cc Simon Tanner 28/3.

BM/DACD

COMMUNITY HOSPITALS ASSOCIATION

Mr Gareth Crudance
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Hampshire and Isle of Wight Strategic Health Authority
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SO16 4GX

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Simon, this report is fwdd to you and Richard Samuel. As Richard is on holiday, please ~~write + thank for work.~~ let Richard have it once you've had a chance to run through it. 28/3

21st March 2003

Brenda fyi

Dear Mr Crudance,

The Community Hospitals Association has completed the work which was commissioned by Michael Taylor, on behalf of the Health Authority, as part of the Gosport War Memorial Hospital Independent Inquiry.

Enclosed please find four copies of the document "What Characterised Conventional Clinical and Managerial Practice in Community Hospitals during the period 1988 - 2000." As agreed with Michael Taylor there is anonymity for the Trusts identified in the document.

If you need clarification or would like to discuss any part of this document please contact me, you will find the details on this letter or on page 73 of the document.

As agreed with Michael Taylor we have enclosed an invoice for the work undertaken. The cost reflects the amount of time collating the details for the report, report writing and stationery plus printing costs. We do hope this meets with your approval.

If we can be of any further assistance please contact me.

Yours sincerely

Code A

Barbara Moore
Chief Executive

Pls sign + let me have BC finance Year end.

CHA Office
Meadow Brow, Broadway Road, Broadway
ILMINSTER, Somerset TA19 9RG

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COMMUNITY HOSPITALS ASSOCIATION

What Characterised Conventional Clinical and Managerial Practice in Community Hospitals during the period 1988 - 2000

CONTENTS

1. SUMMARY

1.1 This report has been commissioned by the Hampshire and Isle of Wight Strategic Health Authority to identify good practice in service quality and governance within Community Hospitals from 1988 – 2000.

1.2 The report addresses quality and governance in three specific areas of England. This includes the west, east and north of the country.

1.3 Management arrangements varied and developed in slightly different ways in the three areas during this period but the Health Authority or Trust maintained overall responsibility for quality and risk management. The Community Hospitals received direction from the Health Authority or Trust and there was either a general manager or professional manager who held responsibility for implementation of quality initiatives locally.

1.4 Despite some differences in the three areas, each had a professional advisory network to ensure good practice.

1.5 Between 1988 and 2000 a plethora of documents and national policies were published and the report has identified those which are relevant to Community Hospitals and the process for implementation.

1.6 The governing body of nursing, the United Kingdom Central Council (UKCC), issued 'The Scope of Professional Practice' [(1)] and this report has identified the changes in responsibility and accountability of nurses. Further UKCC documents, which include standards and guidelines, are referred to in this report. The identification of training needs, records of training undertaken and the development of the nursing process are also discussed.

1.7 In each area a District-wide policy for the administration of medicines was adhered to in addition to the UKCC 'Standards for the Administration of Medicines'. [(2)] In all areas specific training was provided in relation to the use of syringe drivers in pain relief. Initially the use of syringe drivers was part of the 'Extended Role' for nurses and latterly under the UKCC 'Scope of Practice' [(1)] where nurses took responsibility and were accountable for their own professional practice.

1.8 The report has identified the published documentation on clinical record keeping and training and audit of record keeping is evidenced in all three areas.

1.9 Quality in specific areas of health care was in place in 1988 and with the developments of Trusts the overarching Clinical Governance structure was formulated and introduced during 1998 and was in evidence in the Community Hospitals.

1.10 The report may provide the basis for further discussion with the Hampshire and Isle of Wight Strategic Health Authority.

2. BRIEF

2.1 The Community Hospitals Association has been commissioned by the Hampshire and Isle of Wight Strategic Health Authority to undertake a piece of work to identify conventional clinical and management practice in Community Hospitals during the period 1988 – 2000. The work involved identifying:

a) what was expected of Unit/Trust Management Teams in areas of service quality and management of risk

b) what would have been expected from key advisory professional staff e.g. GP Advisor / Consultant Advisor

c) methods of recording training and competencies of nursing staff in clinical procedures and practice

d) policies and practice at ward level in respect of responsibility for prescribing, administration and recording of medicines

e) description of evolving guidance about standards of clinical record keeping at ward level

f) an overall statement of conventional working arrangements between ward based staff and General Practitioners in relation to the management of beds, admission and discharge

g) a review of national policies and the implementation, at a local level, of quality initiatives

2.2 The report has involved a review of pertinent documentation and interviews of key staff from existing and relevant organisations.

2.3 The Community Hospitals Association has worked with representatives from three specific geographical areas in England.

2.4 The report covers the period 1988-2000, which was a period of significant management change within the NHS. This, in turn, had an impact on the management arrangements of Community Hospitals.

3. CONTEXT

3.1 Role of Community Hospitals

Community Hospitals provide accessible health care and associated services to meet the needs of a defined and local population. As an extension of primary care, they enable the GP and the Primary Health Care Team to support people within their own community. Rehabilitation is a major role of the community hospital, and many offer a wide range of health promotion, diagnostic, emergency, acute and therapeutic services.

Description

Community Hospitals are usually defined as local hospitals, where GPs have a significant role in providing medical services, usually through the provision of GP community beds and a minor injuries service. Community Hospitals will often have a range of clinics, such as consultant-led clinics and community clinics. Busy physiotherapy and occupational therapy departments are at the hub of the community hospital where rehabilitation teams work with patients to help to maintain and improve health, mobility and independence.

Definition

Although there are a wide range of Community Hospital definitions the four following examples have been selected.

"A general practitioner community hospital can be defined as a hospital where the admission, care and discharge of patients is under the direct control of a general practitioner who is paid for this service through a bed fund, or its equivalent." [3]

"Community Hospitals vary widely in structure and function but all aim to provide patients with a friendly service close to their community. They generate a feeling of ownership and are frequently well supported by voluntary organisations with time, effort and fund raising. Ease of access is an important consideration, particularly for visitors or patients requiring palliative and terminal care. No single model of community hospital can cover the needs of every locality and patient group." [4]

"A local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources. These will include inpatient and may include outpatient, diagnostic, day care, primary care and outreach services for patients provided by multidisciplinary teams. Medical care is normally led by general practitioners in liaison with consultant, nursing and paramedical colleagues as necessary. Consultant long stay beds, primary care nurse led and midwife services may also be incorporated.....

A hospital or unit, providing a range of health care services, where the first point of contact for medical care and advice is a local general practitioner or general practice and where the admission, care and discharge of patients is under the direct control of a General Practitioner." [5]

The description is an amalgam of the British Medical Association, the Royal College of General Practitioners and the Association of General Practitioner Community Hospitals. [5]

3.2 For the purpose of this report the review of literature and working practices within Community Hospitals has been divided into three key stages reflecting the developments in the NHS as follows: -

1988 - 1990
1991 - 1995
1996 - 2000

3.3 These time scales will be addressed, in three geographical areas, covering the areas outlined in the Brief.

4. What was expected of Unit /Trust Management Teams in areas of service quality and management risk 1988 - 1990

AREA A

4.1 During this period the District Health Authority was in overall control of health service provision for the District. The management structure for services, including Community Hospitals, varied between different areas of the district.

4.2 The Locality Administrator and Senior Nurse Manager were responsible for the monitoring of service quality and management of risk at a local level. Their line managers were the Unit Administrator and Director of Nursing Services respectively who were directly responsible to the Unit General Manager. **Fig 1**

4.3 District operational policies and procedures included: -

a. Health and Safety at Work
b. Serious Incidents
c. Standards of Care in the Health Authority
d. Financial Instructions

4.4 The Health and Safety at Work policy [6] was implemented by the site managers and was monitored by designated members of staff throughout the Community Unit. There was a planned preventative maintenance programme for equipment and recording methods were in place. Medical equipment was checked for accuracy and calibration and a record system was maintained.

4.5 All accidents and incidents were reported to the on site managers and Community Unit reporting systems were in place.

4.6 A "Standards of Care" leaflet [7] was produced by the Health Authority and given to each member of staff. This referred to the responsibility of all staff to protect and represent patient's interests and to report any abuse. It actively encouraged staff to report if a patient was deprived of treatment, care, food, comforts or any other benefit.

4.7 The local managers dealt with letters of appreciation and complaint. Any complaints were investigated by the appropriate Senior Manager in the Community Unit and appropriate action taken.

4.8 The National Association of Health Authorities published: *Towards Good Practices in Small Hospitals - some suggested guidelines.*[8] This resulted in the introduction of an Accreditation Programme (initially throughout the South West Region) for Community Hospitals who were invited to join the programme. The Community Unit agreed to introduce this programme to four Community Hospitals. [9] The programme involved answering a series of questions, which covered most aspects of Community Hospitals including: -

- The consumer
- Facilities and Equipment
- Nursing Services
- Medical Services
- Administration
- Day Hospitals
- Outpatients
- Casualty
- General Medicine, Care of the Elderly
- Maternity
- Surgery and Anaesthesia
- Pathology
- Pharmacy
- Radiology
- Rehabilitation
- Catering/Domestic Services
- Medical Records
- Pastoral and Voluntary Services
- Personnel
- Sterile Supplies
- Works

The format of the programme included:

- The completion of a series of questions on all aspects of a Community Hospital

- Following completion, the document was returned to the Hospital Accreditation Programme Manager

- A team of external assessors visited the Community Hospital to review policies, procedures and working practices. The assessors included a Doctor and a Nurse who had management as well as clinical expertise

- The Hospital Accreditation Professional Board, made up from representatives and advisers from the Royal Colleges and professional bodies, then assessed the detailed report

- The report was then presented to the hospital. The report identified areas of good practice and areas of concern and recommendations for improvement

Finally, the Community Hospital was either passed or failed in meeting the standards of the Accreditation Programme. Accreditation status was awarded (for one year) to the four participating hospitals in the Community Unit. These Community Hospitals went through the Accreditation process the following year and were awarded Accreditation for two years. This was an on-going process which was dependent on the Accreditation status awarded. The standards were revised in 1994, 1996 and 1999. [10] [11] [12]

Eventually all Community Hospitals in the Community Unit/Trust participated in the on-going Accreditation Programme using the standards at that time. All received Accreditation status for between one to three years.

4.9 At this stage there were very few specific policies for Community Hospitals. The School of Nursing provided nursing policies and procedures and there was a 'District wide' medicines policy.

It was a requirement of the Accreditation Programme that there were robust systems with supporting documentation in place for all departments. In the early stages motivated Senior Nurse Managers initiated the writing of policies and procedures for services but these were specific to that Community Hospital and were not 'Unit wide.'

4.10 Regular meetings between the Director of Nursing and Senior Nurses were held where directives and publications from the Department of Health were discussed these included "Working for Patients" [13] and "A Strategy for Nursing" [14]. Action plans were formulated to introduce changes throughout the Community Unit.

Similar meetings were held between the Community Unit Administrator and the locality administrators.

The Senior Nurse held monthly meetings with the ward sisters. It was the responsibility of each ward sister to hold meetings with their nursing teams.

Professions Allied to Medicine met regularly with the District Heads.

4.11 In the latter part of this period the management structure of the localities changed and the locality administrators, on reaching retirement, were not replaced.

4.12 The Community Unit reviewed its management structure and Locality Managers were appointed. In some areas they had overall responsibility for up to five Community Hospitals. The Community Hospital Senior Nurses became Senior Nurse Managers. This gave them added responsibilities which included some general management. They were directly responsible to the Locality Manager whose line manager was the Unit General Manager but clinical issues were still addressed by the Director of Nursing.

4.13 Team Briefing was introduced throughout the Community Unit and this was cascaded throughout the organisation. Initially the Team Briefing meetings were between the senior members of the Community Unit with the information being disseminated to all local staff via the Senior Nurses and other professionals. Senior Managers closely monitored the process, to ensure all staff were kept up-to-date on current issues within the Community Unit.

4.14 The Community Health Council (CHC) visited health service providers in localities including Community Hospitals. Although members of the CHC toured each department in the hospital they also had a brief to look in depth at any specific service. A detailed report on their findings was then provided to the Health Authority and the Community Unit who had to respond. An open meeting followed this with an invitation to the members of the

general public to hear and comment on the report of the local health services including Community Hospitals.

4.15 Members of the District Health Authority visited the Community Hospitals on an ad hoc basis to meet with the patients and staff.

