Fiona Cameron,
Operational Director,
F&G Primary Care Trust,
Fareham Reach,
Gosport,
PO13 OFH

Fareham and Gosport NHS
Primary Care Trust

Clinical Governance Committee
Meeting to be held on Thursday 22nd May 2003
12.30 – 2.30pm, Board Room, Fareham Reach
(Lunch provided)

AGENDA

1. **Apologies for absence**

2. **Minutes of last meeting** — *Attachment A*

3. **Matters arising;**
   - i. Patient Group Directions update
   - ii. Violence Training
   - iii. Community Pharmacist Clinical Governance role
   - iv. Cytotoxic drugs
   - v. NICE implementation group
   - vi. Appraisal Update
   - vii. Appointment of GP Tutor

4. **Policies for approval**
   - *i.* Pain management — *Ann Dalby*
   - *ii.* Discharge — *Jan Peach*
   - *iii.* Pressure Ulcers — *Babs Gray*

5. **Pharmaceutical Industry policy** — Code A — *Attachment B*

6. **Child Protection Audit** — *Fiona Cameron* — *Attachment C*

7. **DRIVE update** — *Nicky Heyworth*

8. **Primary Care Information Services (PRIMIS)** – *to discuss membership of PRIMIS steering group* — *Nicky Heyworth*

9. **Ratification of Community-based guidelines** — *Nicky Heyworth*

10. **Twice yearly meetings between Risk Management Committee & Clinical Governance Committee** — *Ian Piper*

11. **Risk Event Statistics, Complaints Report, Litigation Summary and the minutes from the Risk Management Committee** — *Attachment D*

12. **Setting audit priorities** — *Nicky Heyworth / Justina Jeffs*

13. **Infection Control Accountability Chart** — *Nicky Heyworth* — *Attachment E*

14. **Any other business**

Distribution;

Andrew Paterson	Chris Kelly	Code A	Code A
Rachael Boyns	Ian Piper	Code A	Fiona Cameron
Ian Reid	Justina Jeffs		Ann Stewart
Nicky Heyworth	Code A	Ann Turner	Mike Wagg

Attachment A

Fareham and Gosport NHS
Primary Care Trust

Minutes of the meeting of the Clinical Governance Committee held on 13th March 2003 in the Conference Room at Fareham Reach

PRESENT:	APOLOGIES:
Code A	Rachael Boyns
Fiona Cameron	Code A
Nicky Heyworth	Ian Piper
Justina Jeffs	Ian Reid
Chris Kelly	Code A
Andrew Patterson (Chair)	
Anne Stewart	
Ann Turner	

1. Apologies for Absence

Apologies for absence were received from Rachael Boyns, Code A Ian Piper, Ian Reid, Code A

2. Minutes of the last meeting

These were agreed as being a true reflection of the meeting.

- Chris informed the meeting that the Practice Nurse meeting in January 2003 had raised issues regarding signing and dissemination of Patient Group Directions and the way PGDs are currently distributed and evaluated needs to be addressed. Chris Kelly, Nicky Heyworth, Code A and Code A are to meet and discuss these issues.

3. Matters Arising

i) GP Appraisal Update

To date there are 6 trained GP Appraisers for the PCT. Funding for the training has been provided by the Deanery and all trained GPs have been appraised.
The requirement is for all GPs to be appraised by the end of March 2004 and a programme has been developed with appraisers and appraisees to ensure this is met.
The LMC previously agreed the financial aspects of appraisals. However, discussions continue regarding the final sum allocated to both appraisers and appraisees.
The PCT is working with East Hants PCT to develop a reciprocal arrangement for the sharing of trained appraisers. Further information on these arrangements will be given as appropriate.

ii) Violence Training in Primary Care

Nicky, Code A (EHPCT) and Code A (PCPCT) have met with Crime Concern to discuss personal safety training in Primary Care.
The quote from Crime Concern was prohibitively costly, so it has been decided to ask the shared Training Service to develop training for primary care reception and administrative staff in the first instance.

4. Proposal for GP Patch Tutor & Future Developments

One session of GP Tutor time has been agreed for each PCT. There was some discussion concerning the need within F&G PCT to extend this for a further session at the cost of £6,500 however this has been declined by the PEC due to cost pressures. The committee agreed to investigate other possible sources of funding to include drug company sponsorship and the Workforce Development Confederation.

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5. Pharmacy Update & Proposal

Code A fed back to the Committee regarding the Community Pharmacist's Clinical Governance role. The PEC declined funding and required further clarification of the benefits. Code A will address this and it will go back to PEC.

6. Clinical Governance Development Plan

The Clinical Governance Development Plan was tabled for discussion. The development of the plan is a requirement and forms part of the national reporting structure for PCT's. The plan sits within PCT's Clinical Governance Framework, which includes the elements of clinical governance derived by CHI and clear accountability arrangements. It is expected that the Framework and Development plan will form the basis of the annual report. Final amendments will be made prior to the April Trust Board meeting, however the plan may require amendment in year to respond to national and local imperatives.

7. CHI Action Plan Update

Fiona Cameron updated the committee on the CHI Action Plan and requested that this remain on the agenda for future meetings.

8. Complaints Update

Fiona Cameron spoke to the tabled Complaints Policy and requested members to provide feedback by 14 April 2003.

9. Cytotoxic Drugs

District Nurses are currently administering Cytotoxic drugs as per the protocol for the drug and with appropriate training. There have been issues around handling and disposal. However these are now resolved. Practice nurses are also administering Cytotoxic drugs but recent guidance from the LMC stipulates that Cytotoxic drugs should not be given in General Practice. Code A to discuss with Code A

10. Progress on NICE Implementation Group

The PCT has established a NICE group who are currently reviewing the dissemination mechanisms for NICE Drug guidance. Following discussion it was agreed to extend the membership of the group and further broaden the remit to include all NICE Guidance.

