorate manager surgery, the head of midwifery, one of the medical secretaries, a locum middle grade doctor in general surgery, a human resources manager, two medical staffing officers and a consultant in obstetrics and gynaecology.

8.21 We considered the implementation of this recommendation alongside recommendations 5, 6 and 18.

Documentation

8.22 We reviewed the documents listed under recommendations 5, 6 & 18 – which are all relevant here.

Findings

8.23 The recommendation has been accepted.

8.24 See findings for recommendations 5, 6 and 18 – which are all relevant here.

Analysis/discussion

8.25 See analysis for recommendations 5, 6 and 18 – which are all relevant here.

Assessment

8.26 The recommendation has been partly met.

8.27 See assessments for recommendations 5, 6 and 18 which are all relevant here.

8.28 Recommendation 20

The chief officer and senior management team should minimise the use of locums by tackling the underlying medical staffing problems. Figures for locum usage should be reported to the chief officer monthly. *Urgent*

Approach

8.29 As part of our consideration of recommendation 20, we met Paul Jones, interim director of human resources and members of his HR team, Angela Body, directorate manager surgery, a consultant in obstetrics and gynaecology, a locum middle grade doctor and the head of midwifery. We also had discussions with Andrew McLaughlin and various other senior managers.

Documentation

8.30 We reviewed:

- H&SS locum usage (medical staff) – 12 month rolling analysis.
- Locum usage paper – December 2010

Findings

8.31 The recommendation has been accepted but appropriately modified for use – to recognise that the structure of the organisation has now changed.

8.32 A locum trend analysis was introduced in March 2010 which – in view of changes to the organisational structure - is reported through the managing director of the hospital to the chief executive. The trend analysis is also regularly reported at the Integrated Governance Committee.

8.33 Paul Jones explained that the current medical staffing strategy is to seek to attract permanent doctors to the island by paying a 'finder's fee' of £5,000 to a recruitment agency. While more expensive than paying locum rates in the short term, he believes it will prove more cost efficient over the medium and longer term – as well as leading to a more stable workforce.

8.34 While this initiative will probably take time to filter through the system we were pleased to learn at the time of our re-visit that the department of medicine was about to become fully staffed with doctors "*for the first time in a long time*".

8.35 However, we have since learnt that this never in fact happened, on account of doctors – who had originally been offered positions – not actually taking them up.

Analysis/discussion

8.36 The H&SS locum usage (medical staff) 12 month rolling analysis shows that in the month ending January 2010, across the hospital there were a total of 426 locum doctor days used. Of these, 117 were at consultant level, 222 at staff grade and 33 at registrar level. A total of 166 locum days were used in obstetrics & gynaecology and 53 each in anaesthetics and psychiatry – the second highest specialties.

8.37 In the month ending September 2010, there were a total of 411 locum doctor days used. Of these, 123 were at consultant level, 219 at staff grade and 49 at registrar level. A total of 105 locum days were used in obstetrics & gynaecology (many of which were attributable to long-term consultant cover) and 60 in acute medicine – the second highest specialty.

8.38 Between January and September 2010, an average of 407 locum days were used each month within the hospital – indicating a full year predicted figure of over 4,800 days.

8.39 This figure, when compared to those included in our original report, suggests that the overall level of locum usage within the hospital was higher at the time of our revisit than at the time of Elizabeth Rourke's death, In 2006, there were 2,902 locum days; 4,403 in 2007; and 3,716 in 2008.

8.40 However, we were made aware in December that the hospital had carried out its own further analysis for the period to the end of October 2010. This shows that when comparing the quarter August to October 2010 with the quarter February to April 2010 – and when removing long-term locums and exclusions from the calculations - there had been a 14 per cent reduction in locum usage.

Assessment

8.41 The recommendation has been partially met in that the hospital has made tangible efforts to attract doctors to permanent positions. However, this has so far been with only limited success and the example given above (with the husband and wife team) illustrates the need to have joined up working across the States on this issue.

8.42 However, importantly, the hospital is making a good effort to capture and understand locum data. For instance senior managers now distinguish between planned and predictable locum usage (say, to cover long periods of absence and exclusions) and unplanned and unpredictable locum usage – which carries with it a higher associated risk.

8.43 While data are now regularly produced and reported upon, they indicate that locum usage remains high and on the increase – suggesting that the attempts made to address the underlying medical staffing problems have not yet had the desired impact.