ORGANISATIONAL CHART 1988 - 1990

AREA A

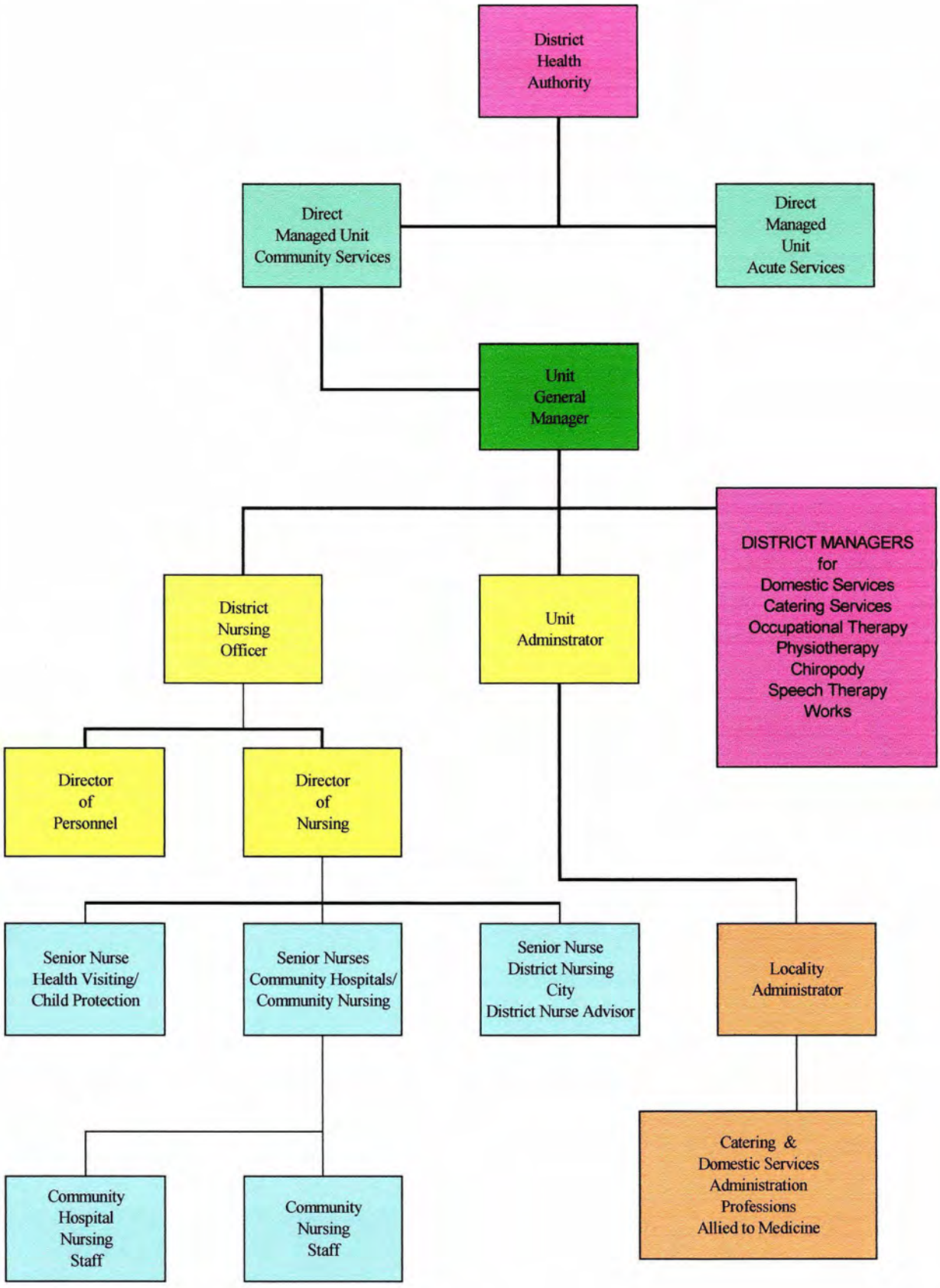


Fig 1

AREA B

4.16 During this period the District Health Authority was responsible for all health care provision in the district. The district consisted of three units, the acute hospital and two community or priority services units, each with a Unit General Manager. **Fig 2**

4.17 In this district the management structure consisted of professionals having both management and professional leadership responsibilities for their staff groups e.g. District Physiotherapist, District Occupational Therapist and District Nursing Officer.

4.18 The Senior Nurse Manager of the Community Hospital was responsible for the nursing services and for the hospital site. All other professional and support services had individual managers including administration, catering, domestic and portering.

4.19 At this time there were a range of district-wide policies which included:

a. Health and Safety
b. Personnel
c. Accident reporting
d. Untoward incident reporting
e. Implementation of action following Hazard Warnings and reports from the Medical Devices Agency
f.. Investigation and responses to complaints
g. Patient satisfaction

4.20 Nursing policies and procedures were developed by the School of Nursing which was based within the acute hospital.

4.21 In Community Hospitals it was the responsibility of the Senior Nurse Manager to ensure that the District and nursing policies were introduced and adhered to following relevant reporting systems.

4.22 Some services provided by the acute hospital were delivered across the District and their policies implemented District-wide. Examples of these are Infection Control, Estates Management, Medical Engineering and Pharmacy.

4.23 Regular meetings between Senior Clinical Managers were the forum for dissemination of directives, publications, discussion on action plans and for implementation of any changes. The Senior Nurse Manager was responsible for informing and involving Community Hospital staff in responding and taking relevant action.

4.24 During this period an appraisal system was introduced throughout the District. This system included the identification of staff training needs. Appraisal, in conjunction with workforce planning, enabled the Senior Nurse Manager to ensure that staff with appropriate skills and competencies were recruited. Those in post were clinically developed to meet the needs of the patients cared for within the Community Hospital. [14]

4.25 The Senior Nurse Manager was also responsible for facilitating meetings with the General Practitioners who had admitting rights to the Community Hospital. These meetings

provided a forum for sharing new documents, updating General Practitioners on District policies and procedures and addressing any concerns relating to clinical issues.

4.26 The CHC visited annually and following the visit issued a report on their findings and held a public meeting to share their report and action to be taken.

4.27 As the voice of the local population the Community Hospital League of Friends also reported annually on the number of letters of support and thanks received. They also passed on any complaints to the Senior Nurse Manager.

ORGANISATIONAL CHART 1988 - 1990

AREA B

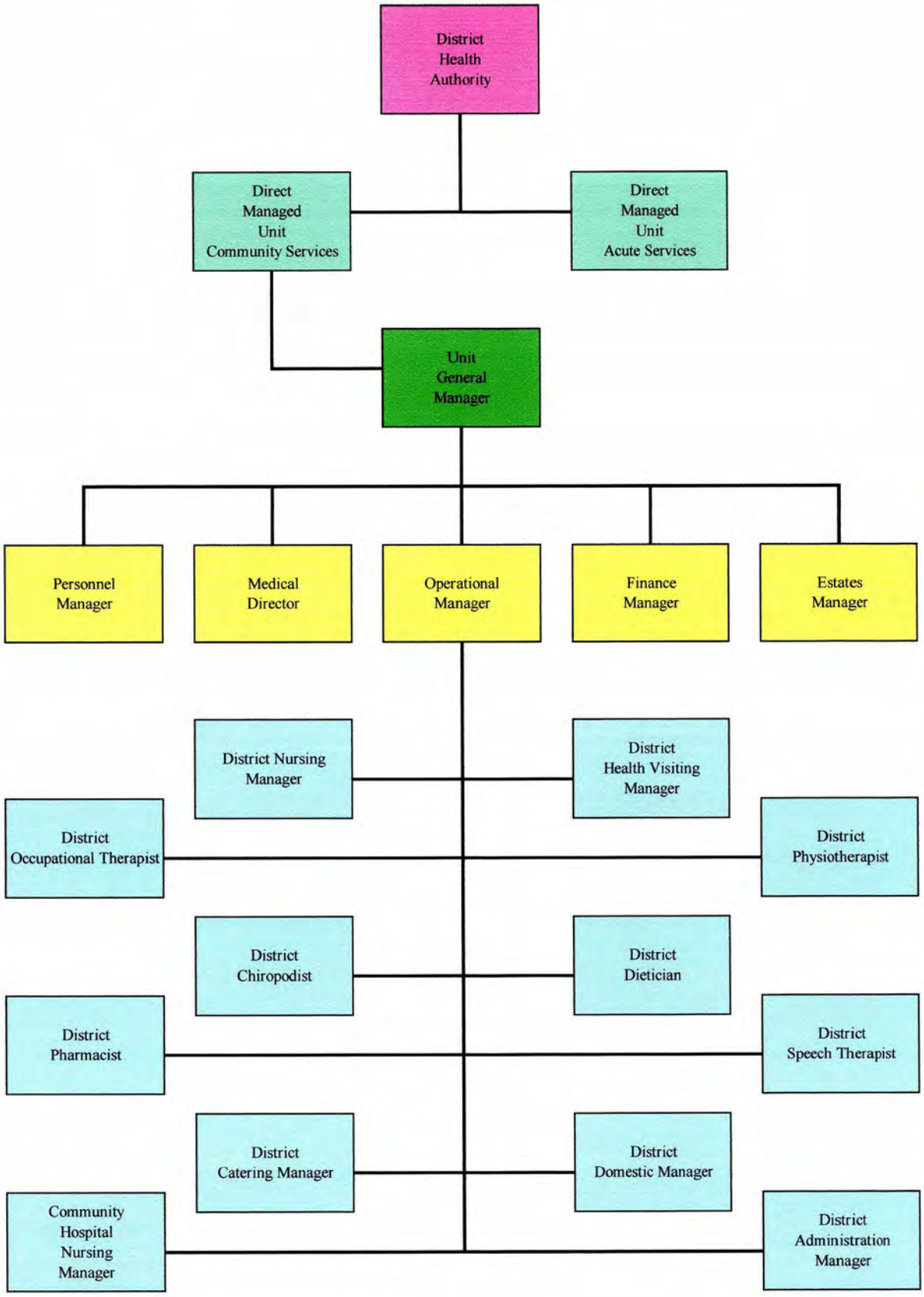


Fig 2

AREA C

4.28 During this period the District Health Authority was responsible for all health care provision for the district. The district consisted of a combined acute and community arrangement. This was similar to Area B with Unit General Managers for the two areas.**Fig 3**

4.29 In this district the management structure consisted of professionals having both management and professional leadership responsibilities for their staff groups e.g. District Physiotherapist, District Occupational Therapist and District Nursing Officer.

4.30 The Director of Nursing and Nursing Officer were responsible for the hospital and community services. There was a Hospital Administrator, other professional management, District Heads and managers of Support Services including administration, catering, domestic and portering services.

4.31 At this time there was a range of district-wide procedures e.g. Standing Financial Instructions, Child Protection Guidelines, departmental operational procedures and some nursing policies.

4.32 The Director of Nursing had responsibility for hospital and community services and provided the link between the Nursing Officers and senior managers at the acute hospital.

4.33 The Director of Nursing was involved in recruitment of staff, complaints resolution and overall running of the Community Hospital.

4.34 Monthly meetings were held by the Director of Nursing where a strategy for implementation of reports/documents was agreed. Papers from the UKCC were also discussed and implemented at a local level, as were training e.g. English National Board (ENB) courses and all nursing courses.

4.35 In Community Hospitals it was the responsibility of the Nursing Officer to ensure that District policies and nursing policies were introduced and adhered to.

4.36 Some services provided by the acute hospital were delivered across the District and their policies implemented District - wide. Examples of these are Infection Control, Estates Management, Medical Engineering and Pharmacy.

4.37 Audit and research were limited at this time but there was some financial audit of patient's monies and valuables and checks on nurses PIN numbers.

4.38 The Nursing Officer was responsible for ensuring adequate staffing levels, undertaking ward rounds, development of team nursing, induction of new staff, extended role facilitation and nursing duties when there was a shortage of trained staff.

4.39 The ward sisters were responsible for a weekly check of Controlled Drug Register and order book, monitoring nursing records, duty rotas, patient admission and discharge, mandatory training and training records.

4.40 Monthly Management Committee meetings were held between the Director of Nursing, Nursing Officer and a local GP.

ORGANISATIONAL CHART 1988

1990 AREA C

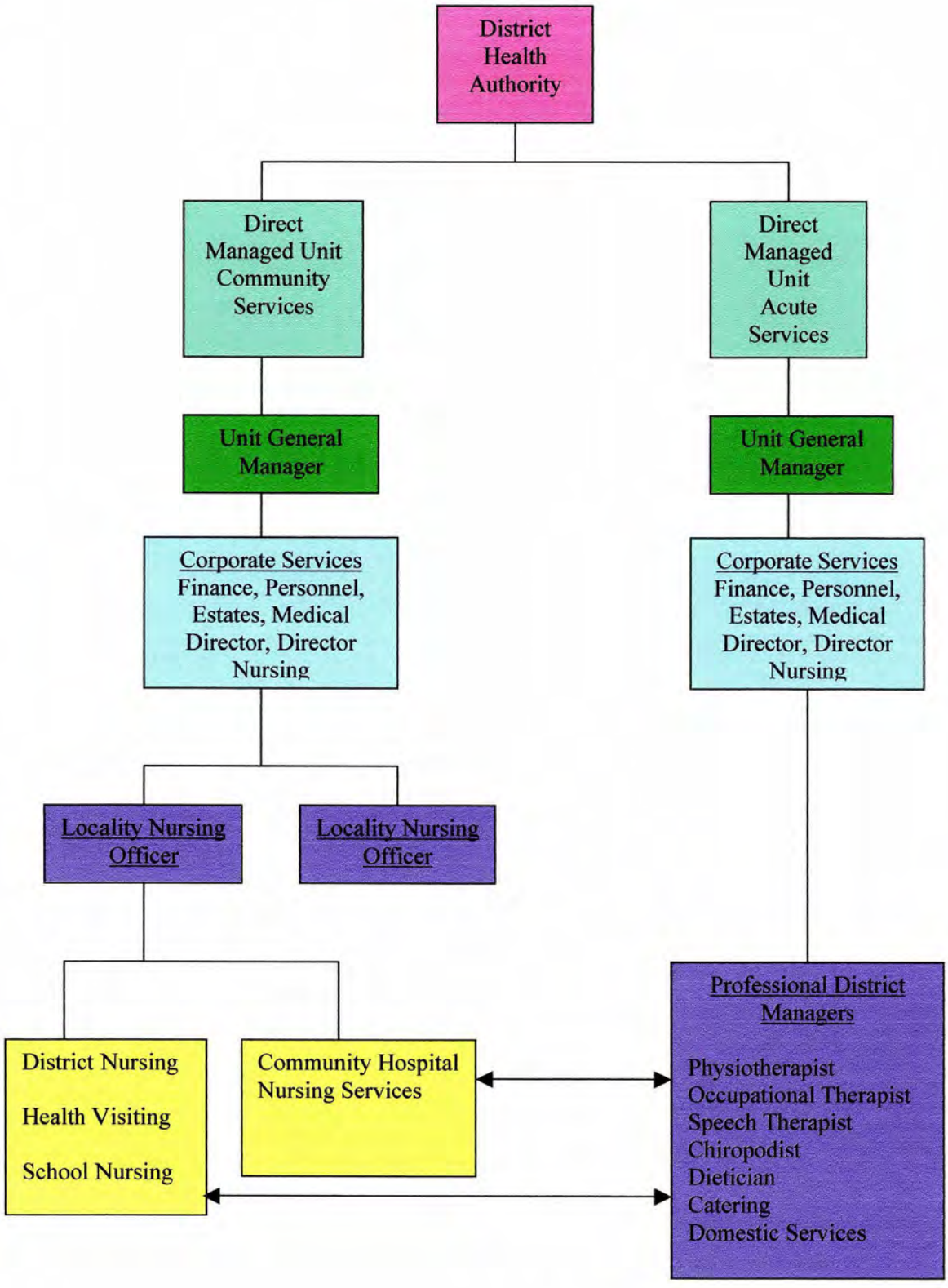


Fig 3

5. What was expected of Unit /Trust Management Teams in areas of service quality and management risk. 1991 - 1995

AREA A

5.1 During this period the Community Unit became a Trust in shadow form for one year and then a Community Trust in 1992. [13] With the emergence of Trust status corporate policies and procedures were introduced throughout the Trust.