11. Risk Management Committee Minutes to note

12. Any Other Business

- Anne Stewart gave feedback on a recent Patient Involvement Conference training event she had attended.
- Haslar is currently exploring connections to pathlinks
- Infection Control guidelines were welcomed by GP Practices.

Date of Next Meeting:

22 May 2003, 12.30 – 2.30pm in the Conference Room, Fareham Reach.

Attachment B

2.99.4.2(a)

Portsmouth and South East Hampshire Health Authority

Policy on Relationships with Commercial Organisations with particular reference to the Pharmaceutical Industry

Introduction

In order to satisfy issues concerning probity and confidentiality and to establish a proper rapport with commercial organisations, a Health Authority (HA) policy is required. There needs to be recognition of the following factors:-

- All commercial activity is potentially part of a marketing exercise.
- The agenda of commercial organisations is not necessarily the same as the Health Authority's but the HA and a commercial organisation may be able to work together when the agendas match. On occasions the HA may be giving different educational messages to those from commercial organisations, particularly the pharmaceutical industry.
- All staff need to understand the HA's attitude towards sponsorship, payments for services rendered and the degree of advertising with which the HA is prepared to be associated.
- The acceptable purposes of any association with industry need to be defined.
- Guidance on confidentiality is required.
- EL(94)94 "Commercial Approaches to the NHS regarding Disease Management Packages" gives advice about approaches from pharmaceutical companies offering disease management packages or similar agreements for the preferential purchase of drugs and other pharmaceutical products. Advice on this issue can be obtained from the Authority's pharmaceutical advisers.

Statement of Policy

- **Health Authority Attitude**

  The HA recognises that commercial organisations are often integral to or strongly supportive of the NHS and that joint working within clearly defined limits may often produce benefits for patients, providers and purchasers.

  The HA staff may have contact with commercial organisations and accept sponsorship providing such activity is within the guidelines of this policy document. If staff are in doubt about the acceptability of any meeting with commercial organisations or if a project is to be sponsored or resources accepted from a commercial organisation, then guidance should be sought from a Director who will consider whether or not the Executive Team should advise.

The general principles to be upheld are that the HA may be involved with commercial organisations with non promotional educational activity, but will not be involved with any activity which has a marketing potential for an organisation's specific products or services.

Criteria that Directors may use to assess the suitability of meetings or projects will include the following:-

- Is there likely to be benefit to the individual or the Health Authority or services to patients?
- Is the meeting or project likely to compromise any initiative or objective of the Health Authority?
- Is the meeting or project likely to result in any adverse criticism for the Health Authority?

- **Sponsorship and Advertising**

The HA will accept sponsorship of educational activity and facilities, providing it is not associated with any specific product or service offered by the commercial organisation. Accounts recording the use of sponsorship monies and services should be prepared for record and audit.

For educational events the HA will be associated with the name of the sponsor and will allow printed material with its name and that of the sponsor with company logo to be produced in relationship to such sponsored educational events but not for any other purpose.

The marketing potential of any educational event sponsored by a pharmaceutical company should be checked in the planning stages with the Pharmaceutical Advisers with relevant Directors for events sponsored by other commercial organisations.

The Health Authority will refuse:-

- to display any specific product information,
- to allow the presence of a company stand at meetings
- to allow company representatives to speak at meetings other than those where staff of the HA alone are being advised.

- **Seeing Representatives of Commercial Organisations**

HA staff may see representatives of commercial organisations for the following purposes:-

- For information about products relevant to health care or NHS management and administration.

- To discuss joint working and/or acceptable sponsorship.

- With regard particularly to the pharmaceutical industry to learn of their current approaches to the district's primary care contractors, their education enterprises and new products in the pipeline.

It is recommended that representatives of commercial organisations provide an agenda for any meeting in advance, preferably in writing.

The HA will not accept fees from commercial organisations for the granting of meetings with their representatives.

The HA requires that its Prescribing Advisers have knowledge of any contacts with the pharmaceutical industry so that they advise on the implications of any proposed joint working.

- **Involvement of Health Authority Staff with Sponsored Events and Activities**

HA staff may speak at meetings sponsored by commercial organisations providing no reference is made to trade names of commercial products or proprietary names and that the content of what they say can in no way be interpreted as promoting a specific product, other than by generic name.

Health Authority staff may attend sponsored courses and accept the minimum associated hospitality, ie food and drink. Staff should claim the relevant travelling and subsistence expenses from the HA and also overnight subsistence, should the course be residential.

HA staff may co-operate with projects of commercial organisations, eg research and audit or support of guidelines, but only with the express permission of a Director. In the case of proposed involvement with a pharmaceutical company the advice of the Pharmaceutical Adviser must be sought in order to assess the marketing potential of the proposal.

The HA and its staff will not accept fees for services rendered except with the express permission of the Chief Executive.

- **Confidentiality**

All HA documentation not in the public domain by virtue of it having been published as a public document, or a minute of the public part of a meeting, is to be regarded as confidential. Any information not falling into this category should not be divulged to commercial organisations without permission of a Director.

Guidelines and management policies issued to primary care contractors will be regarded as in the public domain.

Prescribing data, whether generalised or practice specific is regarded as confidential unless it has been anonymised and forms part of a HA public document.