8.44 With usage remaining high, the hospital should continue to reassure itself that the appropriate systems and processes governing the employment of locums are in place and being followed (see also recommendations 18 and 19)

9. Day surgery unit and theatres

Recommendation 21

The directorate manager and clinical director should ensure that the theatre team remains unchanged during the course of an operating list. This may require separate public and private lists or that the consultant anaesthetist is present for the entire list.

Approach

9.1 We met Angela Body, directorate manager, surgery, the clinical director for surgery, consultants in anaesthesia and critical care, obstetrics and gynaecology, orthopaedics and Trauma, general surgery, pain management and haematology, the lead nurse for theatres, DSU and endoscopy and the sisters for DSU and main theatres.

Documentation

9.2 We reviewed:

- a PowerPoint presentation to the surgical clinical leads
- minutes of clinical leads meeting
- minutes of the theatre management group
- minutes of the WHO steering group
- minutes of the Verita steering group
- the 'productive operating theatre' paperwork
- the department of anaesthesia, critical care and pain medicine policy for departmental staffing and resource allocation
- team briefings.

Findings

9.3 Following extensive discussions by the relevant parties the recommendation has been modified to:

"The directorate manager and clinical director should ensure that the theatre teams have identified specialty leads who remain unchanged during the course of an operating list."

9.4 We heard that there would be three leads for each operating session: a theatre nurse, a surgeon and an anaesthetist/ODA.

Analysis/discussion

9.5 The proposed changes were discussed in detail, including possible problems. Although this change may lead to what might possibly be considered as an additional staffing load, we were reassured that the benefits of such as system would easily outweigh the potential disadvantages.

Assessment

9.6 The modified recommendation has been implemented.

9.7 We consider it would be sensible for the directorate manager, surgery to review the benefits and/or disadvantages of the modification after six months

Recommendation 22

Consultant surgeons should check the records of the patients on their operating lists before the operating order is finalised to ensure that each list is balanced, safe and in the right order. *Urgent*

Approach

9.8 We met Angela Body, directorate manager, surgery, the clinical director for surgery, consultants in anaesthesia and critical care, obstetrics and gynaecology, orthopaedics and Trauma, general surgery, pain management and haematology, the lead nurse for theatres, DSU and endoscopy and the sisters for DSU and main theatres.

Documentation

9.9 We reviewed:

- a presentation setting out the previous situation and proposals to meet the recommendation
- comprehensive copies of theatre diaries and operating lists.

Findings

9.10 The recommendation has been accepted.

9.11 We heard that the consultants check the theatre lists and patients notes with the pre-admission clinic nurse when the lists are completed.

9.12 If the lists are thought to be too long the pre-admission nurse on the day surgery unit can refuse to admit the patient.

Analysis/discussion

9.13 This recommendation generated more discussion that most, mainly from the consultant surgeons who were clearly committed and concerned that patient safety should

come before everything else. There was some reluctance on the part of a small minority of consultants to the changes, which they felt might have been unnecessary.

Assessment

9.14 The recommendation has been put into practice and we were told that it is working well.

9.15 We suggest that in six months time, the directorate manager, surgery should undertake a review of the benefits and/or disadvantages of the change.

9.16 In addition, and in conjunction with representatives of theatre staff, including surgeons, anaesthetists and theatre nurses, she should review the safety and function of the theatres at regular - three to six-month - intervals. The results of these reviews should be reported to the medical director and managing director.

Recommendation 23

The theatre management group should ensure through regular audit that instrument trays remain standardised and contain all appropriate equipment.

Approach

9.17 We met Angela Body, directorate manager, surgery, the clinical director for surgery, consultants in anaesthesia and critical care, obstetrics and gynaecology, orthopaedics and Trauma, general surgery, pain management and haematology, the lead nurse for theatres, DSU and endoscopy and the sisters for DSU and main theatres.

Documentation

9.18 We reviewed:

- a comprehensive list of instruments used in the operating theatres
- the standardisation of instrument policy
- the related procedures.

Findings

9.19 The recommendation has been accepted.

9.20 We learnt that there is agreement between the surgeons and theatre staff with regard to standardisation of surgical instruments.

9.21 There is also agreement about which procedures require what instruments

9.22 Individual surgeons can also request particular equipment sets

Analysis/discussion

9.23 There was a good general discussion about this recommendation, which was well accepted.

9.24 The theatre nurses were very clear that certain items of equipment, such as resectoscopes, would not be put onto the theatre trays unless specifically requested by the surgeon.