5.2 The management structure changed throughout the localities. Locality Managers were appointed to manage Community Hospitals and Community Services. The majority of these managers had a nursing background with general management experience. The Locality Manager managed all staff and the Trust's Professional Heads provided professional advice. Locality Managers were directly responsible to the Director of Operations (an Executive Director of the Trust Board) with access, at all times, to the other Directors. **Fig 4.** Monthly meetings were held between the Executive members of the Trust Board, Locality Managers, General Manager Mental Health and Learning Disability.

5.3 Locality Boards were set up in each locality with planned meetings between representatives from the local GP Practice, Social Services, Mental Health, Learning Disabilities, a Voluntary Organisation and the Locality Manager, others were invited depending on the agenda. This group had an overall view of the locality, which included the Community Hospital.

5.4 Locality Planning meetings were developed. The Locality Board members were part of this group. However, it involved all services in the local area. This included schools, Health Services, Social Services, Church Organisations, League of Friends, CHC's and others. This group had a wider remit than the Locality Board. The local health services were a regular agenda item with the Locality Manager providing a report at each meeting.

5.5 With the introduction of GP Fundholding, the role of Community Hospitals changed. They were now Provider Units and GPs, Health Authorities and others commissioned services with quality issues being paramount. Purchasers met on a regular basis for monitoring meetings with key personnel from local and Trust Board level. This involved purchasers from other geographical areas in the country each with their performance standards. [15] [16] [17]

5.6 In 1991 the Community Unit established a Department of Quality with the appointment of identified personnel to undertake quality initiatives including the "Patients Charter". [18]

A Strategy for Quality 1991 – 1994 was introduced by the Head of Quality Development, which included:

- sampling customer views
- routinely analysing and collating information on letters of complaint and appreciation
- Professional Standards - disseminating Good Practice

- information about performance and a training programme was introduced for all disciplines throughout the Community Unit

In 1991 the Patient's Charter was published and included in the nine national standards was the 'named nurse' concept [18] [18a] This was introduced across the Trust and following its implementation, compliance was monitored by the Locality Managers and the Department of Quality.

As part of the Quality Strategy a Senior Nurse from the Community Unit attended a course on the Quality Assurance Ward Audit. [19] [20] These audit tools looked at specific areas in a Community Hospital:

- Ward environment
- Ward Management
- Patient care - including patient opinion
- Administration of medicines

The Senior Nurse group reviewed the documentation and standards. A decision was made to introduce the ward audit to all Community Hospitals throughout the Trust. The audit process was undertaken by two assessors (Senior Nurse Managers) from other localities. Feedback was given to the ward staff on areas of good practice and improvements to be made. Action plans were drawn up to address items requiring improvement. The audit results were collated and disseminated by the Department of Quality. This was an ongoing process which took place annually.

5.7 With the introduction of Trust status, Crown Immunity was no longer applicable. Commercial insurance cover had to be purchased by the Trust. Potential insurers visited Locality Managers who were responsible for Community Hospitals and insisted on proof that robust safety systems were in place.

5.8 Service level agreements were introduced with clauses that included quality as well as quantity of service provision.

5.9 Health and Safety and risk management gained a higher profile and committees for health and safety issues and risk assessments involved personnel from each locality. Corporate operational policies with clear lines of accountability were introduced throughout the Trust.

Control of Substances Hazardous to Health (CoSHH.) - Identified staff became assessors in each locality/department and registers of all substances were introduced in each hospital.

Manual Handling – Training became a local responsibility with key staff becoming trainers. Training was compulsory for all staff throughout the Trust and staff records were kept on site. **Fig 10**

Fire – Training for all staff was mandatory this was organised with the Senior Fire Officer by each locality and recorded. **Fig 10**

Hospital Acquired Infection – reporting and recording systems were introduced. The Senior Nurse Infection Control made regular visits to each Community Hospital.

Hazard warnings and reports from the Medical Devices Agency were implemented. A reporting system was introduced to monitor that these had been read and actioned.

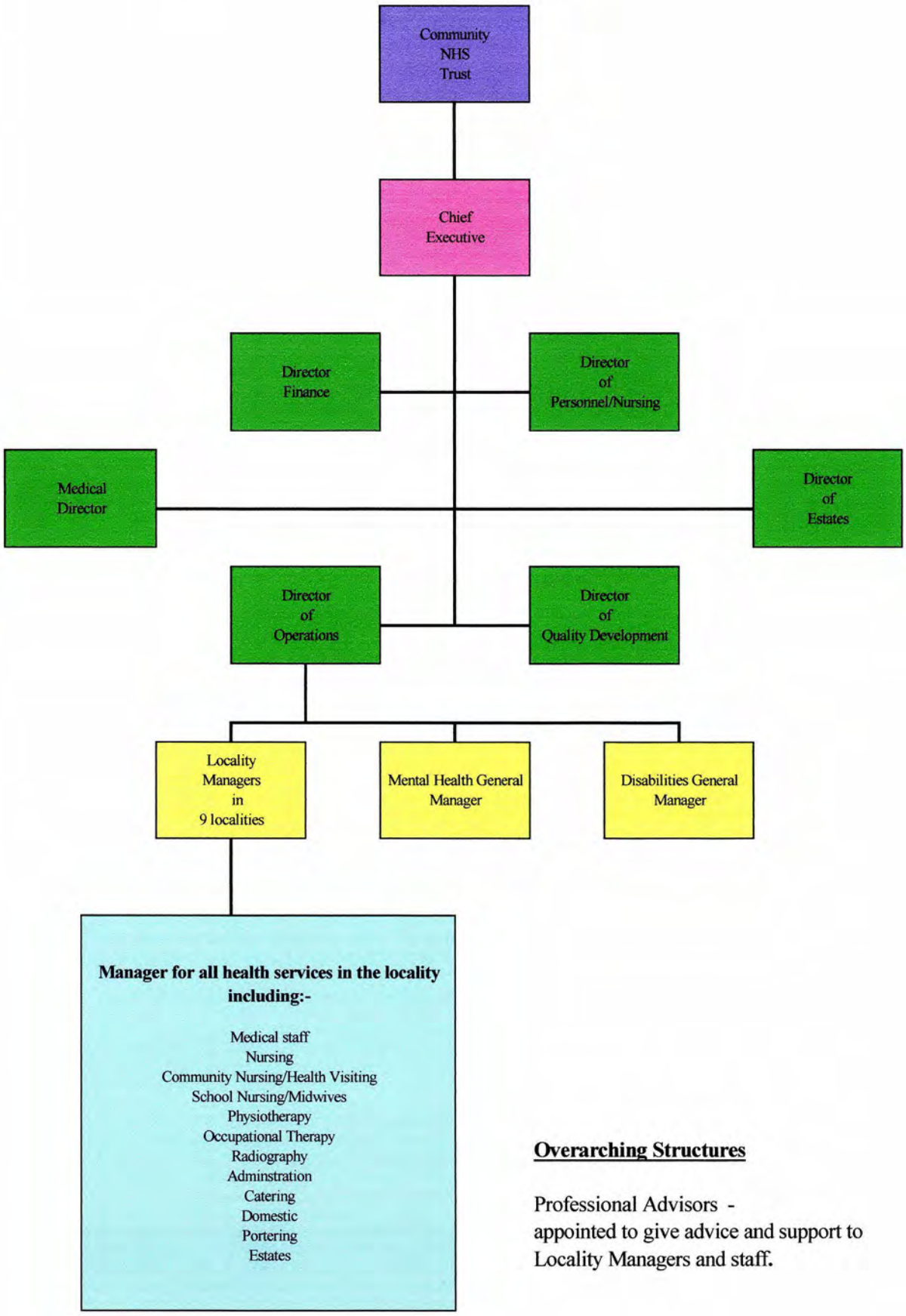
5.10 Complaints and letters of appreciation were closely monitored by the Department of Quality. The Trust's complaints procedure had to be strictly adhered to. The Trust Executive Directors closely examined each complaint and the action taken. All complaints received by the Trust were collated and circulated throughout the Trust. The Health Authority arranged regular meetings with the Trust's managers who were expected to attend if a complaint had been received. (15)

5.11 Systems were introduced to report, monitor and learn from untoward incidents, accidents and near misses. The recording systems provided results for each locality. These were circulated monthly to each Locality Manager. A summary of all accidents and incidents throughout the Trust were also provided. This helped to identify Community Hospitals and localities which showed any increase in numbers of reported accidents/incidents and areas of concern. A Senior Trust Manager addressed any issues with the Locality Manager.

5.12 During the latter part of this period Team Briefing was discontinued and replaced with a Trust newsletter. Meetings were held monthly between the locality manager, departmental heads, ward managers and community nursing staff. Senior staff then held regular meetings with staff from their departments. A three monthly meeting was held between the locality manager and all disciplines within the locality.

ORGANISATIONAL CHART 1991 - 1995

AREA A



Overarching Structures

Professional Advisors -
appointed to give advice and support to Locality Managers and staff.

Fig 4

AREA B

5.13 The Community/Priority Health Services Unit became a first-wave NHS Trust in April 1991. [13] The services provided were for those with learning difficulties, children and families, older people and those with mental health problems. Services provided by this new NHS Trust included five Community Hospitals.

5.14 The management structure changed and three Directorates were created to be responsible for operational issues and for advising the Trust Board. General Managers were appointed and Professional Leads undertook the role of advising and supporting their specific professional staff group. **Fig 5**

5.15 Each Community Hospital had a Service Manager. The Service Manager had a nursing qualification and this new position included responsibility for all staff groups, service delivery, quality and site management.

5.16 Local Management Teams were introduced in 1993, these included a Trust Board member, General Practitioners, Service Manager, Social Services, a therapy representative, League of Friends and a CHC representative. The main aim of this group was to involve clinicians, managers and local representatives in the management and monitoring of quality in the Community Hospital.

5.17 Within the application for NHS Trust status, quality initiatives were highlighted as a key area between the purchaser and provider. Quality Assurance and Quality Improvement Plans became a cornerstone of the organisation. [21]

5.18 Service Level Agreements were developed with value statements relating to equity, access, effectiveness, efficiency, appropriateness and responsiveness, which were used to test service provision.

5.19 A department for Health and Safety was created with Health and Safety Groups being developed. Health and Safety audits were undertaken within the Community Hospitals. Designated staff undertook Health and Safety, Risk Assessment and COSHH training.

5.20 Community Hospital Service Managers were responsible for ensuring staff attended annual training and updates on fire and manual handling and that the Hospital met the Trust standards for Health and Safety, Risk Management and CoSHH.

5.21 Minimum acceptable standards were identified through patient satisfaction surveys, relatives/carers opinions, CHC and voluntary bodies, performance indicators, patient statistics and manpower information.

5.22 Systems were in place to monitor untoward incidents, accidents, near misses, hazard warnings and reports from the Medical Devices Agency.

5.23 Nursing developed to meet the key areas and targets identified in "A vision for the future: the nursing and midwifery and health visiting contribution to health and health care." [22] [22a]