Code A
Medical Adviser
September 1996

Attachment C

AGENDA ITEM
PCTB 09/04

Fareham and Gosport NHS
Primary Care Trust

BOARD SUMMARY PAPER

Title
CHILD PROTECTION MANAGEMENT ARRANGEMENTS – COMMISSION FOR HEALTH IMPROVEMENT AUDIT

Background and Summary

The Commission for Health Improvement (CHI) has been commissioned by The Secretary of State for Health to develop a programme of work, which will assess PCT's Child Protection arrangements and support the implementation of the Victoria Climbie Enquiry Report.

The work is in three stages

- Development of a self-audit tool for organisations related to their strategic management arrangements for child protection and progress against the Victoria Climbie Report recommendations.
- Development of self-assessment tools for clinicians.
- Inspection of Child Protection arrangements in the NHS.

The self-audit tool was posted to the CHI web site on the 31st March 2003 and the completed audit due by 30th April. An extraordinary meeting of the Child Protection management team was organised for the 11th April and the Audit completed with support from Gordon Sommerville in the absence of a named GP for Child Protection. CHI have recommended that the tool be used to offer the Board the opportunity to reflect on its responsibilities for child protection, identify and prioritise areas for improvement.
Given the timescales involved it was necessary to return the completed audit prior to the board meeting. However attached are the summarised discussions of the Child Protection Management Team and the completed audit including three improvement objectives.

Work is progressing in relation to the Victoria Climbie Report Action Plan and an updated copy is attached. There has been some interest in the post of Named Doctor Child Protection and interviews will be held early May.
The Team has also ratified the district wide policy on Child Protection and the board is asked to adopt. A relationship chart is attached to clarify local arrangements as they relate to the PCT.

Recommendations

To: The Board is asked to review the summary of discussions regarding Child Protection Management arrangements and to note the updated Victoria Climbie Action Plan and Relationship chart.

Date 14th April 2003

Paper Prepared by

Fiona Cameron

Background

Thank you for completing this audit. We hope you will find it an interesting and useful exercise.

Following the publication on 28 January 2003 of the Victoria Climbié Inquiry Report, the Secretary of State for Health has asked the Commission for Health Improvement (CHI) to provide a report on the protection of children in the NHS.

Every child and young person has a right to life free from abuse. Article 19 of the United Nations Convention on the rights of the child, to which the United Kingdom is a signatory, states that:

"parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical and mental violence, injury or abuse, neglect or negligent treatment, malpractice or exploitation, including sexual abuse, while in the care of the parent(s), legal guardian(s) or any other person who has the care of the child" (United Nations 1992)

Child protection is a highly emotive subject, evoking strong feelings in all of us. In order to provide the most effective support and help for vulnerable children, young people and their families, all staff managing services and involved in working directly with children and young people need to be able to acknowledge their feelings and examine their values and beliefs.

This audit tool builds on the 2002 joint chief inspectors' report on arrangements to safeguard children and its recommendations to the NHS and on Lord Laming's concerns about the failures of all agencies, including health services, in his inquiry into the case of Victoria Climbié. In particular, this audit is designed to give weight to Lord Laming's concerns about the need for those in senior positions to be accountable and responsible for child protection. Before undertaking this audit, NHS boards should ask themselves if they have seen the checklist of recommendations provided by the Secretary of State as a precursor to the audit and whether they know how their organisation is responding to them. You will find a copy of the Secretary of State's checklist of recommendations in this introduction along with a note indicating the relationship between individual recommendations and statements in the audit tool. Statements 2, 4, 8, 9 and 11 do not directly correspond with the recommendations, however they are fundamental and underpin all child protection services.

The audit is designed to achieve a number of specific objectives:

- to raise the awareness of the board of the responsibility and accountability it carries for protecting children and young people, and to help board members establish what they know about how well the organisation protects children and young people
- to raise awareness inside NHS organisations of the importance of protecting children and young people and to help organisations identify their own strengths and weaknesses in this area
- to help people inside NHS organisations share information, take stock and reflect, and challenge colleagues
- to support NHS organisations in implementing the recommendations of the Victoria Climbié Inquiry by helping them to identify and make progress in areas for improvement

Print this page

Primary care trust data collection		
	Yes	No
1. Does the PCT have a designated doctor for child protection?	◉	◉
2. Does the PCT have a named doctor for child protection?	◉	◉
3. Does the PCT have a designated nurse for child protection?	◉	◉
4. Does the PCT have a named nurse for child protection?	◉	◉
5. Does the PCT have access to a named midwife for child protection? (please indicate below if not applicable)	◉	◉
6. Does the PCT have a named public health professional with responsibility for child protection?	◉	◉
7. Is one of the PCT executive directors named as the lead for services for children?	◉	◉
8. Does the PCT have a lead person at board level with responsibility to report to the board on child protection?	◉	◉
9. Does the PCT have a representative on the area child protection committee?	◉	◉
10. Does the PCT have a specific person whose role it is to ensure checks are made with the Criminal Records Bureau?	◉	◉
11. Does the PCT have a specific person whose role it is to ensure professional clinical staff are registered with their professional statutory body?	◉	◉
12. Does your organisation have 24 hour access to all the Child Protection Registers retained by the local authority	◉	◉
13. Can you supply 24 hour access to all previous case records	◉	◉
14. Does the PCT have 24 hour access to a person with experience in child protection?	◉	◉
15. Do the PCT's service specifications include clear service standards for safeguarding children and promoting their welfare, consistent with local area child protection committee procedures?	◉	◉
16. Does the PCT have a training strategy for child protection?	◉	◉
17. Is the training strategy funded?	◉	◉
18. Does the PCT board receive an annual report on child protection?	◉	◉

Additional Comments

DOH801146-0013

Print this page

What three key areas for action have arisen from this audit?

It may help to identify your key areas for action by selecting the statements where the extent to which you meet the statement is low, and your influence to improve in this area is high.