9.25 The theatre sister in charge of a case can refuse to provide an instrument which he or she feels the surgeon is not competent to use.

Assessment

9.26 The recommendation has been implemented.

9.27 We suggest that there should be an annual review of this instrument policy to ensure that it remains fit for purpose.

Recommendation 24

The theatre management group should continue to develop and disseminate guidelines on the management of major bleeding with a view to establishing a simple, agreed approach.

Approach

9.28 We met Angela Body, directorate manager, surgery, the clinical director for surgery, consultants in anaesthesia and critical care, obstetrics and gynaecology, orthopaedics and Trauma, general surgery, pain management and haematology, the lead nurse for theatres, DSU and endoscopy and the sisters for DSU and main theatres.

Documentation

9.29 We reviewed:

- the gynaecology guideline
- an SMT 6 point algorithm.

Findings

9.30 The recommendation has been accepted.

9.31 The gynaecology guideline for major bleeding has been adapted for the entire organisation, with recognition of early call for help and sharing decision-making with most senior of colleagues.

9.32 The gynaecology guidelines are in place for all theatres including endoscopy. They are supported by an SMT 6-bullet point algorithm (regarding the recognition of a problem) - in line with the airline industry.

9.33 We were told that there is no difficulty in obtaining whole blood in the event of a major emergency on the island.

Analysis/discussion

9.34 The consultant haematologist's contribution to the guideline has been very useful and of benefit to the hospital and its staff and patients.

9.35 There have not been any major bleeding incidents

Assessment

9.36 The recommendation has been implemented

9.37 We suggest that:

- It should in future be hospital policy for all new members of staff to be informed about guidelines for major bleeding incidents.

- The directorate manager of surgery and representatives of theatre staff, including surgeons, anaesthetists and theatre nurses should conduct a review of any incident involving major bleeding.

- The guidelines and their implementation should be reviewed at regular intervals.

Recommendation 25

The theatre management group should continue to develop the use of the World Health Organization (WHO) pre-operative/surgical safety checklist and ensure that it is used in all theatres.

Approach

9.38 We met Angela Body, directorate manager, surgery, the clinical director for surgery, consultants in anaesthesia and critical care, obstetrics and gynaecology, orthopaedics and trauma, general surgery, pain management and haematology, the lead nurse for theatres, DSU and endoscopy and the sisters for DSU and main theatres.

9.39 We also met with a group of staff from the day surgery unit.

Documentation

9.40 We reviewed:

- guidelines for implementing WHO safe surgery checklist
- audit report – June 2010.

Findings

9.41 The recommendation has been accepted.

9.42 HSSD published guidelines in July 2010 mandating the use of the checklist throughout theatres. This followed a pilot of the checklist in theatres.

9.43 The expectation is that all patients who attend theatres (main and DSU) will have a checklist completed.

9.44 An audit conducted in June 2010 found that four specialties (ENT, dental, gynaecology and orthopaedics) were fully compliant with the expectation. By contrast, general surgery and ophthalmology showed low levels of compliance. A re-audit of these specialties in September 2010 reported full compliance in general surgery and 88 per cent

compliance in ophthalmology though the sample size was small (eight sets of notes from each specialty).

Analysis/discussion

9.45 Discussion with DSU staff suggested a continuing commitment to the checklist. They have adapted it to fit local circumstances (WHO are happy the checklist should be modified) and to ensure that the procedure remains current and appropriate.

9.46 One consultant described how in most lists they try to ensure that junior – and new – members of the team are comfortable speaking up if something is not right.

9.47 They do this by getting everyone – before the list starts – to talk about (for example) something they had done recently. For instance, a consultant might talk about a training seminar he went to in Southampton and so on. Sometimes the day's topic might be quite light-hearted but the point is it encourages junior and new members of staff to speak up – and therefore make it more likely that they will feel confident & empowered to do so if they spot a problem.

Assessment

9.48 The checklist was being piloted at the time of our original investigation and we observed it being used in the DSU. It has been adopted throughout theatres since then. The June audit results suggest widespread adoption with two specialties as significant outliers. The September results show improved performance in these specialties.

9.49 Discussions with staff suggest that the checklist has been adopted and is seen as an important patient safety check and a device for encouraging team members to talk. The initiative has the support of consultant surgeons including the new medical director.