ORGANISATIONAL CHART 1991 - 1995
AREA B

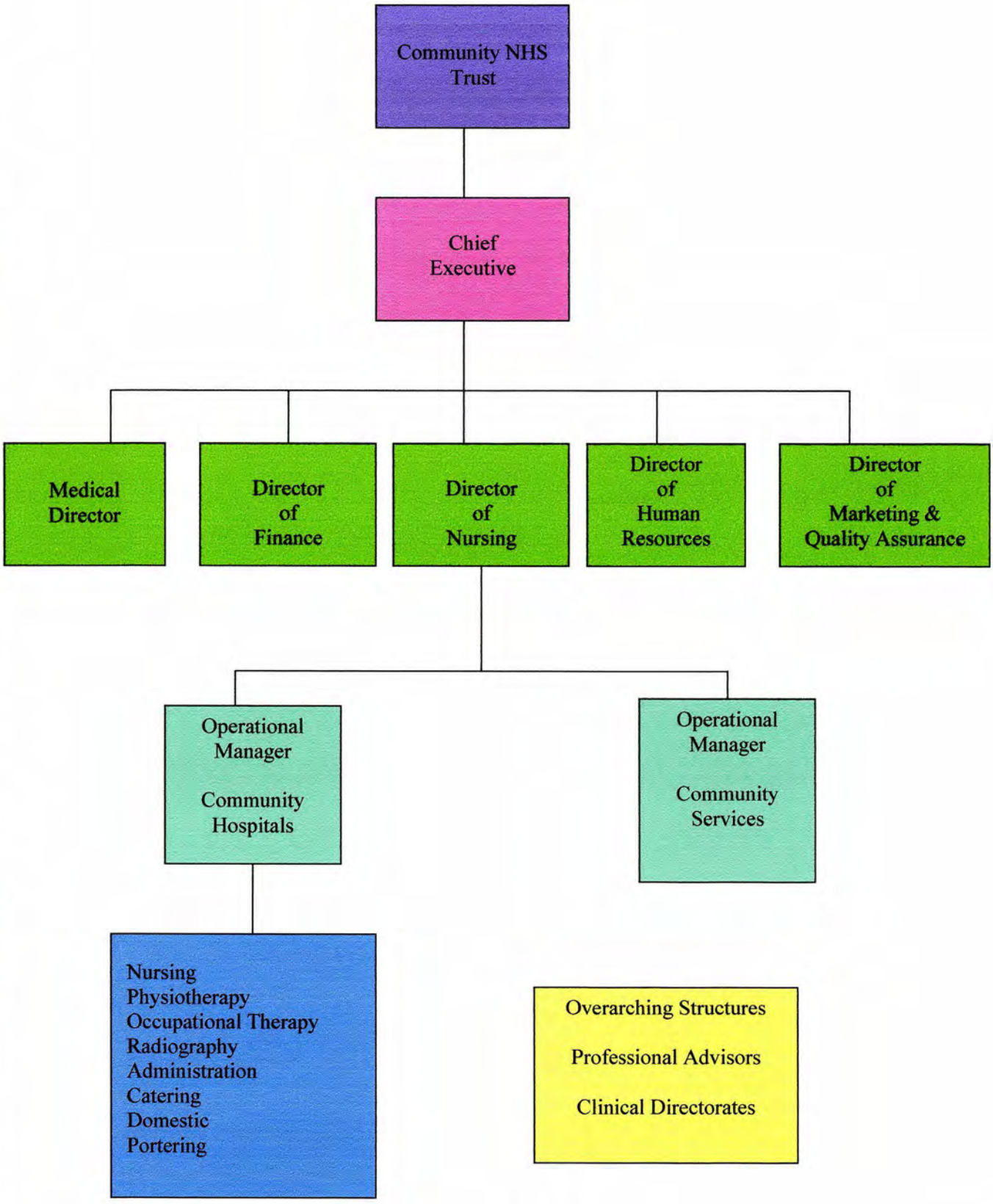


Fig 5

AREA C

5.24 In this area there was a combined Acute and Community Trust from April 1991 and within the management structure there were two Directors of Operations. One was responsible for the acute services and the other for community services, including Community Hospitals. **Fig 6**

5.25 Three Clinical Directorates were created for Medicine, Surgery and Children. This model was not reflected in the Community Hospitals where the Director of Nursing and the Nursing Officer were replaced with a Business Manager.

5.26 This new position of Business Manager included responsibility for business management and the post holder was also the Senior Nurse on site and held site responsibility. Areas of responsibility included:

- Standard setting
- Business management & planning
- Patients Charter
- Fundholding contract negotiations & monitoring
- Service Level Agreements
- Workforce planning
- Budget management
- Service development
- Complaints investigation
- Recruitment and retention
- Audit

5.27 At this time there was no medical staff committee and medical input to the management of the Community Hospitals was on an ad hoc basis.

5.28 The Business Manager was responsible for the hospital and community nursing services. There was an H Grade community nurse who assisted the Business Manager with the management of the community nursing service. The ward managers retained responsibility for monitoring standards of care, the controlled drug book and nursing records. During this time there was a devolution of budget to ward managers and an increase in the autonomy given to the ward managers.

5.29 The Business Manager and the ward managers were responsible for ensuring staff attended annual training and updates on fire and manual handling. They also ensured that the staff met the Trust standards for Health and Safety, Risk Management and CoSHH. A staff appraisal system was initiated and within this the training and development needs of staff were identified, especially in relation to the Scope of Professional Practice. [1]

5.30 The Business Manager attended monthly Senior Nurse manager meetings and ran Team Briefing, sisters meetings and departmental heads meetings. The ward managers organised their own meetings with their staff. New reports, documents, policies and papers were all discussed and implementation plans made in these forums.

5.31 Management meetings between the Business Manager and the Operational Manager and the Management Accountant were held monthly. By 1995 these also included the Chief Executive.

ORGANISATIONAL CHART 1991- 1995

AREA C

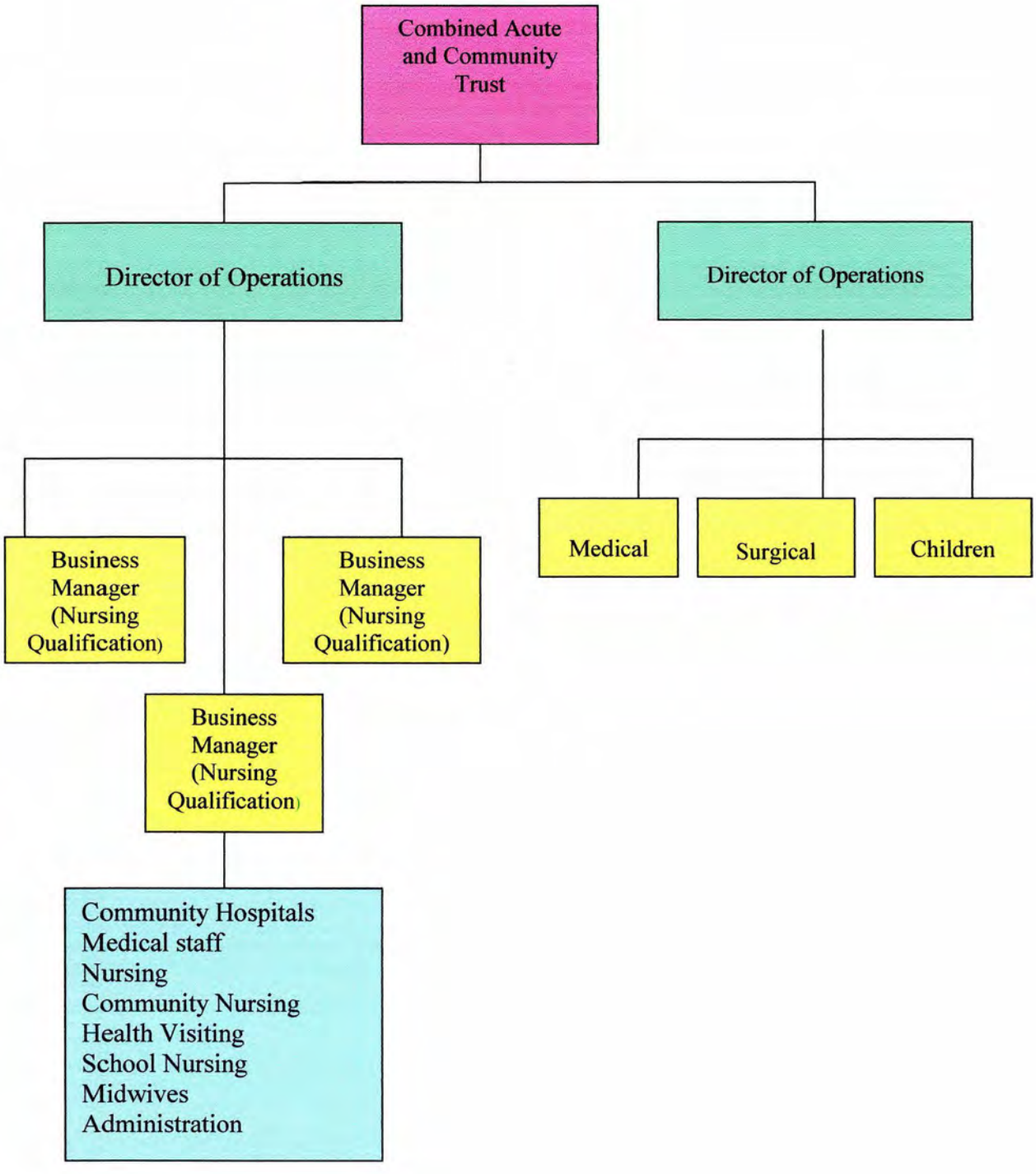


Fig 6

6. What was expected of Unit /Trust Management Teams in areas of service quality and management risk 1996 - 2000

AREA A

6.1 Community Trusts continued to maintain control of Community Hospitals in this period of time. **Fig 7**

6.2 Locality Managers, or Senior Nurse Managers, continued to manage Community Hospitals and Community Services. Professional advice continued to be provided by the Trust's Professional Heads. Some management changes were made following the retirement of the Director of Operations. Three Area Managers were appointed across the Trust. They were responsible for a number of Community Hospitals and services. Locality Managers were responsible to the Area Manager who was directly responsible to the Chief Executive. The Locality Managers had access to the Trust Executive Directors at all times.

6.3 Locality Boards and Locality Planning meetings continued and the Senior Nurse Manager/Locality Manager had overall responsibility for implementation of service quality and risk management in the community and Community Hospitals.

6.4 Review of National Policies were taken from the appropriate Director and working groups were formed to look at the implication to practice and to implementation.

6.5 Training was provided as new policies were introduced and an active Research and Audit committee worked closely with the Locality Managers and staff. The Senior Nurse Clinical Group received directives from the Director of Nursing, which were fed to the Senior Nurse Group. From this group, Clinical Nurse Managers and Ward Managers were informed and involved in implementing new policies. [22] [23]

6.6 New policies and quality initiatives were disseminated to the specific Head of Department.

6.7 During the later part of this period there was more emphasis on quality standards, openness and accountability. The standards were applied locally through systems of clinical governance as outlined in "The New NHS – Modern and Dependable". [24]

6.8 Service Level Agreements continued but with more emphasis on quality.

6.9 Health and Safety and Risk Management gained a higher profile and became an integral part of induction programmes and mandatory training.

6.10 During this period Primary Care Groups were established and consultation commenced on Primary Care Trust status for implementation in 2001.

ORGANISATIONAL CHART 1996 – 2000

AREA A

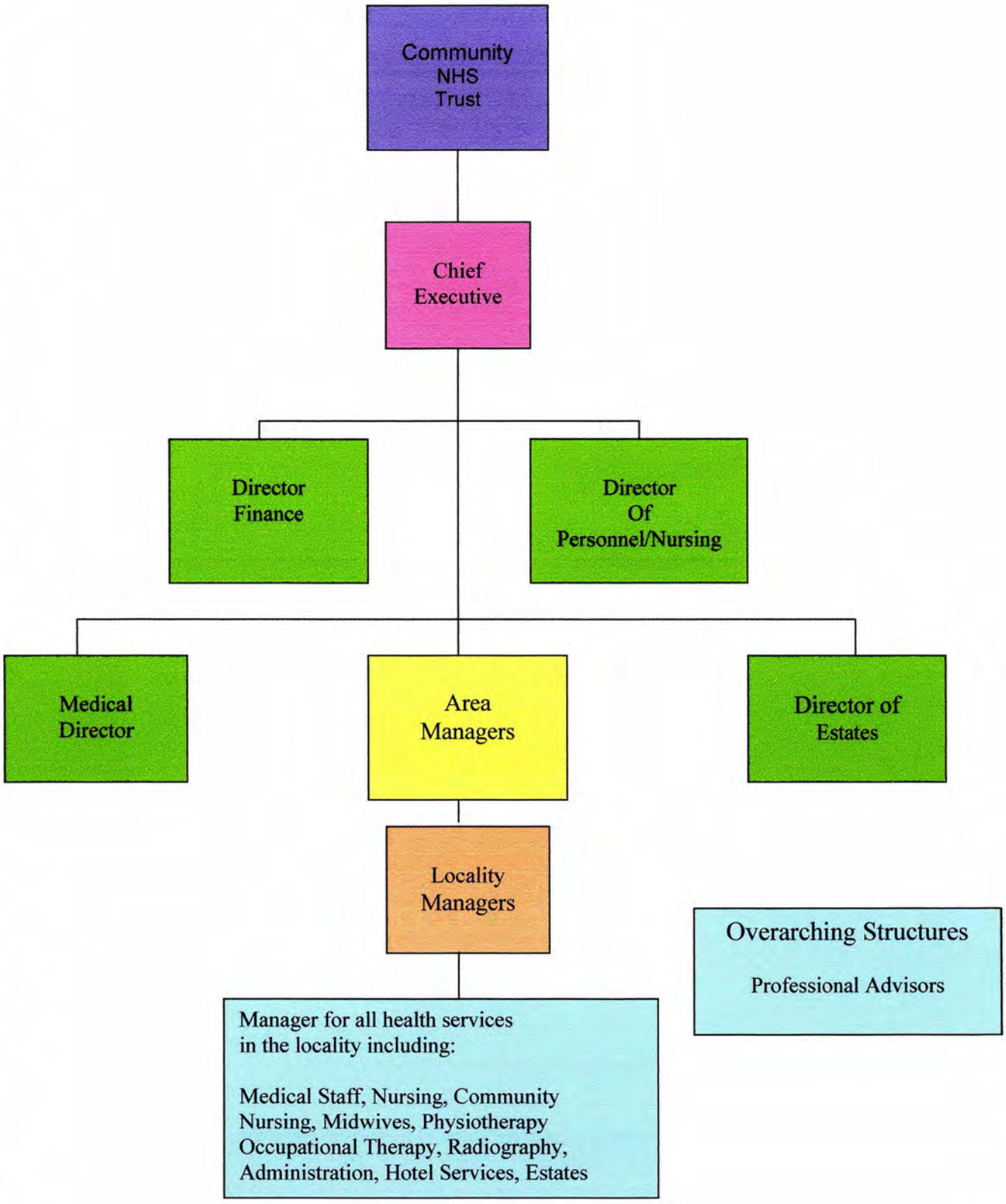


Fig 7

AREA B

6.11 During this period the Community Hospitals became part of a countywide Community NHS Trust. The Trust provided community services, mental health services and services for those with learning difficulties and the management structure consisted of three directorates. **Fig 8**

6.12 The Director of Services was responsible for the Community Directorate and this was divided into six geographical localities, each with a Community Manager. The Community Managers had responsibility for all health care services and staff within the locality including Community Hospitals. These localities reflected the proposed and subsequently established Primary Care Groups.