Key area 1

Formalise a training strategy for child protection - to be rolled out to Primary Care with links back into the PCT Training and Development Strategy. Responsibility: Named Nurse/Named Dr

Key area 2

Appointment of named GP to lead on Child Protection. The PCT has advertised this post. The closing date of 11th April 2003 will enable the PCT to progress actions highlighted by this audit. Responsibility: Operational Director (Quality and Community Services) Deadline: End May 2003

Key area 3

To develop the role and remit of the Trust"s Child Protection Mnagement Team which will include a review of the following: membership/monitoring and reporting arrangements/input into planning processes.

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Do keep a note of the people who participated in this audit. This will be helpful information for your senior team if you carry out the audit again in the future.

Participants

Name	Job title
• Fiona Cameron	Operational Director (Quality and Community Services)
• Charlie Childs	Non Executive Director
• Tina Tompkins	Service Planning Manager
• Kate Roberts	Clinical Team Manager and Named Nurse for Child Protection
• Justina Jeffs	Clinical Governance Manager (Community Services)
• Gordon Sommerville	GP and PEC Chair
• Trust Board meeting 30/4/03	

Statement 1 - a child and young person centred culture

We know the extent to which staff* in all areas respond sensitively to the needs of individual children and young people.

Guidance

Consider, for example:

1. what you know about children and young people's experience of your services and how this information is obtained
2. what you know about the extent to which staff in all areas respond sensitively to the needs of individual children and young people (including cultural needs)
3. the arrangements in place to support children, young people and their families who do not speak English wherever and whenever they access services including the use of an interpreter
4. what you know about the arrangements in place to guide and support staff looking after children and young people with emotional difficulties, children and young people with physical or learning disabilities and those unable to communicate verbally

Statement 1 - a child and young person centred culture

We know the extent to which staff* in all areas respond sensitively to the needs of individual children and young people.

- 1.No formal monitoring arrangements but informal feedback through parents/children and complaints system. Questionnaire for parents of children attending behaviour management/sleep and other specialist clinics as standard.
- 2. Unclear at present
- 3. Interpreters accessed by GPs as required. In some cases children translate for their parents and vice versa. Language Line telephone service currently being implemented in provider services. GPs confident in accessing services (telephone child and family therapy etc for advice)
- 4. Primary Care - poor area, no compulsion to attend. Training is provided for PCT staff. Access to specialist services through referral and telephone liaison. Clinical Supervision - support. Objectives set for individuals.
- Informal links with formal systems.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ○	Somewhat ◉	Substantially ○	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ◉	De facto ○	Strong ○	Full ○

Statement 2 - a safe environment

We know the environments in which we care for/treat children and your people and are able to minimise the risks to those using our services.

Guidance

Consider, for example:

1. what you know about whether, and to what extent, children and young people are cared for outside explicitly designated children and young people's areas
2. what you know about how your organisation ensures the safety (physical and psychological) of those that use your services

Statement 2 - a safe environment

We know the environments in which we care for/treat children and your people and are able to minimise the risks to those using our services.

- All premises have Health and Safety procedures. Attempt to minimise risk. Clothier checks on staff as required. No formal risk assessment for areas not under PCT management - environments outside normal treatment areas.
- Risk event reporting systems would pick up particular issues. GPs do not see children without a responsible adult - unless in exceptional circumstances.
- Action Add into annual risk assessment those premises outside the PCT"s management.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ○	Somewhat ◉	Substantially ○	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ◉	De facto ○	Strong ○	Full ○

Statement 3 - policies and communication

We have been able to make sure that all our staff know what to do, and how to do it, in cases of suspected neglect and/or abuse.

Guidance

Consider, for example:

1. what you know about whether you have a policy on child protection, how it links to policies of the area child protection committee (excluding ambulance trusts) and of other local organisations involved in child protection, how adherence to it is audited, who is responsible for it, who updates it and whether it is updated regularly
2. the arrangements in place to ensure all staff across the organisation, (including new staff, volunteers, students and temporary staff) as well as those working in services explicitly designated for children and young people, are made aware of the child protection policy and procedures, for example at induction, and how are these audited.
3. what you know about the arrangements in place to ensure that policies and procedures are acted on
4. what you know about arrangements in place for staff to access child protection registers and what you know about whether the arrangements work

Statement 3 - policies and communication

We have been able to make sure that all our staff know what to do, and how to do it, in cases of suspected neglect and/or abuse.

- 1. Trust-wide policy updated and across 4 organisations. Child protection training. Most GPs would have an idea of what to do - refer to social services.
- 3. Working on this through child protection management team/clinical audit/clinical governance development plan/Climbie action plan
- 2. There are structures eg induction but are unsure of compliance - informal.
- 4. No access - access through social services for community and primary care. Most GPs unaware of the district policy.
- Actions formailse training through shared Training and Development service (already in progress) PGEA approved and fully funded.
- Need to ensure that information going to GPs needs to be broadened through to all primary care services. Named GP will progress this (communication flowchart being amended)

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ○	Somewhat ○	Substantially ◉	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ◉	Strong ○	Full ○

Statement 4 - accountability and responsibility*

We have appointed appropriately experienced individuals for child protection and can demonstrate that they are leading planning, monitoring and improvement of services to protect children and young people effectively.

Guidance

Consider, for example:

1. how you ensure the board's knowledge and understanding of the roles of the named and designated professionals, and how they interact with the rest of the organisation
2. how you know that all staff know the names of the named and designated professionals and how to contact them
3. how you know whether the named professionals have protected time to carry out their role
4. how you know what difference they have made across your organisation to improve child protection services
5. what you know about how the named and designated professionals are performance managed
6. what you know about the support available to your named and designated professionals

* All trusts and PCTs must have a named doctor and nurse and where appropriate, a named midwife. All PCTs must have a designated doctor and nurse. All trusts, PCTs and StHAs must have a named lead person at board level for child protection.