9.50 The checklist has an important part to play in supporting the management team's efforts to develop an open culture in HSSD.

9.51 We would recommend a more detailed audit of compliance, based on a larger sample of records.

9.52 The policy document should make it clear that the standard is that all patients who attend theatres will have a checklist completed.

10. Information

Recommendation 26

The chief officer and information governance lead should ensure that patient records are clearly numbered under a single system and that all records are filed safely and in correct sequence *by hospital number*, not by name. Any records on a particular patient held by another medical organisation, for example a private consultant or another hospital should be filed in the original patient record folder.

Approach

10.1 We met the information governance manager, Angela Body, directorate manager surgery, the head of risk management, one of the medical secretaries and a clinical audit officer.

Documentation

10.2 We reviewed:

- the Unique Patient Identifier paper - November 2009 ICR board minutes
- Julian Woolfson also made an impromptu visit to the medical records department and to wards, to look at the numbering and content of randomly selected case notes.

Findings

10.3 The recommendation has been accepted.

10.4 The Unique Patient Identifier recommendation paper dated November 2009 showed that the hospital had already identified, before our initial report, the potential risks to patient safety created by the existing system, which has six figure HSS numbers for patients and different and indistinguishable six figure CUR numbers for filing physical records such as handwritten notes, x-rays and computer print outs of tests and investigation results.

10.5 Because of the way HSS numbers were originally allocated, there is a risk that the unnoticed mis-keying of a single digit within an HSS number might result in the misidentification of patients with similar names, for example 121345=Julie Brown and 121346=Julia Brown. A number of possible solutions to the problem were identified, including a completely new numbering system, using people's social security numbers and various ways of adding a number or letter to the existing number.

10.6 The pros and cons of each of these were set out in the paper, and the recommendation was that the existing HSS number should be retained, with the addition of a letter at the end which would be allocated by a computer programme in such a way that it would not be possible to inadvertently enter the new identifier wrongly into the IT system.

10.7 We learnt that the recommendation in this paper was accepted, and that when the impending integrated care records IT project goes live, all HSS numbers will be automatically allocated their final letter as the data is transferred from the current system to the new one.

10.8 We were told that the new identifiers will also be used for patients' physical records, replacing the CUR numbers.

10.9 Presently patients' physical records are filed on more than one site (because the original storage space is now too small), the filing room at the hospital is unpleasant and overcrowded and most of the files are held on unsatisfactory and overloaded carousels. This problem has been recognised for years.

10.10 That situation has now changed, as the interim managing director recognised the unacceptable risks posed by the existing setup and allocated funds for this purpose. All the files will be moved into a temporary, but secure, setting at the hospital, and before being moved back to their refurbished permanent home they will be renumbered with a new identifier.

10.11 We were told that managers and consultants had discussed the second part of our recommendation - that records on a particular patient held by another medical organisation, for example a private consultant or another hospital, should be filed in the original patient record folder.

10.12 We heard that private patients may not wish to have their private notes kept at the hospital and that as private consultants are their own data controllers, the hospital could not insist that private patient records – or copies of records – be filed in HSSD public notes. Currently, when a private patient is admitted, the private notes are filed with the hospital notes for as long as the patient episode lasts. Thereafter, the consultant takes the private notes back to his rooms, including any notes made by him or her during the patient's admission, e.g. operation notes.

10.13 The discussion arising from our recommendation concluded that a good way forward would be to add to the current system by ensuring that a copy of the discharge summary routinely sent to the patient's GP at the end of an episode would also be sent to the hospital to be filed with the patient's hospital notes.

10.14 Our meeting with staff, together with a visit to the medical records department showed:

- notes are filed by HSS hospital number, not name
- there is a functional system in place for scanning in records that have been inactive for five or more years and for destroying the paper records
- private notes for current inpatients are filed with the hospital notes
- there is effective procedure coding
- an effective system for tracking records.

Analysis/discussion

10.15 We consider that the hospital's plans for providing each patient with a unique identifier are sensible and will improve patient safety, particularly when the patients' records have also been given the unique identifier.

10.16 We understand why the CUR numbers are still in use; it would have been inefficient to have manually renumbered and re-filed all the records currently held in the medical records department while there was still a hope that this work could be combined with the long-hoped-for refurbishment. Now that the refurbishment has been agreed, it is clearly sensible to do the renumbering as the records are re-filed, in due course, in the refurbished medical records department.