6.13 The Community Trust had personnel and corporate services departments of Human Resources, Training and Development, Health and Safety and Risk Management, Complaints, Clinical Governance and Audit, Hotel Services, Transport and Professional Leads for all clinical specialities. [24]

6.14 In each locality services were centred on clusters of GP practices and Community Hospitals where the local GP practices had admitting rights. These smaller units had Service Managers who were also nurses and were responsible for both community services and staff and Community Hospital services and staff. The Service Manager was directly responsible to the Community Manager.

6.15 The Community Managers had meetings with the Director of Services bi-weekly and monthly meetings were held which included all corporate services representatives. At these meetings any new Department of Health documents and professional publications were discussed and implementation plans agreed. The Community Managers met weekly with the Service Managers to keep them updated, listen and respond to local service issues and support them in implementation of new directives.

6.16 Professional Leads and their professional groups developed clinical policies and protocols. These would be taken to the Director of Services where they would be discussed and agreed within the Clinical Governance group and ratified by the Trust Board.

6.17 The Community Hospitals became part of the Hospital Accreditation Programme, with three hospitals achieving accreditation status for the first time in 1996. The Hospital Accreditation Programme was initially developed in the South West Region in 1988 and provided a range of organisational standards for Community Hospitals. In 1994 updated standards were published and the Programme was expanded and offered countrywide. Once again the standards were updated in 1996 and 1999 the latest version included standards for community services such as District Nursing and Health Visiting. The Community Hospitals in this area all successfully achieved accreditation status on two occasions.[10] [11] [12]

6.18 Service Level Agreements for a range of services, provided by three acute trusts in this area, became more comprehensive and included quality standards in addition to quantity. Some of the services provided under Service Level Agreements were Infection Control, Pharmacy, Speech and Language Therapy, Dietetics, Medical Engineering, HSDU and Radiology.

6.19 General Practitioners with admitting rights to the Community Hospitals continued to play a major role in Community Hospital Management Teams. GPs also attended Trust Executive Board meetings, their input was valued both clinically and managerially. The GP contract for work in Community Hospitals was re-negotiated and this included quality measures.

ORGANISATIONAL CHART 1996 - 2000

AREA B

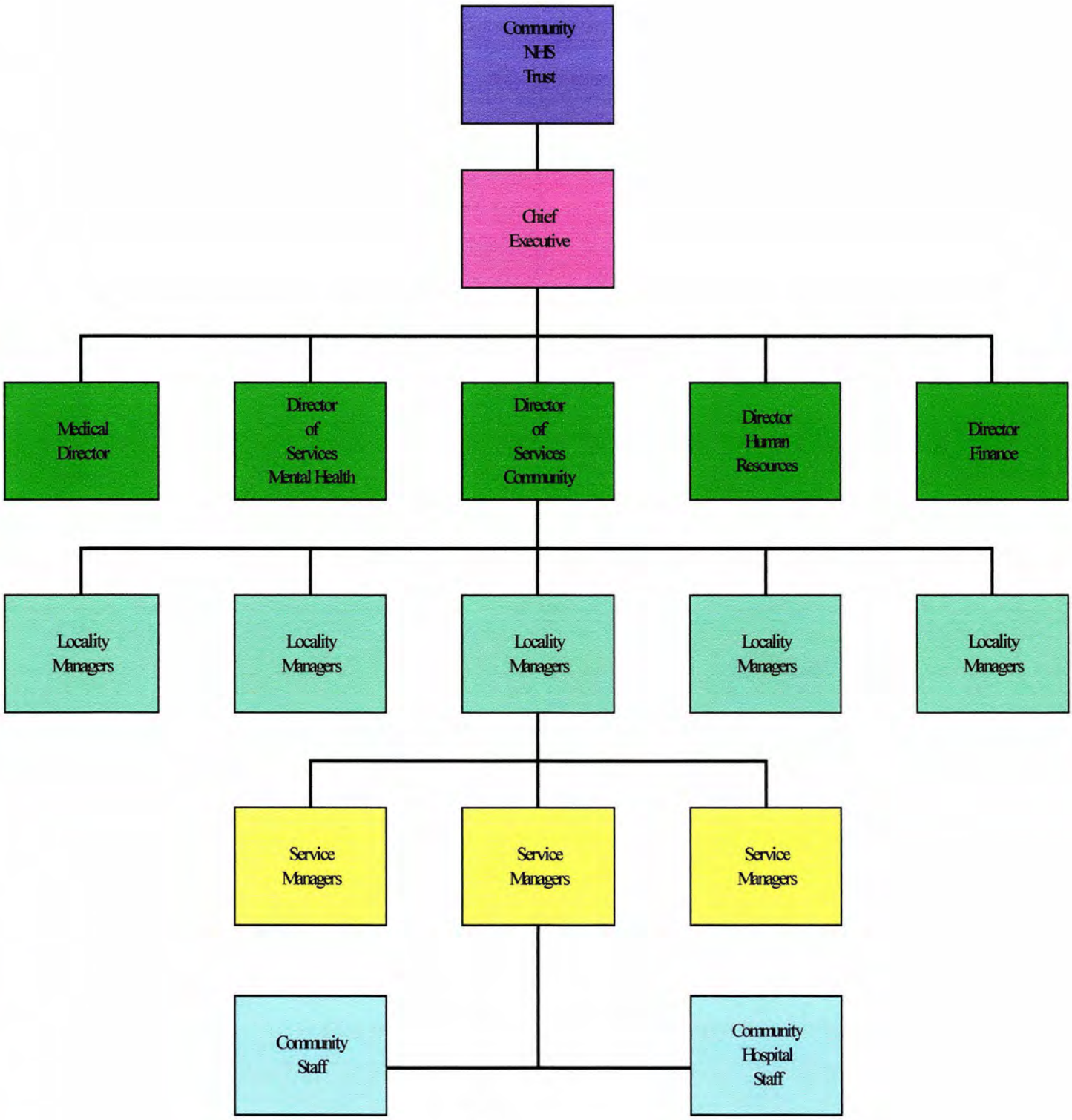


Fig 8

AREA C

6.20 During this period the Community Hospitals continued to be part of a combined Acute and Community Trust. In 2000 the Primary Care Group consulted on becoming a Primary Care Trust and in 2001 the Community Hospitals became the responsibility of the Primary Care Trust. **Fig 9**

6.21 By 1996 the management structure changed. A General Manager of Medical, Community, Community Hospitals and Therapy Services was appointed with a second General Manager with responsibility for Surgical Services. There was still no designated medical input other than visiting consultants, clinical assistants and local GPs.

6.22 Following the threat of major closure the Health Authority employed a part time GP in one hospital to run a local forum to engage with hospital managers/GPs and public representatives. The aim of the forum was to support developments within the community hospital.

6.23 Professional Advisors, District Pharmacist and the local management of Community Hospitals continued as in the previous period. The Business Manager, Senior Nurse Community and ward sisters continued to hold the same responsibilities as previously. There was a greater emphasis on monitoring quality of care using the 'Monitor Tool & Criteria for Care' [25], regular control of infection monitoring, pressure area care audit, skill mix calculations were linked to budgets and ward stock control was introduced.

6.24 During this period Shared Governance in Nursing was developed consisting of four councils:

- Corporate Council
- Practice Council
- Education Council
- Research Council

6.25 Nurses became empowered to develop principles, guidelines, protocols and Patient Group Directions, which were evidence based. All nursing staff could, and were encouraged to, refer to Councils who made recommendations for change which were then ratified by the Corporate Council. [26] [27]

6.26 Some other areas of development were in the:

- Development of Core Care Plans
- Development of Pathways of Care
- Risk Assessment undertaken hospital wide
- Audit of Clinical Practice
- Financial Audit
- Skill-mix Assessment
- Clinical Governance
- Health and Safety
- Introduction of Nurse Practitioners in Minor Injuries Units

- Nurse led clinics
- Introduction of additional risk assessment tools, nutrition assessment, moving & handling assessment etc.
- Defensible documentation

6.27 The Business Managers had meetings with the Director of Nursing. Team Briefings were disbanded, newsletters were introduced and Ward Sisters and Departmental Heads continued to meet. These meetings again were the forum for new report/documents to be discussed and implementation plans agreed.

ORGANISATIONAL CHART 1996-2000

AREA C

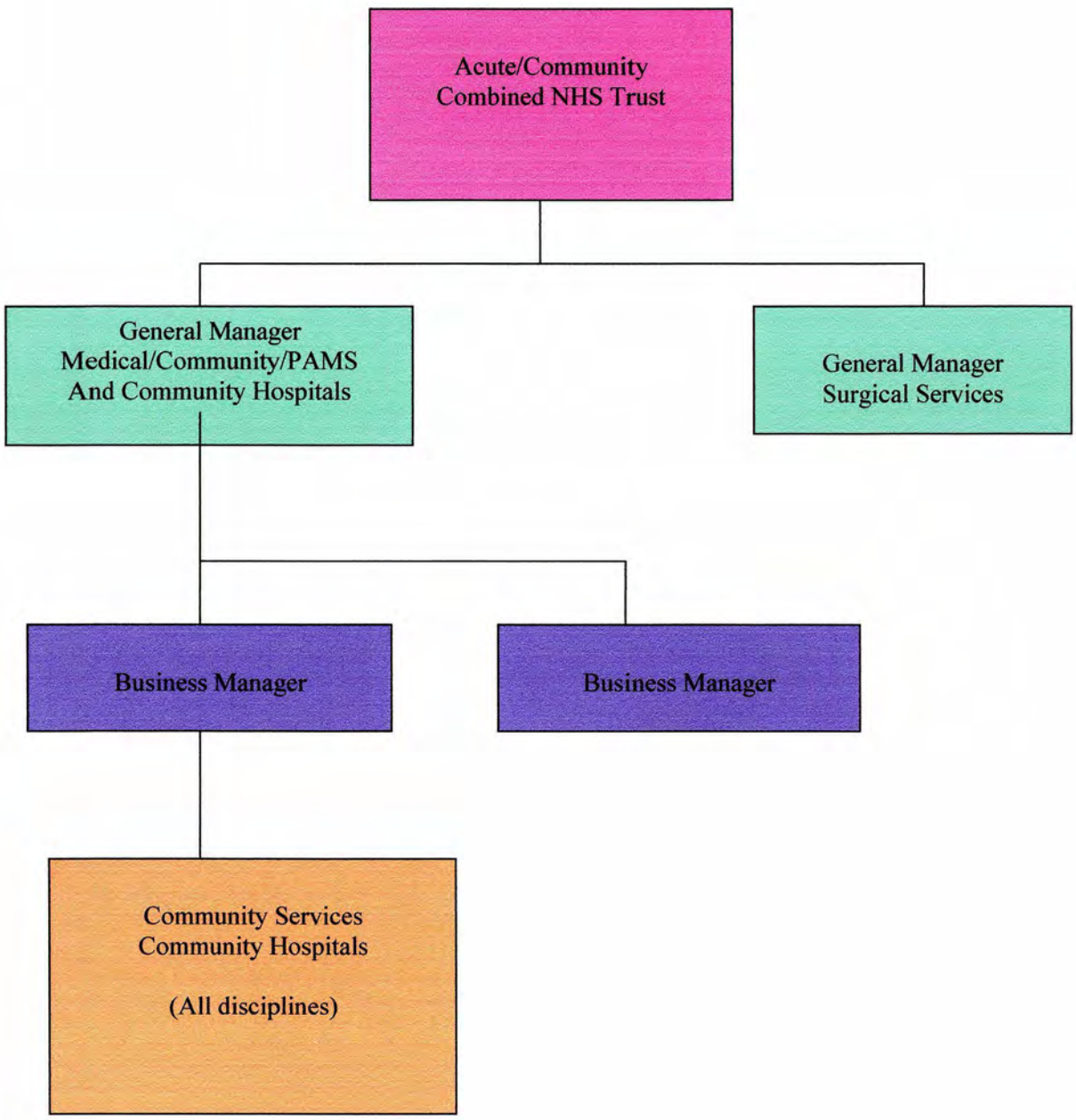


Fig 9

7. What would have been expected from key Advisory Professional staff e.g. GP Advisor / Consultant Advisor 1988 -1990

AREA A, B & C

7.1 For this period District Heads for Physiotherapy and Occupational Therapy provided managerial and professional input to the local staff. Training and staff development was part of their role.

7.2 The District Catering Manager provided professional support to the catering staff, with the on site administrator managing the service in Areas A and C and in Area B, the District Catering Manager provided management of the service.

7.3 The District Domestic Manager provided professional support to the domestic services team, which included portering. The on site administrator managed the service on a day to day basis in Areas A and C and in Area B the District Domestic Manager provided management support.

7.4 The District Dietician provided a service to the local Community Hospitals and staff referred patients directly to the service.

7.5 The District Speech Therapist provided professional and managerial support to the local Speech Therapist in Area A and in Areas B and C the Speech Therapist was employed by the acute unit.

7.6 The District Chiropodist managed the Chiropody Service.

7.7 District Pharmacy provided a service to Community Hospitals via the, Community Pharmacist. The Community Pharmacist visited the hospital on a fortnightly basis in Area A and monthly in Areas B and C. This visit included checking the Controlled Drug Register and a selection of prescription sheets. The Pharmacist liaised on a regular basis with the ward staff and Senior Nurse. Part of his/her role was to ensure medical and nursing staff received information on drug updates.

7.8 Senior Nurse Infection Control and Senior Nurse Promotion of Continence Advisor provided a service to the Community Hospitals in Area A. Only a Senior Nurse Infection Control provided a service in Areas B and C.

7.9 Senior Nurse Training provided input at a local level. In service training was provided at the post basic training centre or locally in Areas A, B and C.

7.10 Professional advice for the local medical staff was provided by the District Health Authority and visiting Consultants. In many Community Hospitals outpatient clinics operated on a regular basis. The local GPs would meet with the visiting Consultants to discuss clinical issues.