Statement 4 - accountability and responsibility*

We have appointed appropriately experienced individuals for child protection and can demonstrate that they are leading planning, monitoring and improvement of services to protect children and young people effectively.

- 1/2 Communication chart/PGEA approved/Service Level Agreements/Policy
- 3. Communication chart/PGEA approved/Service Level Agreements/Policy plus specific contract for named dr/nurse - part of job description.
- 4. Named Nurse objectives - unsure of differences currently unmeasured.
- 5/6. Other named nurses and designated nurse. Links with social services. Backed by Chief Executives. Clinical Supervision.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ○	Somewhat ○	Substantially ◉	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ○	Strong ○	Full ◉

Statement 5 - working across boundaries

Our organisation works well with other relevant organisations to identify, assess and manage children and young people in need of protection.

Guidance

Consider, for example:

1. which organisations you work with on a regular basis
2. the management, supervision and accountability of multi agency teams working with children and young people
3. what strategic planning takes place across boundaries, including with those organisations outside health services, such as voluntary organisations
4. how you share and monitor information across services
5. your own organisation's track record of working with other local organisations at corporate and senior levels. What you have done to improve the quality of your working relationships across services caring for children and young people and between other relevant services
6. what you know about the evaluation of working arrangements between organisations involved in child protection locally
7. what you know about referral procedures and continuing support for children and young people in need of child protection

Statement 5 - working across boundaries

Our organisation works well with other relevant organisations to identify, assess and manage children and young people in need of protection.

- 1. Social services/police/education/youthservices/Sure Start/ Connexions/PCTs and out of area PCTs/ Hospitals Trust/ Named nurse groups/regional groups/navy family welfare.
- 2. Multi-agency planning meetings/case conferences. There are clear ways of running meetings (plans minutes etc)
- 3. Unsure of voluntary organisation input at present.
- 4. Information sharing protocol. On ground largely done. GPs have informal systems although there is potential for breakdown. (AMH and childcare protocol between health and social services)
- 5. Health professional seconded to Sure Start. Planning meetings with other services. Health Chair of Sure Start management team.
- 6. Unsure problems can arise at planning meetings.
- 7. Referral process good from primary care but unsure what then happens. Case conference/planning meetings. Suspected gap in primary care knowledge. Health visitor and school nurse follow-up from referral.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ○	Somewhat ●	Substantially ○	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ●	Strong ○	Full ○

Statement 6 - national clinical standards for child protection

We know the extent to which all areas of our organisation comply with clinical standards and requirements for child protection.

Guidance

Consider, for example:

1. the arrangements in place to review the implications for your organisation of national reports and guidance on child protection
2. the range of clinical standards and requirements that will impact on your organisation, arising out of:

   a. findings from recent inquiries
      - Lord Laming (2003) The Victoria Climbié Inquiry Report*
      - Safeguarding Children: A Joint Chief Inspectors Report on Arrangements to Safeguard Children (2002)*

   b. key guidance and requirements
      - checklist of practice recommendations from the Victoria Climbié Inquiry from the Secretary of State for Health (2003)*
      - Department of Health, Home Office, Department for Education and Employment Working Together to Safeguard Children.. London (1999)*
      - Department of Health, Department for Education and Employment, Home Office: Framework for the Assessment of Children in Need and their Families (2000)*
      - Department of Health, letter from Jacqui Smith MP to PCTs (2002)

   c. additional guidance
      - Department of Health – Promoting the Health of Looked After Children (2002)*
      - Department of Health, Home Office, Department of Education and Skills, Home Office, Safeguarding Children in whom Illness is Fabricated or Induced: Supplementary Guidance to Working Together to Safeguard Children: (2002)*
      - Department of Health. Safeguarding Children Involved in Prostitution: Supplementary Guidance to Working Together to Safeguard Children (2000)*
      - LAC guidance – Department of Education and Skills and Department of Health - Guidance on the Education of Children and Young People in Public Care (2000)*

2. how you ensure that relevant parts of your organisation are aware of their responsibilities

3. how you ensure that compliance is being monitored

Statement 6 - national clinical standards for child protection

We know the extent to which all areas of our organisation comply with clinical standards and requirements for child protection.

- ~~1. Child protection management team and non executive director.~~
- 2. Area Child Protection Committee and district-wide child protection group drive initiatives. Lead nurse implements. Service manager for childrens services.
- Action Child Protection management team to ensure actions/recommendations are progressed.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ◉	Somewhat ○	Substantially ○	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ○	Strong ◉	Full ○

Statement 7 - clinical performance monitoring and improvement

We use our systems for clinical performance monitoring and forward planning to bring about improvements in the protection of children and young people.

Guidance

Consider, for example:

1. all of the ways in which you make yourself aware of your organisation's clinical performance in relation to child protection, for example:
    1. assessment against internal or external targets
    2. benchmarking in relation to other relevant organisations
    3. the involvement of external bodies/organisations in helping the organisation monitor and review performance
    4. trends in comments, complaints, incidents and litigation
    5. feedback from staff and children/young people
    6. feedback you receive from other local organisations involved in child protection
2. what you know about reports and feedback from the area child protection committees
3. whether you receive reports on all findings and actions arising out of *Working together* Chapter 8 serious case reviews
4. whether you monitor actions on recommendations in *Working together* Chapter 8 serious case reviews that apply to you
5. how you have used the information from the monitoring of child protection services to bring about change and how you use the same information for forward planning

Statement 7 - clinical performance monitoring and improvement

We use our systems for clinical performance monitoring and forward planning to bring about improvements in the protection of children and young people.