10.17 With regard to the second part of our recommendation, we consider that the plan to have a copy of the discharge summary kept with the hospital records accords with good practice elsewhere.

Assessment

10.18 The recommended has been partly implemented.

10.19 We consider that the hospital's response to our recommendation has been sensible and practical.

10.20 However, much has been promised, but so far, little has been delivered. We mean no criticism by this comment, as we accept that these issues take time to get right and to implement.

10.21 We understand that the timetable for the Integrated Patients Records system has slipped, but the single numbering project actually depends far more on the refurbishment of the medical records room. It is therefore important that this takes place without unnecessary delay.

10.22 Regarding private notes, we hope that discussion will continue about ways in which copies can be held safely with the hospital notes. Increasing computerisation is likely to reduce the practical obstacles to this, and consultants might also consider pointing out to their private patients the value in having copies of their notes at the hospital, and seeking their consent to this.

10.23 There needs to be an audit programme to check that:

- the record storage system is functioning
- unique patient identifiers cannot be entered on the system wrongly
- private notes of hospital patients are kept at the hospital for the length of the episode
- discharge summaries are on all private patient files after the end of the episode
- Three-monthly audit of missing notes/notes taken by doctors
- new filing storage units are functioning.

Recommendation 27

The chief officer and information governance lead should ensure that no original patient records are removed from hospital premises under any circumstances. Where a request for records is made - for example by another hospital, a private consultant or in the course of litigation or similar review (and with the patient's consent) - the records should be photocopied and only the copies sent.

Approach

10.24 We met the information governance manager, Angela Body, directorate manager surgery, the head of risk management, one of the medical secretaries and a clinical audit officer.

Documentation

10.25 We reviewed:

- the health and social care records policy - May 2008
- the health and social care records policy - September 2010.

10.26 Julian Woolfson also made an impromptu visit to the medical records department and to wards, to look at randomly selected case notes.

Findings

10.27 The information governance manager explained that the hospital understood that our recommendation sought to reduce the risk of records being unavailable for patient care when needed. However they felt that in the particular circumstances applying in Jersey, this risk would best be managed by modifying the wording of the recommendation to:

> *"The chief officer and information governance lead should ensure that the location of original patients' records is known at all times, and mechanisms are in place to ensure notes are available when needed for clinical care. Processes should be in place for providing copies of records to, for example another*

hospital, a private consultant or in the course of litigation or similar review (with the patient's consent or appropriate other authority), without jeopardising the availability of records for clinical care."

10.28 We noted that the amended policy of September 2010 provided that:

"…with the exception of private practices and the medical board, no original records should be sent to any non-HSSD organisation. Photocopies or scanned copies only should be sent."

10.29 In relation to private consultants the Policy provides that:

"*Wherever possible public notes which are required to be viewed by a consultant working in a private capacity should be reviewed on hospital premises…however if it is necessary to review the notes in private rooms, HSSD consultants working in a private capacity may request G&A records to be sent to their private rooms. Notes are permitted to remain in private rooms for a maximum of 48 hours, on the condition that they are returned upon request if required by HSSD…*"

10.30 The Social Security Department Medical Board can request access to hospital medical records for the purposes of their clinicians assessing incapacity benefit and other relevant benefits. The policy provides that "*The Medical Records Department are permitted to send the original records to the Medical Board under the following conditions, they are collected and returned within the same working day and any hospital need for the records take priority over Medical Board's need*".

10.31 We asked why the recommendation had been changed in this way. We were told that hospital records are held on more than one site and that - even setting aside private care - records have to be moved according to the location of patients and services. This means that the risk of records being lost or damaged whilst in transit from the main hospital site already exists and cannot be eliminated.

10.32 Conversely, there is some advantage to patients in their consultants being allowed to take their hospital records to their private rooms on a temporary basis.

10.33 If a consultant is seeing a patient in private rooms for a condition for which they have received treatment in hospital, it is in the best interest of patient care that the consultant has the hospital records available during the consultation.

10.34 The hospital recognised, however, the importance of being able to trace records easily and it has now greatly improved its file tracking system. Files have to be signed for and the medical secretaries keep a note of the files that have been removed. They also ensure that the files are returned within the 48 hour time limit.

10.35 When the new computerised patients' records system is working, it will be possible to trace these records electronically, and provide automatic reminders for the return of records.