7.11 In some Community Hospitals, with designated care of the elderly beds, local GPs acted as Clinical Assistants. The Consultants would visit on a weekly basis to review the patient's condition and treatment.

7.12 Medical Staff Committees met on a monthly basis these were attended by the Senior Nurse and Locality Managers in Area A. In Area B monthly Medical Staff meetings were held with the Senior Nurse Manager. In Area C a GP met with the Director of Nursing and the Nursing Officer. [28]

8. What would have been expected from key Advisory Professional staff e.g. GP Advisor / Consultant Advisor 1991 -1995

AREAS A, B and C

8.1 With the emergence of Trust status service agreements were in place for all professional advice which was not provided by the Trust. [13]

8.2 Physiotherapy and Occupational Therapy services were managed by the Locality Manager in Area A, the Service Manager in Area B and the Business Manager in Area C. Professional Advisors for each service gave professional advice and were involved in identifying training needs with staff development continuing to be part of their role.

8.3 In Area A Catering/ Domestic Managers were appointed and they were responsible to the Locality Manager. In Area B and C the catering and domestic services and staff were the responsibility of the Service Manager and Business Managers respectively. The Trust catering and domestic advisors provided professional advice in all Areas. Domestic/catering and nursing staff attended training and obtained Food Handling and Hygiene certificate.

8.4 A Trust wide Dietician was appointed in Area A. In Area B a Service Level Agreement with the acute hospital allowed for the provision of a service to the local Community Hospitals. In Area C the Dietician worked across the combined Acute and Community Trust and Community Hospitals referred patients directly to the service.

8.5 Speech Therapy was managed locally in Area A and the professional head of the service provided professional and managerial support to the local Speech Therapists. In Area B there was a Service Level Agreement with the acute hospital for a Speech Therapy service and in Area C the arrangements were the same as for dietetics.

8.6 Chiropody was managed locally with a professional head providing advice and support in Area A. Chiropody in Area B and Area C was managed by the District Chiropodist.

8.7 Pharmacy Services were provided by the acute trust with a Service Level Agreement and a Community Pharmacist in Areas A & B. In Area C the District Pharmacist provided a service across both the Acute and Community services of the trust. The number of Community Pharmacists increased and they continued to visit on a fortnightly basis in Area A and monthly in Areas B and C but their time input was increased. This visit included checking the Controlled Drug Register and a selection of prescription sheets. The Pharmacist liaised with the ward staff, GPs and the Senior Nurse. Part of his/her role was to update medical and nursing staff on drug updates.

8.8 In Area A following the introduction of syringe drivers the Community Pharmacist organised regular training sessions for medical and nursing staff on the use of drugs and their interactions. Graseby (the manufacturers of the syringe drivers) provided the training on use of syringe drivers. In Areas B and C the Post Basic Nurse Training Department and the Pharmacist provided training. These sessions provided regular updates on drugs and their interactions. Syringe drivers were used to administer a measured dose of pain relieving drugs over a period of 12 - 24 hours. There were two types of syringes with one measuring

the dose over a 12-hour period and the other over a 24-hour period. They were used almost exclusively for terminal care patients dying from cancer.

8.9 In Area B "A Guide to Symptom Relief in Advanced Cancer" [29] was used in conjunction with the Medicines Policy to assist in the administration of pain control, especially in relation to the use of syringe drivers.

8.10 The Control of Infection Service was provided by the Acute Trust with service level agreements in place. A Senior Nurse made regular visits to each Community Hospital and undertook infection control audits in each area.

8.11 In Area A a Trust Medical Director was appointed and each locality appointed a Lead General Practitioner who liaised with the Director on behalf of the GPs providing medical services to the Community Hospitals.

8.12 In Area B a Trust Medical Director was appointed and lead GPs from the Community Hospitals liaised with the Director.

8.13 In many Community Hospitals the number of outpatient clinics increased. Other specialities were introduced which increased the choice of professional advice available for the local GPs. The local GPs would meet with the visiting Consultants to discuss clinical issues. In some Community Hospitals, with designated care of the elderly beds, local GPs acted as Clinical Assistants. The Consultants would visit on a weekly basis to review the patient's condition and treatment.

8.14 Medical Staff Committees met on a monthly basis these were attended by the Locality Manager in Area A. The Service Manager in Area B met monthly with a GP from each practice who had admitting rights and in Area C a local GP met with the Director of Nursing and the Business Manager.

8.15 The Estates Department provided building maintenance and a programme of planned maintenance. The Director of Estates met on a regular basis with the Locality Managers or Service Managers. Health and Safety was part of the Estates Department remit with Health and Safety Committees functioning well. Locality Managers or Service Managers were part of this group.

8.16 All clinical issues were addressed by the Locality Managers, Service Managers or Business Managers with the Directors of Nursing. Monthly meetings were held and this provided a forum for dissemination of directives, publications and discussion on action plans for implementation. The Managers were responsible for informing and involving Community Hospital staff in responding and taking relevant action.

9. What would have been expected from key Advisory Professional staff e.g. GP Advisor / Consultant Advisor 1996 - 2000

AREAS A, B and C

9.1 Throughout this period there were some changes in management structures and the key role and responsibilities of managers in Areas A, B and C. More responsibility for the development and provision of health services were devolved, closer to the point of care delivery.

9.2 Systems of professional leadership and advice continued and developed within the context of Clinical Governance. [22] [23] [24] Clear lines of responsibility and accountability for quality of clinical care were developed and responsibility for quality was defined in the managers job description.

9.3 Audit became an integral component of Trusts and many multi-disciplinary audits were developed with professional leads.

9.4 GPs with contracts for Community Hospital work continued to be more involved in both management and clinical groups, with some providing education and training for all Community Hospital staff e.g. resuscitation and defibrillation.

9.5 Consultant Medical staff, who held outpatient clinics within the Community Hospitals, continued to provide professional support and advice for GPs and also multidisciplinary study sessions e.g. Symptom Control and Pain Relief.

9.6 A new GP contract for Community Hospital work was implemented in Area B in 1999 and this included quality markers in respect of clinical care, case management, training and development.

10. Methods of recording training and competencies of nursing staff in clinical procedures and practice. 1988 – 1990 Areas A, B and C

10.1 In all areas training undertaken by nursing staff was recorded in a 'Kardex' and this was filed in each member of staff's individual record.

10.2 All members of nursing staff were required to attend training sessions on: -

- Fire Safety
- Resuscitation
- Moving and Handling

This was an on-going programme. Training dates were provided by the Senior Nurse and off duties arranged accordingly to enable the member of staff to attend. Proof of attendance would be recorded in the personal record of the individual concerned. **Fig 10**

10.3 During this period some clinical procedures were identified as extended roles.
In the three areas the Health Authority issued: -

A Policy and Procedure for the identification and achievement of competence for the undertaking of Extended Practices by Nurses, Midwives and Health Visitors.

10.4 To meet the changing demands of both the Profession and developing services, it was essential that the identification of Extended Practices and the achievement of competence should be managed and determined at a local level.

10.5 A clearly defined list of Extended Role Procedures were identified: -

- Intravenous Therapy
- Venepuncture
- Cytotoxic Drugs (in Area A only)
- Male catheterisation
- Immunisation and Vaccination
- Bladder washout
- Application of Plaster of Paris (In Area A only)
- Blood glucose monitoring
- Entonox administration

To be eligible to undertake the above procedures nurses required a minimum of six months post registration experience.

10.6 Each procedure required a study day(s) of theoretical input by the Post Basic and Continuing Education Department. Practical competence was assessed by an appropriately experienced practitioner **Fig 11 &12**

10.7 A Certificate of Competence was issued, signed by the tutor and the assessor. This certificate was valid only in the area covered by the issuing Health Authority who 'covered' the nurse with vicarious liability in case of litigation. **Fig 13**

10.8 The Senior Nurse maintained records of nurses competence, monitored performance and ensured updating. **Fig 10**

Example of Staff details and training record held locally 1988 – 2000

Name_____ **Qualifications** _____

Address_____

Telephone No_____ **Date of Birth** _____

Next of Kin _____ **Telephone No**_____

Date of Appointment_____ **Contract Hours** _____

Changes in contract

Date	Details	Signature
Appraisals		

Training Attended in 10 years prior to appointment
(details of content, length of course and year attended)

Date **Details** **Signature**

Training Attended During Employment

Date **Details** **Signature**

Internal Appointments and Experiences

Fig 10

Example of Form retained by Post Basic Education Dept 1988 - 1990

HEALTH AUTHORITY

AGREED EXTENDED PRACTICES FOR QUALIFIED NURSES AND ACCOMPANYING NAMES OF KEY INSTRUCTORS RESPONSIBLE FOR TRAINING

Signature of person in charge of ward/dept/clinical area.....

Hospital/Community Location:	**Ward/Department:**	**Date Practices Agreed**

TITLE OF EXTENDED PRACTICE	ANY LIMITATIONS TO PRACTICE	NAME(S) KEY INSTRUCTOR(S) RESPONSIBLE FOR TRAINING
1.		
2.		
3.		
4.		
5.		
6.		

To be sent to Senior Nurse Post Basic Dept

Fig 11

EXAMPLE OF TRAINING RECORD EXTENDED ROLE PROCEDURE

HEALTH AUTHORITY

Hospital/Community Location:	**Ward/Department:**	**Agreed Procedure**

NAME OF KEY INSTRUCTORS:

_____ _____ _____

NURSING STAFF TRAINING INFORMATION:

Name	Grade	Date training commenced	No.of Practices	Date Assessment Passed	Signature of Nurse

Fig 12

TO BE RETAINED IN LOCALITY

EXAMPLE OF CERTIFICATE OF TRAINING EXTENDED ROLE PROCEDURE

HEALTH AUTHORITY

To: Senior Nurse, Post Basic & Continuing Education Department

From: .....

Name of Key Instructor (BLOCK CAPITALS).....

Hospital/Department.....Ward/Clinical Area.....

NURSE (BLOCK CAPITALS).....GRADE.....

Has completed his/her training with the extended practice of:: .....

.....

Date Training commenced: .....

Number of supervised practices: .....

Date assessment passed: .....

Signature Key Instructor: .....

Signature of Nurse: .....

Fig 13

11. Methods of recording training and competencies of nursing staff in clinical procedures and practice. 1991 – 1995 Areas A, B and C

11.1 The Scope of Professional Practice, introduced in 1992 [1] provided for yet greater expansion and enhancement of the nurses role and placed responsibility for practice squarely on the individual nurse. In addition, it introduced the concept of flexible practice according to patient need, service requirements and current legislation.

11.2 It applied to every Registered Nurse, whatever his/her grade or level. The guidance for the Scope of Practice emphasised the nurses' professional accountability in key principles thus enabling nurses to regulate their own practice in changing circumstances.

11.3 In all Areas working parties of Senior Nurses reviewed the current extended role procedures. In agreement with members of nursing staff it was agreed to offer training for nurses to enhance their competencies still further. Staff were encouraged to acknowledge their skills and experience to identify the need to advance their practice.

11.4 All registered nurses were expected to achieve some or all of the following competencies:

- Intravenous Therapy
- Using a syringe driver
- Venepuncture
- Cytotoxic Drug administration (Area A only)
- Male catheterisation
- Immunisation and Vaccination
- Bladder washout
- Blood glucose monitoring
- Cannulation (Area A only)
- Minor suturing
- Advanced Cardiac Life Support Training
- Application of Plaster of Paris/Scotchflex (Area A & C)
- Removal of fishhooks (Area B & C)
- ECG
- Asthma techniques

11.5 Training courses were organised jointly between the Acute and Community Trusts and other organisations.

11.6 The Locality Managers continued to maintain records of nurse's competences, and the individual nurse was responsible for ensuring that updating took place on a regular basis.[30]

11.7 In all areas a staff appraisal system was initiated and within this the training and development needs of staff were identified, especially in relation to the Scope of Professional Practice. [1]

11.8 Nurse Education was going through re-organisation with nurse training moving into the Universities with some satellite units in the localities. Project 2000 students commenced training and clinical placements were provided in Community Hospitals.

11.9 There were continuous developments with Trust policies and procedures and during this period the Community Hospitals replaced locally agreed clinical procedures with The Royal Marsden Hospital, Manual of Clinical Nursing Procedures. [31]

11.10 Community Hospitals provided care for a wide range of patients with some examples being; post operative, palliative, rehabilitation and care of the elderly. The Managers were responsible for local workforce planning and, in completing this, were able to identify the number of places required, through the Education and Training Consortium, for English National Board (ENB) courses. It was the responsibility of the Manager to ensure that there were local staff with a range of ENB courses who could act as a resource for other staff e.g. Care of the Dying, Care of the Elderly. [22] [22a] [22b]

12. Methods of recording training and competencies of nursing staff in clinical procedures and practice. 1996 – 2000 Areas A, B and C

12.1 During this period of time training and development needs continued to be identified through Appraisal and latterly through Personal Development Plans.

12.2 Recording of training and competencies was held locally in the individual's personal file and on a Trust wide database, which included other information such as annual leave, sickness absence and compassionate leave.

12.3 There were continuous developments with Trust policies and procedures and during this period all the Community Hospitals in Areas A, B, and C replaced locally agreed clinical procedures with The Royal Marsden Hospital, Manual of Clinical Nursing Procedures. [31a]

12.4 The Locality Manager, Service Manager and Business Manager in the three Areas continued to hold responsibility for ensuring that staff were appropriately trained and updated to meet the clinical needs of the patients. The recording of manual and database records were also the responsibility of these Managers.

12.5 The Managers continued to hold responsibility for local workforce planning and for ensuring that staff were trained and updated to meet the needs of the patients, who accessed the services provided by the Community Hospitals.