- 1. Climbie inquiry action plan. Benchmarking tool (part of policy). CHI audit. Complaints/incidents etc go to PCT Board already. No mechanism for children/young people to feedback formally. Case conferences for staff and multi-agency child protection forum.
- 2. No but agenda often on District Child Protection Liaison Group.
- 3. Via ACPC to designated named nurse and doctors.
- 4. Nothing at present
- 5. Training from national documents incorporated into child health records. No direct link into planning systems for implementation of documents has been invested in named nurse.
- Action Child Protection Management Team to pick up.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ◉	Somewhat ○	Substantially ○	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ○	Strong ○	Full ◉

Statement 8 - legislation and guidance relating to child protection and employment

We know the extent to which the recruitment and selection of staff who may come into contact with children and young people (including independent contractors* and their staff, volunteers, temporary, agency and bank staff) compiles with legislation and guidance related to child protection.

Guidance

Consider, for example:

1. what you know about whether checks are made with the Criminal Records Bureau prior to the appointment of staff
2. what you know about whether checks are made to ensure professional clinical staff are registered with their professional regulatory body
3. what you know about the periodic rechecking of criminal records and professional qualifications
4. the information available to you about procedures for auditing your recruitment and selection processes
5. your knowledge of how such systems are standardised and integrated across the PCT

- primary care professionals who provide a defined range of primary care services via a nationally negotiated NHS contract but are not directly employed by primary care trusts. The majority of general practitioners, optometrists, dentists and community pharmacists provide NHS services as independent contractors.

Statement 8 - legislation and guidance relating to child protection and employment

We know the extent to which the recruitment and selection of staff who may come into contact with children and young people (including independent contractors* and their staff, volunteers, temporary, agency and bank staff) compiles with legislation and guidance related to child protection.

- 1. Policy including risk assessment for failure of returing information from the Criminal Records Bureau. Need to issue in Primary care.
- 2. Provider services covered but an issue in primary care
- 3. Rechecking of professional qualifications - only if changing jobs to one with children
- 4. This issues is currently being addressed by effectiveness and personnel
- 5. Not standardised and integrated for primary care but are in provider services.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ○	Somewhat ○	Substantially ◉	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ◉	Strong ○	Full ○

Statement 9 - training and competence

We have systems in place to monitor, maintain and improve the competence of all our staff in protecting children and young people.

Guidance

Consider, for example:

1. what you know about whether an assessment of training needs has been undertaken. Whether it has informed a training strategy for all staff in relation to child development and child protection as highlighted in chapter 9 of *Working together*
2. what you know about whether your staff participate in inter agency training with staff from local organisations involved in child protection and how attendance is monitored
3. how well your performance management systems keep you regularly informed about the frequency and quality of child protection training for all your staff. Whether the performance management systems effectively ensure staff training and development needs are met
4. how good your organisation is at identifying and addressing staff competence issues. These might relate to changing service requirements such as new evidence, new techniques, or to individuals/teams such as length of time in post, introduction to new/extended roles, degree of autonomy/supervision

Statement 9 - training and competence

We have systems in place to monitor, maintain and improve the competence of all our staff in protecting children and young people.

- Benchmark in policy 1. Training and Development forum (Childrens services) assessment of need. Training offered
- 2. Attendance is monitored - although currently no feedback to managers Training is available Training portfolios
- 3. Nothing in place
- 4. Nothing directly addressing staff competency however, various personnel policies for management of poor performers eg disciplinary procedures.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ◉	Somewhat ○	Substantially ○	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ◉	Strong ○	Full ○

Statement 10 - record keeping

We regularly review the quality of records on children and young people, both electronic and hard copy, and can demonstrate record keeping meets the required standards.

Guidance

Consider, for example:

1. what you know about agreed standards for the format, content (including the recording of basic information) and timeliness of children and young people's records, including summaries, care plans and discharge plans
2. whether you measure the quality of all health records and the evidence you have of improvement as a result of reviews
3. whether there is one set of case notes per child or young person in the organisation.
4. whether, and how often, the quality of children and young people's records are audited and evidence of action taken arising from the findings
5. what you know about how consent is obtained from children and young people and their parents/carers
6. whether you have clear protocols for sharing written/electronic information across organisations that have responsibility for child protection

Statement 10 - record keeping

We regularly review the quality of records on children and young people, both electronic and hard copy, and can demonstrate record keeping meets the required standards.

- 1. Supervision reviews paperwork
- 2. Reviews
- 3. Records work currently being undertaken by Barbara Hall including itegrated records and electronic records.
- 4. Climbie action plan. Record keeping policy Audit Programme
- 5. Implied consent. PCT leaflet
- 6. Protocol written but no formal system at present.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ○	Somewhat ◉	Substantially ○	Strongly ○	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ○	Strong ◉	Full ○

Statement 11 - open and honest reporting

Within this organisation we have a culture of open and honest reporting and effective management of any situation that may threaten the quality of a child or young person's care.

Guidance

Consider, for example:

1. recent situations that have actually or potentially compromised the care of children and young people for example:
    - clinical incidents
    - near misses
    - whistle blowing situations
    - complaints
    - breaches of patient confidentiality
    - relatively minor or local issues as well as major local and national incidents, since local problems may stay hidden but result in a greater cumulative impact on the organisation
2. how such incidents come to light and how confident you are that incidents are always reported
3. the actions taken in response and what was done to ensure the whole organisation learned
4. the findings of the Victoria Climbié Inquiry report and whether the omissions and failures reported would come to light if they occurred in your organisation

Statement 11 - open and honest reporting

Within this organisation we have a culture of open and honest reporting and effective management of any situation that may threaten the quality of a child or young person's care.