10.36 We were told that compliance with the policy is monitored, and any persistent non-compliance will be drawn to the attention of the Clinical Advisory Group by the clinical lead, which will lead into the audit by the Care Quality Group.

Analysis/discussion

10.37 We felt that the hospital had properly understood the purpose of this recommendation, and had sensibly amended it to take account of the particular circumstances on Jersey – i.e. records go off the main site in any event, all private consultants also work for HSSD, records can be traced and tracked through the medical secretaries, and the Island's size means that records can quickly be retrieved.

10.38 We discussed the possibility of all public records being photocopied so that consultants could take copies to their private rooms, but were told that this would be time consuming and would use scarce resources in a way that could not be justified in light of the extent of the risk that it would be seeking to reduce. We accepted this. (Mr Woolfson had a look at the tracing system, and considered that it was robust and satisfactory).

10.39 We discussed the risk that might be posed if records were off site at night in the event of an emergency and could not quickly or easily be retrieved from the consultant's private room. Mr Woolfson considered that in an emergency the notes would not likely be of immediate relevance

Assessment

10.40 This recommendation has been sensibly adapted and meets the risk that the original recommendation was intended to reduce.

Recommendation 28

All staff should ensure that records – including patient records and departmental rotas – are accurate and comprehensible and include last-minute amendments and changes.

Approach

10.41 We discussed this recommendation with the information governance manager, Angela Body, directorate manager surgery, the head of risk management, one of the medical secretaries and a clinical audit officer. We were provided with documents shown below, which we discussed during our meeting.

Documentation

10.42 We reviewed:

- the results of the medical division documentation audit – March 2010
- the results of a nursing documentation audit (undated).

Findings

10.43 The recommendation has been accepted although the hospital interpreted it as focusing essentially on medical records rather than departmental rotas.

10.44 The audit process was explained to us by the head of risk management and the clinical audit officer. They explained to us that it is the hospital's policy to have staff carrying out audits designed by the Audit Department. In this way staff will 'own' the results of the audit.

10.45 They talked us through the audit records that were provided to us, which related to an audit of medical division documentation. We noted that 19 doctors in the medical division took part in this audit, including five consultants, five middle grades and nine more junior doctors. This is a high proportion of the total staffing in the medical division. An audit tool was developed using a combination of the Royal College of Physicians Generic Record Keeping Standards tool, with questions added following a previous in-house audit carried out in 2009. Each doctor was asked to audit three sets of patients'

notes, which had been anonymised. No doctor audited their own work or that of other members of their team.

10.46 The audit took place in March 2010 and was due to be repeated at the end of October. Doctors have been given feedback as a result of the audit, so that they can improve their record-keeping, and the success of this will be revealed by the next audit.
We were told that this method of auditing was received with considerable enthusiasm by the doctors, who entered whole heartedly into the exercise and who understood the value of auditing in this way.

10.47 We also heard that similar audits had been carried out in and were planned for other departments in the hospital.

10.48 We learnt that the results of audit feed into the Care Quality Group which in turn feed into the Integrated Governance Group. The process of audit is subsequently becoming a normal feature of hospital life, with individual initiatives - to monitor usage, standards and outcomes - being developed on wards and in departments.

Analysis/discussion

10.49 We were impressed by the obvious enthusiasm of those organising these audits, and also by the responses of staff, which we were able to discuss with individuals during the week.

10.50 It is important that the results of audits should be monitored, to ensure that they lead to individual and collective improvement in record keeping.

10.51 Although this recommendation dealt with departmental rotas as well as patient records, the accuracy of departmental rotas has been dealt with more comprehensively under recommendation 5, so we do not criticise the hospital for focusing this recommendation on the accuracy of patient's records.

Assessment

10.52 The recommendation has been implemented – but with a specific focus on the accuracy of patient records.

10.53 We consider that the importance of accurate record-keeping has been understood and is being disseminated throughout the hospital by way of audit and discussion.

10.54 The need for accurate record-keeping needs to be continuously re-enforced through training and audit. Audit results need to be carefully monitored by clinical leads and persistent problems need to be escalated through the governance system.