13. Policies and practice at ward level in respect of responsibility for prescribing, administration and recording of medicines 1988 – 2000 Areas A, B and C

13.1 Throughout the whole period between 1988 and 2000 the Community Hospitals used the medicines policy provided by the District Pharmacy on guidelines for prescribing, administration and ordering of medicines. [2] This included information on the completion of the prescription sheet. Guidance was provided on the completion of each section as follows: -

- Patients details
- Regular prescription
- Once only medicines
- As required
- Non- prescribed section (Area A)
- Non administration
- Hypersensitivities
- Date, Medicine, Dose, Route and signature of a medical practitioner required for each prescription
- Discontinued prescriptions
- No prescription should be altered

NB

a) Any cancelled prescriptions should have a line drawn through the whole section referring to the prescription concerned. The date of cancellation and the initials of the medical practitioner to be recorded

b) Changes in medication should involve complete cancellation of the existing prescription and writing of a new one

13.2 The Community Pharmacist played a vital role within the Community Hospitals. Regular visits were made to each ward area. The controlled drug register and ordering book were checked. Stock levels were checked and out of date drugs were recorded and disposed of by the pharmacist. A spot check was made of a number of prescriptions. Any problems or concerns would be reported to the Senior Nurse.

13.3 The Pharmacist provided drug update advice to the local GPs and nursing staff. If at all possible, the Pharmacist would attend case conferences when the progress of each patient was discussed.

13.4 An out of hours Pharmacist based at the District General Hospital provided an on call service for advice and emergency supply.

13.5 The Senior Nurse checked the Controlled Drug Register on a weekly basis. The Senior Nurse also checked a selection of prescriptions and care plans on a regular basis. On occasions the Senior Nurse had to work on the wards due to staff shortages or as part of their role and this was helpful for monitoring purposes.

13.6 Administering medication – "*The exercise of professional judgement (which involves the application of knowledge and experience to the situation faced) will lead the registered nurse to satisfy himself/herself that he/she is competent to administer the medicine and prepared to be accountable for that action. Once that decision is made, the registered nurse follows a sequence of steps to ensure the safety and well being of the patient, and which must, as a prerequisite, be based on a sound knowledge of the patient's assessment and the environment in which care is given.* " [(2)]

13.7 In October 1992 the UKCC's 'Standards for Administration of Medicines' paper replaced the 'Administration of Medicines' (which was issued in 1986) [(2)] This paper was prepared to *"assist practitioners to fulfil the expectations which it has of them, to serve more effectively the interests of patients and clients and to maintain and enhance standards of practice."* This paper, in conjunction with the District Pharmacy Medicines Policy, and the Code of Professional Conduct were the standards followed by all registered nurses. [(2)] [(30)]

14. Description of evolving guidance about standards of clinical record keeping at ward level 1988 - 2000

AREA A

14.1 In 1988 nursing was task orientated and on admission the nursing staff assessed the patient's condition. Nursing documentation was completed, this included a 'Kardex' for recording the care given to the patient and the patient's progress during that care. Every entry in the Kardex had to be dated and signed. All problems identified were written in a separate column and numbered. A date for reassessment of the problem was entered and an entry was made in the evaluation column.

14.2 Each patient had a care sheet where some problems identified in the Kardex were entered. Nursing procedures or nursing orders were written alongside the problem. All relevant information on the day-to-day care of the patient was entered on the care sheet. The nurse initialled the care sheet in the appropriate 'box', when he/she carried out the prescribed tasks/procedures. The Nurse in Charge reviewed the care sheets every 24 hours.

14.3 Major changes were taking place in nursing. Primary nursing or team nursing was promoted as the way forward for the delivery of patient care. The nursing process was promoted as this encouraged a problem solving approach to patient care.

> Good nursing records are of vital importance: to patients and clients, to nurses, midwives, health visitors and other members of the health care team and to the Health Authority. Such records are visible evidence of the care given. They provide basic information for the development of nursing, midwifery and health visiting practice and research and facilitate communication between nursing staff and other members of the health care team.
>
> A care plan is the best way forward of achieving adequate documentation of nursing and midwifery care. Frequently such plans are based on the nursing process, which is a method, which encourages a problem solving approach to care. [32]

14.4 In 1990 Team Nursing was introduced using Nursing Process documentation, which included nursing notes and nursing care plans based on the 'Roper, Tierney and Logan' or 'Orem' model of nursing. Care plans were developed jointly with patients/ relatives and carers and were a major step forward in involving patients in the planning of their own care.

14.5 A letter was issued by the Chief Nursing Officer to draw attention to Nursing Records. [34] The letter referred to a study of nursing records which had taken place. The summary of the study made a number of recommendations including:

- There is a need for better education and motivation of staff raising awareness and understanding of the purpose and status of patient/nursing records
- Consideration should be given to providing information on the effectiveness of core care plans in providing satisfactory recording systems for nurses
- Nurses should be factual and precise in their description of nursing observations

- Regular internal audit of nursing records should be encouraged, as part of quality assurance and also staff education

14.6 The Senior Nurses considered the recommendations with the Audit Department who agreed to audit nursing records in Community Hospitals and provide a report to the Trust.

14.7 In 1993 the Department of Health issued a training course on record keeping. Entitled '*Keeping the Record Straight -'A guide to record keeping for Nurses, Midwives and Health Visitors'.* [34] The Trust's Senior Nurses Group and the Senior Nurse Training were charged with implementing the course in the localities. This was in conjunction with the UKCC 'Standards for Record Keeping' . [35]

14.8 The next development was the introduction of multidisciplinary documentation for all inpatients in 1995 and by 1996 GPs records were also included in the documentation. This method of recording clinical activity continued until 2000.

14.9 Ward and Department philosophies of care underpinned the nursing records and care delivery.

14.10 A Clinical Supervision group was established to implement effective Clinical Supervision throughout the community and Community Hospitals. [36] [36a] [36b]

AREA B

14.11 In this area the Nursing Process was introduced in 1985 with staff development and training in holistic nursing care and documentation. Care plans were introduced and used in conjunction with the nursing 'Kardex'.

14.12 Primary Nursing [37] was introduced on 1st January 1989 and with this, nursing notes and updated care plans. Primary nurses held 24-hour responsibility for a group of patients (approx 8-9 patients) and this included ensuring all documentation was completed and updated as required.

14.13 Multidisciplinary notes were introduced in 1992 and this included all professionals who provided care for the patient. All disciplines and patients/carers were encouraged to enter relevant information on the care plans, which were held by the patients.

14.14 Other documentation could include charts for monitoring vital signs and symptoms e.g. temperature, pulse, respiration and blood pressure, fluid balance and pain control.

14.15 Auditing of care plans was undertaken quarterly by a senior member of nursing staff from another Community Hospital. An audit of multidisciplinary notes was also undertaken twice yearly from 1996.

14.16 Training courses for nurses in record keeping and the legal aspects of record keeping were held regularly and all registered nurses were expected to follow the UKCCs 'Standards for Record Keeping' – 1993 and latterly 'Guidelines for Records and Record Keeping' – 1998. [35]

AREA C

14.17 As in the other areas, between 1988 and 1991 nursing was task orientated and documentation included:

- Nursing Kardex for day-to-day reporting of patients condition
- Dependency forms based on a 'Criteria for Care' model
- Medicine Charts
- Observation charts e.g. Temperature, Pulse and Respiration/ Blood Pressure

14.18 It was the responsibility of the ward sister to monitor nursing records and standards of care were audited by using the 'Monitor Tool'.[25]

14.19 In 1993 the UKCC issued 'Standards for Records and Record Keeping' [35] and these were the standards to which Community Hospital nursing staff worked.

14.20 Between 1995 and 2000 nurses were empowered to develop principles, guidelines, protocols and patient group directives that were evidence based. These were taken to the appropriate Council (Practice/Education/Research) where recommendations for change were taken to the Corporate Council for ratification. [26] [27]

14.21 1At this time Core Care Plans and Pathways of Care were developed for a range of specialities/conditions.

14.22 Audit of clinical practice and documentation became embedded into the organisation.

15. An overall statement of conventional working arrangements between ward based staff and General Practitioners in relation to the management of beds, admission and discharge 1988 – 2000

AREA A

15.1 An admissions criteria determined the type of patients who were admitted to Community Hospitals. GPs had letters of appointment but no contracts or job descriptions. Remuneration was paid via the Bed Fund or Clinical Assistant sessions.

15.2 Medical care in Community Hospitals was provided to the GP beds by the patient's GP. Several GP practices could have admitting rights to the beds. In some localities this could involve 4 GP practices with 20 GPs having admitting rights. Each GP practice had a number of allocated beds. There was flexibility and negotiations between practices on bed utilisation.

15.3 Most GPs visited the wards on a daily basis although this was dependent on whether one of their patients was hospitalised. When the patient's own GP was on leave arrangements were made with a GP colleague to provide medical cover in his/ her absence.

15.4 Some Community Hospitals provided long stay care, this was provided in designated consultant beds. Clinical Assistants, some with a special interest in elderly care, provided 24-hour medical care to the patients. The Consultant would visit the hospital, in most cases on a weekly basis, to review the patients. The Clinical Assistants were responsible to the Consultant.

15.5 In Community Hospitals, with consultant beds for elderly confused patients, Clinical Assistants, who were local GPs with additional training, provided 24-hour medical cover. The Consultant visited at least weekly when each patient was reviewed.

15.6 Bed management was the responsibility of the Senior Nurse and in his/her absence the Ward Sister.

15.7 In Community Hospitals with consultant beds for the elderly the designated beds were managed in conjunction with the Consultant. There was little flexibility in the use of these beds.

15.8 In Community Hospitals with beds for the elderly confused, admissions and discharges were arranged between the Consultant Psychiatrist, Clinical Assistant, Community Psychiatric Nurse (CPN) and the Charge Nurse. The beds were used specifically for elderly confused patients. There was no flexibility in the use of these beds. The Senior Nurse was not involved routinely in the management of the beds but had an overview of the day-to-day situation.

15.9 A weekly case conference was the forum for deciding the dates for planned admissions and discharges and the meeting was attended by the Consultant Psychiatrist, CPN, Charge Nurse, Occupational Therapist, Social Services and the Senior Nurse.

15.10 GP beds could be flexibly used as general medical beds or surgical beds (in Community Hospitals where surgery was undertaken). Admissions could be planned e.g. transfers from District General Hospitals in agreement with the patient's GP and the Senior Nurse. Surgical admissions were arranged between the Senior Nurse and Outpatient/Theatre Sister and clerical officers. A GP could request a bed for an emergency admission or plan to admit a patient on a prearranged date.

15.11 Discharge arrangements were planned through case conferences. Each Community Hospital held a case conference on a weekly basis. These were attended by the Home Help Organiser, community staff including community nurses and health visitors, ward staff, therapy staff, Senior Nurse and on occasions the patient's GP. If appropriate the relatives would also attend. The progress of each patient was discussed and discharge arrangements planned.

15.12 Between 1991 and 1995 there was a concerted effort between the District General Hospital and the Community Unit/Trust to utilise the bed capacity in Community Hospitals. A group of Senior Nurses from the acute and community sector looked at the issue of standardising the care that could be provided in Community Hospitals. Prior to this period some nurses in Community Hospitals were not as skilled as their colleagues. This was identified as a problem by the acute sector when arranging transfers to Community Hospitals. For example Community Hospital A nursing staff could administer Intravenous Therapy whilst Community Hospital B nursing staff may not be competent to carry out the same procedure. With the use of appraisals and staff development plans training needs were identified and training modules developed. This resulted in nurses with increased skills who could provide care to patients with a wider range of diseases. [22] [22a] [22b]

15.13 The Community Trust reviewed the bed usage in Community Hospitals. The acute and community Trust agreed to set up a bed bureau. The system worked well. Each Community Hospital notified the bed bureau on a daily basis of the number of beds available.

15.14 The Health Authority no longer purchased long stay care for the elderly in Community Hospitals. This increased the flexibility of bed usage.

15.15 The GPs negotiated a new system of payments. Part of this package were GP contracts and job descriptions, which included quality issues and audit. [28]

15.16 Admissions were organised using the same process as described in the previous period. The ward managers took responsibility for admissions and liaised closely with the Locality Manager.

15.17 Discharge arrangements continued through weekly Core Care Groups. Following reorganisation of Social Services care managers were appointed. Depending on the severity of the patients condition care packages were organised to enable patients to be discharged to the most appropriate place. [15]

15.18 These arrangements continued throughout the period 1996 - 2000

AREA B

15.19 In this Area between 1988 and 1996 GPs had contracts and letters of appointment but no job descriptions. Payments to GPs were through the Bed Fund or as Clinical Assistants. [28]

15.20 Medical care in the Community Hospitals was provided by GPs, who had responsibility for their own patients and day-to-day care of consultant patients. The Community Hospital beds were designated as either GP or Consultant but there was flexibility in usage according to patient need. Although more than one GP practice had contracts with the Community Hospital and payments reflected the number of beds allocated to each practice, once again flexibility was used according to need.

15.21 The Consultant or 'Care of the Elderly' patients were cared for by Consultants, who visited weekly, and GPs with a Clinical Assistant contract who assessed and treated patients daily.

15.22 Bed management of GP beds was the responsibility of the Senior Nurse or Ward Sister, in his/her absence. Waiting lists were maintained for GP beds and prioritisation of patients was agreed between the Senior Nurse and GP as follows:

- 1st Priority – Acute medical admissions from home
- 2nd Priority – Transfers from the Acute Hospital
- 3rd Priority – Planned admissions from home e.g. Assessment & Respite

15.23 A waiting list for patients requiring 'Care of the Elderly' beds was maintained by the Acute Hospital and these were allocated through discussion between the Senior Nurse and the Consultant.

15.24 At the beginning of this period discharge dates were given by GPs with very little discussion or input from other professionals or patients. With the introduction of Primary Nursing in 1989, [37] the Primary Nurses took on the lead role in discharge planning.

15.25 By 1990 discharge planning commenced within 48 hours of admission and was jointly agreed by the patient/carer, GPs, Primary Nurses and other professionals involved in the patients care. Discharge planning was documented as part of the patients Care Plan.