- The PCT has had a recent incident which highlights these processes.
- 2. Risk event reporting mechanisms. Clinical supervision GP risk event form developed and currently being implemented.
- 3. Risk event reporting mechanism and team brief
- 4. GP isue around registration. Climbie action plan for the PCT.
- Action Whistleblowing policy to be reviewed and renamed which will include primary care. Information required following on from Climbie inquiry report as to possibility of children being seen at a number of practices without being registered.

To what extent is this statement met in your organisation?					
Scarcely if at all ○	Slightly ○	Somewhat ○	Substantially ○	Strongly ◉	Fully ○

How much influence do you have to improve this?					
None ○	Marginal ○	Some ○	De facto ○	Strong ◉	Full ○

Fareham and Gosport NHS
Primary Care Trust

Fareham & Gosport Primary Care Trust
Child Protection Management Team

The Victoria Climbié Enquiry – Lord Laming Report

Recommendations DRAFT Action Plan MARCH 2003

Rec'n	Priority	Recommendation	Action	Date	Accountability
12	1	Front-line staff in each of the agencies which regularly come into contact with families and children must ensure that in each new contact, basic information about the child is recorded. This must include the child's name, address, age, the name of the child's primary carer, the child's GP and the name of the child's school if the child is of school age. Gaps in this information should be passed on to the relevant authority in accordance with local arrangements. (Para 17.97)	Check records annually GPs • Discuss Primary Care aspects with Head of Primary Care • Follow up paper to GPs • GP meetings LMC	Apr/May 03 Achieved 31.3.03 Apr 03	Child Protection Management Team Kate Roberts (|Named Nurse) Community Child Protection Management team
21	1	When a professional makes a referral to social services concerning the well being of a child, the fact of that referral must be confirmed in writing by the referrer within 48 hours (paragraph 4.59)	This is part of the Child Protection Policy * GPs Discuss Primary Care aspects with Head of Primary Care • Training Issue/and briefing	Apr/May 03 Achieved 31.3.03 Apr 03	Child Protection management team KR Community

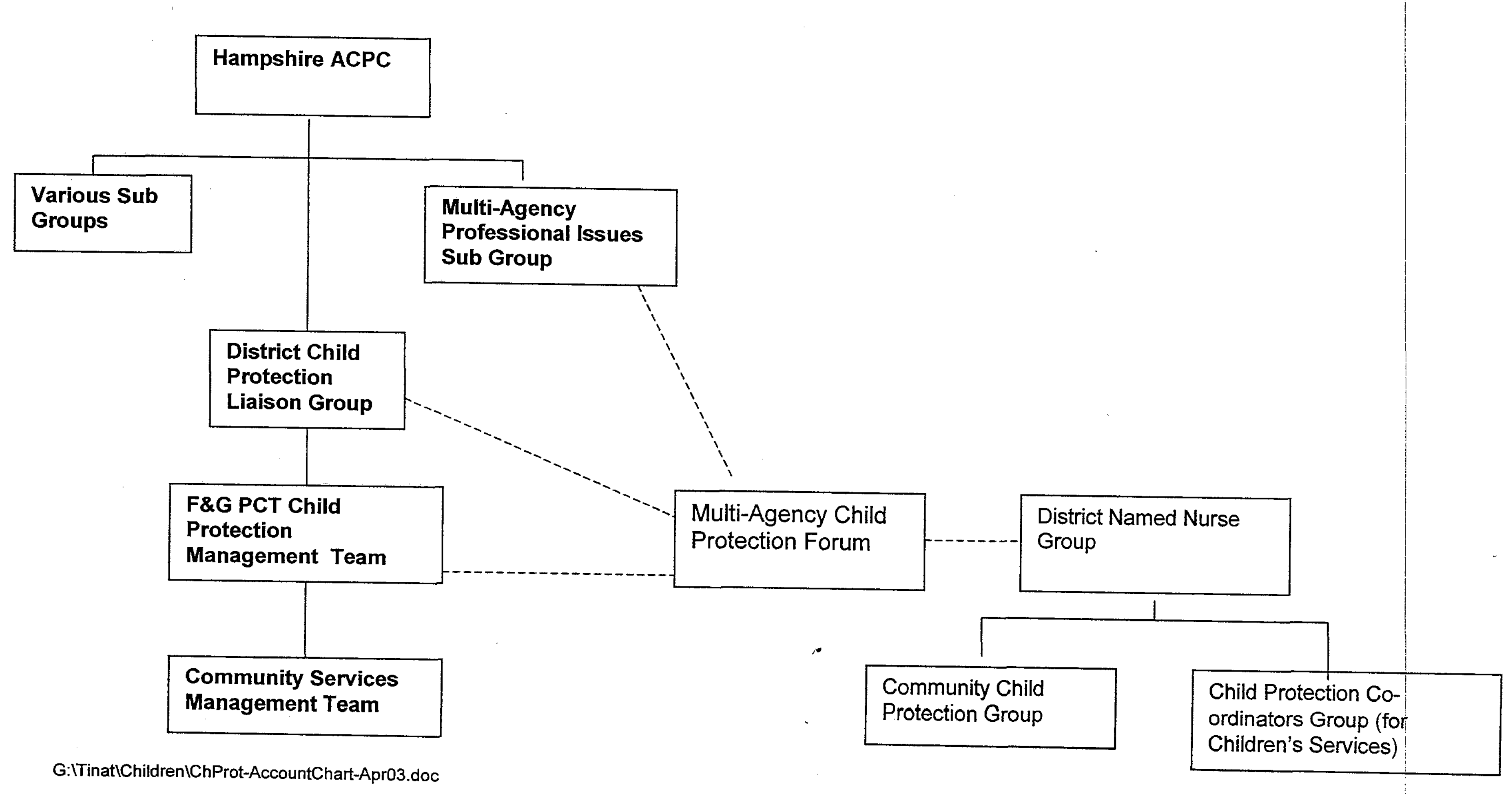
Rec'n	Priority	Recommendation	Action	Date	Accountability
			paper to each GP with receipt		
66	1	When a child has been examined by a doctor and concerns about deliberate harm have been raised, no subsequent appraisal of these concerns should be considered complete until each of the concerns has been fully addressed, accounted for and documented. (Paragraph 9.60)	Training Issue/ and briefing paper to each GP with receipt	April 03	Child Protection Management team
68	1	When concerns about the deliberate harm of a child have been raised, doctors must ensure that comprehensive and contemporaneous notes are made of these concerns. If doctors are unable to make their own notes, they must be clear about what it is they wish to have recorded on their behalf. (Paragraphs 9.72 and 10.30)	See 66	April 03	Child Protection Management Team
69	1	When concerns about the deliberate harm of a child have been raised, a record must be kept in the case notes of all discussions about the child, including telephone conversations. When doctors and nurses are working in circumstances in which case notes are not available to them, a record of all discussions must be entered in the case notes at the earliest opportunity so that this becomes part of the child's permanent health record. (Paragraph 9.95)	See 66 Health Visitor/School Nurse to check		Child Protection Management Team
77	1	All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide social services with a written statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood. (Paragraph 10.162)	See 66		Child Protection Management Team
67	2	When differences of medical opinion occur in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion and if necessary, obtaining a further opinion. (Paragraph 9.65)	See 66		Child Protection Management Team