11. Managing external relationships

Recommendation 29

The chief officer should begin discussions with the States of Jersey Police and the Deputy Viscount about developing a local protocol setting out working relations in the event of a patient safety incident. This should be supported by guidelines for hospital staff and senior investigating officers. The 2006 protocol between the National Health Service, Association of Chief Police Officers and Health and Safety Executive, along with the associated guidelines, would provide a helpful starting point. *Urgent*

Approach

11.1 We met a senior legal adviser from the Law Officers' Department (LOD) and Paul Jones, interim HR director.

11.2 We have also sampled the views of other staff in HSSD to find out what they know about the MoU and the management guidance.

Documentation

11.3 We reviewed:

- memorandum of understanding
- management guidance produced between the Health & Social Services Department, States of Jersey Police and the Health & Safety Inspectorate
- CMEX minutes.

Findings

11.4 The recommendation has been accepted and adapted.

11.5 The States has produced a memorandum of understanding between the States Employment Board (SEB) and a range of investigative bodies. The purpose of the document is to promote liaison and effective communication. The agreement has been approved by the SEB and the signatory organisations. At the time of the fieldwork it had yet to go to

the States corporate management board. The SEB proposes that the document should be widely circulated throughout the States.

11.6 HSSD has produced its own management guidance which draws heavily on the MoU from England. It offers practical guidance to staff involved in an incident.

11.7 The Corporate Management Executive discussed the MoU on 7 September 2010. The minutes record the following:

> *"Memorandum of Understanding – between HSSD, States of Jersey Police and Health and Safety Inspectorate, as recommended in Verita and Solace reports, was approved. Report would be presented to the Medical Staff Committee on 16 September and training workshops would be arranged for end of October."*

11.8 The staff we spoke to were aware of the development.

Analysis/discussion

11.9 The original recommendation has been appropriately adapted to fit local circumstances. The MoU has been drawn up between the SEB (as the employer) and a wide range of investigative bodies. One interviewee commented that the agreement offered a clear structure and process for the management of future cases. The agreement would help avoid some of the 'corridor conversations' of the past and allow organisations to be clear about their own responsibilities.

11.10 The protocol is already informing practice in this area.

Assessment

11.11 The recommendation has been implemented.

11.12 The SEB, LOD HSSD and the various investigatory authorities have achieved a good deal in a short space of time. The adaptation of the MoU to cover a wider group of investigative bodies (and thereby cases) is an excellent idea.

11.13 The HSSD management guidance is a helpful addition as it provides specific direction to staff dealing with such an incident in a health or social care setting.

11.14 ACPO, the NHS and HSE in England found it difficult to get their respective frontline staff to act on a similar MoU and guidance. This was because a lot of effort was put into drafting the documents but far less into spreading the word. Consequently, implementation has been patchy. Old behaviours, for example the police claiming primacy for the criminal investigation, still happen despite the agreement and associated guidance having been in place since 2006.

11.15 The challenge therefore is for the SEB, investigative bodies and HSSD to ensure that frontline staff know about and understand the purpose of the MoU and the guidance and act on it when these difficult and complex circumstances arise. The HSSD training workshops planned for the end of October should help with this.

11.16 The MoU should be produced as an official States of Jersey document, signed and dated. Its use should be reviewed regularly. The SOJP may wish to consider producing guidance for senior investigating officers about the investigation of patient safety incidents. It could be based on the ACPO document.

Recommendation 30

The chief officer should set out in a published action plan a response to this report and account publicly for the actions taken. A status report for each recommendation should be produced six months after publication. This should include evidence of what has been done.

Assessment

11.17 The progress review includes a status report for each of the previous 29 recommendations.

11.18 In addition, the minister has told us that she intends publishing a management improvement plan in due course.

11.19 The recommendation has therefore been met.

Appendix A

Terms of reference

States of Jersey Health and Social Services

Independent investigation into the care, treatment and management of Mrs Elizabeth Rourke

Six month progress review

Commissioner

The Minister of Health and Social Services, States of Jersey, has commissioned this six month review following the publication in February 2010 of the independent investigation report into the care, treatment and management of Elizabeth Rourke. The report made 30 recommendations and the sole purpose of this review is to provide an independent assessment of the hospital's progress implementing them.

Terms of reference

The purpose of the review is to:

- Assess progress made against each recommendation recognising that some will be in progress but not complete
- Provide a written report to the Minister

Approach

The report will be submitted to the Minister and the Chief Executive of the Health and Social Services Department once it is complete.

The team will report immediately any significant concerns to the Chief Officer and/or Health and Social Services Minister. Any matters relating to individual performance or behaviour will be reported to the Chief Officer/or the Minister but not published.