15.26 By 1990 weekly multidisciplinary meetings were held which included all health care professionals and social services to discuss ongoing care and discharge planning.

15.27 Between 1991 and 1995 the Primary Nurses became totally responsible for admission and discharge of all GP patients. Admission was only agreed when the Primary Nurse had all the relevant patient details either from the GP or from the acute hospital.

15.28 The GPs had to state that a patient was medically fit for discharge. The Primary Nurses were responsible for ensuring that all professionals were happy for discharge and that any home care arrangements were made before allowing discharge to take place.

15.29 Between 1995 and 1997 joint working between the Acute Hospital and the Community Hospitals in improving bed utilisation brought about 'nurse to nurse' transfers between the hospitals.

15.30 Up to the year 2000 Primary Nurses continued to retain responsibility for bed management and new Community Hospital admission and discharge policies were agreed to ensure appropriate and effective use of Community Hospital beds.

AREA C

15.31 In this Area between 1988 and 1990 GPs had contracts and letters of appointment but no job descriptions. Payments to GPs were through the Bed Fund or as Clinical Assistants. By approximately 1995 Clinical Assistants had job descriptions.

15.32 Medical care in the Community Hospitals was provided by GPs, who had responsibility for their own patients in GP beds and Clinical Assistants (GPs) for consultant patients in the hospital. The Community Hospital beds were designated as either GP or Consultant but there was flexibility in usage according to patient need. All local GP practices had admission rights to the GP beds within the Community Hospital and payments were through the bed fund.

15.33 Care of the Elderly' patients were cared for by Clinical Assistants to the Consultant Geriatrician. The consultant was available for telephone advice.

15.34 Management of beds was the responsibility of the Ward Manager. There were no waiting lists at this time due to the flexible use of beds between the GP/Consultant beds.

15.35 At the beginning of this period discharge dates were given by GPs/consultants with very little discussion and input from other professionals or patients. With the introduction of Primary Nursing in 1989 [37] the Primary Nurses took on the lead role in discharge planning and the emphasis was on multidisciplinary involvement in discharge planning.

15.36 By 1990 discharge planning commenced within 48 hours of admission and was jointly agreed by the patient/carer, GPs, Primary Nurses and other professionals involved in the patients care. Discharge planning was documented as part of the patients Care Plan.

15.37 By 1990 weekly multidisciplinary meetings were held which included all health care professionals and social services to discuss ongoing care and discharge planning.

15.38 Between 1991 and 1995 the Named Nurse orWard Manager were responsible for admission and discharge of all patients. Admission/transfers were only agreed when the Ward Nurse had all the relevant patient details and had ensured that the GP or Clinical Assistant had agreed that the admission was appropriated for the community hospital.

15.39 The GP/Clinical Assistant and or the Consultant had to state that a patient was medically fit for discharge. The Named Nurses were responsible for ensuring that all professionals were happy for discharge and that any home care arrangements were made before allowing discharge to take place. A discharge liaison role was introduced, this was run by the Senior Nurse Community to ensure District Nurse communications were robust.

15.40 Up to the year 2000 Named Nurses/Ward Managers continued to retain responsibility for bed management and bed states for the community hospitals were sent to the Bed Manager at the District General Hospital three times a day. Joint discharge policies were agreed with the District General Hospital to ensure appropriate and effective use of Community Hospital beds.

16. A review of national policies and implementation at a local level of service quality initiatives 1988 - 1990

16.1 **Department of Health (1989)** [13] *Working for patients - the health service caring for the 1990's*

A white paper that proposed seven key measures these included:

- Responsibility at local level
- Self governing trusts
- Purchaser/providers being able to offer and receive services in other health authorities, with funding crossing administrative boundaries
- GP fundholding

16.2 **Department of Health (1989)** [14] *A strategy for nursing: A report of the steering Committee*

This report looks at the challenges facing nursing in the new NHS particularly in relation to the government policies stated in *Working for patients (1989)*

16.3 **Department of Health (1990)** [15] *The National Health Service and Community Care Act*

- The first legislative reform of the NHS since the founding in 1948. Arises from the two white papers: Working for patients (1989) and Caring for people (1991) makes five key points:
- Quality- as the result of the introduction of market forces, there should be explicit standards of care and patient information (Patient's charter 1991) measurable outcomes and evidence-based practice.
- Flexibility - this legislates for the concept of a NEEDS-led service instead of the other way around. Health services to be redeveloped to suit needs of individuals, communities and population.
- Choice - purchasers of health services - e.g. fundholders - free to choose from a range of providers.
- Accountability - to establish who is responsible for delivering what health care: the responsibilities from the various care-giving agencies.

- Partnership- this is to legislate for good cooperation between: hospital and community agencies, statutory, voluntary and independent organisations, and between patients, professional and informal carers.

17. A review of national policies and implementation at a local level of service quality initiatives 1991 - 1995

17.1 **Department of Health (1991)** [18] *The patient's charter HMSO London*

This launched the government's, Citizen's Charter to the NHS. The three main sections were:

- existing rights, i.e. access to health records and emergency care
- three new rights: information on local services and standards guaranteed maximum two year waiting lists: full investigation and response to complaints
- nine national charter standards such as: respect for religious beliefs; minimum waiting times for ambulances; assessment in accident and emergency departments and the introduction of the 'named nurse' concept
- Strict standards were introduced in all areas to monitor the introduction, on-going process and compliance in achieving the standards.

17.2 **Department of Health PL/CNO(92)** [32] *Nursing Records*

The letter issued by the Chief Nursing Officer to draw attention to a Nursing Records Study undertaken by the Department of Health, during 1991.

The summary of the study made a number of recommendations including:

- a need for better education and motivation of staff raising awareness and understanding of the purpose and status of patient/nursing records.
- Consideration which should be given to providing information on the effectiveness of core care plans in providing satisfactory recording systems for nurses.
- Nurses should be factual and precise in their description of nursing observations
- Regular internal audit of nursing records should be encouraged, as part of quality assurance and also staff education,

17.3 **Department of Health NHSME (1993)** [34] *Keeping the Record Straight – A Guide to Record Keeping for Nurses, Midwives and Health Visitors*

A training course specifically aimed at clinical record keeping. Its contents were relevant to all nursing staff – and other health professionals, from doctors to managers. Some of the messages and real-life examples outlined in the course are deliberately shocking particularly when the potential consequences of poor records are examined.

17.4 **NHS Management Executive (1993)** [22] *A Vision for the Future: the nursing, midwifery and health visiting contribution to health and health care.*

This document examines where the nursing profession fits into recent government changes in the NHS. It identified five key areas and twelve targets which takes into account United Kingdom Central Council for Nursing, Midwifery and Health Visiting Policy Developments.

Five key areas:

- Quality, outcomes and audit
- Accountability for Practice
- Clinical and Professional Leadership, clinical research and supervision
- Purchasing and Commissioning
- Education and Personal Development

It relates policy implications of the four key documents: *Children Act (1989), Caring for people (1991), Health of the Nation (1992) and the Patient's charter (1991).*

In 1993/94 local organizations, Regional Health Authorities, District Health Authorities, Provider Units/ NHS Trusts, monitored progress towards these aims and provided information on progress, which was the basis of a progress review report to the Chief Nursing Officer, the Chief Executive and finally the Secretary of State.

17.5 **Department of Health NHSME January 1993** [21] *The Quality Journey - A guide to total quality management in the NHS*

At the beginning of 1990, the Department of Health embarked on a programme to introduce a managed approach to quality in 23 demonstration sites, ranging from departments within units to entire districts. This booklet describes their progress.

17.6 **Department of Health NHSME (1994)** [22a] *Testing the Vision: A report on progress in the first year of "A Vision for the Future"*

Each area introduced their strategic statements which included:

Quality - Care will be determined on an individual basis with outcomes charted and delivery submitted to audit

Accountability - each practitioner will be enabled to develop, sustain and improve clinical knowledge and professional practice

Clinical Leadership - promoting health and new approaches to care will be facilitated through strong leadership research and supervision

Purchasing - the contribution of nursing knowledge will enhance the efficiency and affect health care by influencing the commissioning and contracting process

Education - the assurance that the development needs of practitioners are met for the delivery of high quality care

17.7 **Department of Health (June 1994)** [18a] *The Named Nurse, Midwife and Health Visitor - checking that it happens*

This publication provided purchasers with monitoring and performance guidelines and providers with an audit tool to monitor their own performance against the Charter standard.

17.8 **Department of Health CNO Professional Letter 94** [36] *Clinical supervision: for the nursing & health visiting professions*

Vision for the Future emphasised the important contribution to the provision of care which is to be gained from effective clinical supervision. All provider units are at differing stages with the implementation of clinical supervision. Discussion on implementation should be taken forward.

17.9 **Department of Health (July 1994)** [22b] *Nursing, Midwifery and Health Visiting Education - A statement of strategic intent*

As highlighted in 'A Vision for the Future' the success of Key Policy Initiatives such as Caring for People and the Patients Charter depend significantly on the contribution of competent and committed nurses, midwives and health visitors, a contribution which is central to the delivery of quality care. It is essential that the provision of education at pre and post-registration levels is both proactive and properly focused in order to prepare practitioners who are able to work flexibly and creatively to realise their potential as key contributors to strategic health care initiatives and to continue to care for some of the most vulnerable people in our society

17.10 **Department of Health (1995)** [36a] *Clinical Supervision - A resource pack*

This was provided to assist with the introduction of Clinical Supervision

18. A review of national policies and implementation at a local level of service quality initiatives 1996 -2000

18.1 Department of Health (1996) [26] *The National Health Service: a Service with Ambition*

The government outlined the fundamental principles on which the NHS was founded. To these principles is added the requirement for a responsive and sensitive service in which the needs of the individual are met. Through a series of case studies, the Government's ambitions are to be realized. This will come about by setting out five strategic objectives:

- a well informed public
- a seamless service
- knowledge-based decision-making
- a highly trained and skilled workforce
- a responsive service

18.2 Department of Health NHS Executive (1996) [23] *Promoting Clinical Effectiveness - A framework for action in and through the NHS*

The booklet was intended to help Chief Executives of Health Authorities and Trusts to develop ways of promoting greater clinical effectiveness throughout the NHS in both primary and secondary care.

- Changing - the way people are treated by the NHS:
- Informing - describes the information available and what is being planned for the future to make information more readily available
- Changing - describes and suggests ways in which changes to services can be encouraged based on well-founded information about effectiveness
- Monitoring - describes ways in which changes to services can be monitored
- Every Trust should take every opportunity to collaborate with the National Centre for Clinical Audit
- Every Trust should foster the development of clinical guidelines

18.3 Department of Health (December 1997) [24] *The New NHS Modern Dependable*

A white paper stressing the importance of primary care. The government proposed substantial savings on administrative costs, to be transferred directly to patient care, by replacing the internal market with "integrated care". This was to be achieved by the following initiatives:

- quality and efficiency to be improved and monitored by a National Institute for Clinical Excellence, setting evidence-based guidelines for clinicians.

- introduction of Primary Care Groups (PCGs) to commission services from NHS Trusts on a long term rather than annual basis. These PCGs replace GP fundholder groups.

- fewer Health Authorities covering larger areas.

18.4 **Department of Health (1998)** [27] *A First Class Service - Quality in the New NHS*

- a consultation document focusing on improving quality standards, efficiency, openness and accountability.

The government proposed:

- a National Institute for Clinical Excellence (NICE) which will assess new and existing interventions for their clinical and cost-effectiveness and produce national guidance for clinicians and patients

- National Service Frameworks which will lay down the care that different groups of patients can expect to receive in major care areas or disease groups

These quality standards will be applied locally through systems of clinical governance, extended life-long learning and professional self-regulation. Standards will be maintained through three new mechanisms:

- a Commission for Health Improvement
- a National Framework for Assessing Performance
- an annual National Survey of Patient and User Experience

18.5 **Department of Health (1999)** [38] *Supporting doctors, protecting patients: a consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England*

A paper that arises from *A first class service (1998)* and the enquiries into medical malpractice. The common themes are a pattern of poor practice over a long period; problems known about but not officially; the failure of systems that were set up to detect problems. Proposals include:

- improving professional self-regulation and accountability

- the clinical governance programme to ensure a thorough review of quality

- measures involving education; supervision and stress to prevent problems occurring in the first place

For handling and dealing with problems, three steps are identified:

1. identifying which category it falls into i.e.: personal misconduct, serious mistake or others' concern about clinical performance

2. setting up Assessment and Support Centres around the country

3. employer or Health Authority to take responsibility for carrying out the findings of the Assessment and Support Centres; Health Authorities to have the power to suspend GPs

18.6 **Department of Health (2000)** [39] *The NHS Plan: a plan for investment; a plan for reform*

A ten-year plan promising financial investment for:

- personnel - increase in the number of consultants, GPs and nurses
- beds - increase in the number of beds
- cleaner hospitals - 'clean up' campaign to start immediately
- equipment for cancer, kidney and heart disease services
- a National Performance Fund
- twenty diagnostic and treatment centres for day and short stay surgery
- hospitals - 100 new hospital by 2010 as well as 500 primary care centres

18.7 **Department of Health (2000)** [40] *An organisation with a memory: report of an expert group on learning from adverse events in the NHS*

The report claims the NHS often fails to learn from adverse events and has an old fashioned approach when compared with other sectors. A fundamental review would provide many benefits in terms of saving lives, preventing harm and freeing up much needed resources. To this end the report recommends:

- a unified mechanism for report and analysis when things go wrong
- a more open culture so as to encourage the reporting of errors
- a mechanism for making sure that recommended changes are put into practice
- a wider appreciation of the 'value system' approach to learning from errors

This section was completed with abstracts from the following publication:
Crecy L (2000) University of Plymouth Directions a guide to Key Documents in Health and Social Care 1986 -2002

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March 2003

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