Review team

The review will be carried out by Ed Marsden, Derek Mechen, Lucy Scott-Moncrieff and Julian Woolfson.

Contact Details

Deputy Anne Pryke, Minister of Health and Social Services, States of Jersey, is the client for this work.

The Chief Executive has nominated Andrew McLaughlin, Interim Managing Director, Jersey General Hospital, to be the main point of contact.

Timetable

The team will aim to complete the work during the week commencing 11th October 2010 and provide a final report by the end of November 2010.

Publication

The Minister will publish a management improvement plan in 2010 which will include the findings of the Verita review.

Deputy Anne Pryke
Minister of Health and Social Services
11th August 2010

Appendix B

Team biographies

Ed Marsden

Ed is a former NHS manager with many years' experience of leading complex organisations and managing sensitive political issues. He has worked for the National Audit Office and the Department of Health, and before founding Verita, he was director of performance management for West Kent Health Authority. Ed has a clinical background in general and psychiatric nursing.

Now the managing director of Verita, a management consultancy specialising in the conduct of investigations and inquiries in health and other public organisations, Ed has handled the political repercussions of high-profile mental health inquiries, including the Michael Stone case. Along with Professor Robert Tinston, Ed carried out the corporate governance review of the Royal United Hospitals Bath NHS Trust. He has also worked with Ruth Carnall on a financial management and governance review of Worthing and Southlands Hospitals NHS Trust. Ed co-wrote the board leadership review of the Maidstone and Tunbridge Wells NHS Trust. This followed the Healthcare Commission's report on the deaths of patients as a result of *Clostridium difficile*. Ed is an associate of the Prime Minister's Delivery Unit and has carried out three assignments on immigration.

Derek Mechen

Derek is director of client work at Verita and has been involved in healthcare in a variety of settings for over 30 years. He has held senior positions in operational management in both the NHS and the independent sector, and has also worked at the National Audit Office, where he led several value-for-money studies and spent a year on exchange at a teaching hospital in Chicago. As director of client work for Verita, he has overall responsibility for the quality of all investigations. He leads high-profile and sensitive reviews, including most recently three independent mental health homicide reviews - one in Broadmoor and two in London. He was a member of the Verita teams that undertook the board leadership review at Maidstone and Tunbridge Wells NHS Trust and an investigation into an unexpected death in the East Midlands following laparoscopic surgery.

Lucy Scott-Moncrieff

Lucy qualified as a solicitor in 1978, and has worked in the fields of mental health and human rights law ever since. In 2005 she was awarded the Mental Health Legal Aid Lawyer of the Year award and in 2009 she was awarded an honorary doctorate by the University of Kent at Canterbury for services to access to justice. She has been a Law Society Council member since 2002 and is President-elect of the Law Society for 2012/13. Lucy is a director of Edge Training Limited, a company that offers training on the law to the purchasers and providers of health and social care, and is a member of the QC Appointments Panel. She is also a commissioner with the Royal Mail regulator Postcomm. Lucy is on the editorial boards of the *Community care law reports* and the *Mental health law journal* and has written and broadcast regularly on legal issues over the years. She has recently been a member of the working party set up by the Law Commission as it prepared its consultation paper on unfitness to plead.

Julian Woolfson, OBE, MB ChB, LLM, FRCOG

With over 35 years' experience in private practice and the NHS, Julian Woolfson is a leading authority on obstetrics and gynaecology. Until 2007 he worked for Queen Mary's Hospital Sidcup NHS Trust, where he combined his clinical role as a consultant with that of associate medical director responsible for all aspects of clinical governance and for devolving and supervising best practice. He was also the trust's clinical risk manager. He is a member of numerous regional and national committees and has only recently stepped down as the chair of the Royal College of Obstetricians and Gynaecologists' Professional Standards Committee, and a member of the college's Ethics Committee and its Specialty Training Committee. Julian is also a lead examiner and hospital visitor for the college, and has published numerous books and articles on obstetrics and gynaecology. Over the last 20 years, he has written 1000 expert reports for claimants and defendants attending court and has given oral evidence in 22 High Court trials. He is a trustee of The Sudborough Foundation (an educational support trust) and Wellbeing of Women (research funding trust), and chair of governors of Ravensbourne College of Design and Communication. He was awarded an OBE for voluntary services to higher education in 2008.