Rec'n	Priority	Recommendation	Action	Date	Accountability
		Health Care Services for whom contact with children is a regular feature of their work. (Para 12.29)	Free training for nurses, PGEA for doctors		

* Check at annual audit

CHILD PROTECTION MEETINGS AND ACCOUNTABILITY CHART

There are four multi-agency Area Child Protection Committees (ACPCs): Hampshire, IOW, Portsmouth and Southampton. The Health Representatives from these groups meet regularly on a district-wide basis.



The Role and Responsibilities of the Designated Doctor and Nurse

The Designated Doctor and Nurse have a District Wide responsibility that includes all doctors and healthcare staff.

The Designated Doctor

The designated doctor post is a requirement of the Department of Health. The post holder has responsibilities across the district

The Designated Nurse

The designated nurse post is also a Department of Health requirement. The post holder again has responsibilities across the district.

The Named Paediatrician for Child Protection

This is a district wide role.

The Named Doctor (GP) for Child Protection

The Named Doctor (GP) will be supported by the Designated and Named Professionals to gain experience in children's health and development, the nature of child maltreatment and local arrangements for safeguarding children and promoting their welfare. The Named Doctor (GP) will work with the Named Nurse for the Trust and their responsibilities are:

The Role and Responsibilities of the Named Doctor (GP) and Nurse

The role of the Named Professionals is a Department of Health requirement for all Trusts who provide services for children and families. Designated Professionals and identified community paediatricians will provide support to these roles.

Their responsibilities include:

- Ensuring support and supervision of all Trust staff occurs.
- Ensuring staff have access to training
- Participating in Inter-agency training
- Membership of the local Inter-agency Forum and District Child Protection Liaison Groups
- As a core member of the Trust Child Protection Management Team they will contribute to Part 8 Reviews as necessary, ensuring Part 8 action plans are implemented and monitored.

Attachment D

Fareham and Gosport NHS
Primary Care Trust

AGENDA ITEM

BOARD SUMMARY PAPER

Title
Quality Team Performance Indicators **PART 1**

Background and Summary

Background and Summary

This report provides performance indicators for the Board in the areas of Risk Events and Complaints received during quarter 4 (1 January – 31 March 2003).

Recommendations

To: Note

Date: 11 April 2003

Paper Prepared by

Ann Turner, Complaints Manager and Caroline Harrington, Risk & Litigation Manager

Complaints – 1st January to 31st March 2003

Fareham and Gosport Primary Care Trust received six written complaints in the quarter 1st January to 31st March 2003. Issues raised were:

- Impact of reconfiguration of the podiatry service
- Discharge arrangements for a patient on Sultan ward
- Drug regime for learning disabilities client
- Appropriateness of level of care given by Child and Family Therapy team
- Podiatry appointment time excessive
- Appropriateness of advice given to member of public at Outpatients, GWMH

A further complaint remains ongoing from the previous quarter.

Two requests for Independent Review were received. Both relate to the care and treatment provided to patients at Gosport War Memorial Hospital.

Date Received	Date Acknowledged (No. of days)	Response Sent (No. of days)	Reason for Delay
22.1.03	28.1.03 (4)	4.4.03 (52)	Discussion of complaint included in meeting previously set up. Issues resolved.
24.1.03	28.1.03 (2)	19.2.03 (18)	
19.2.03	20.2.03 (1)	13.3.03 (16)	
27.02.03	28.2.03 (1)		Further correspondence received and meeting set up with consultant. Outcome awaited
7.3.03		3.4.03 (19)	
11.3.03	13.3.03 (2)	4.4.03 (18)	

Five verbal complaints were reported centrally. Three included issues around transport, one about the appropriateness of information given by a podiatrist and the other raised a concern about the Investing in your Health publication. These complaints were all dealt with by staff at the time and no written complaints were subsequently received

A further 9 written queries were dealt requesting information about:
- Provision of digital hearing aids
- Local Development Plan in relation to diabetes (2 letters)
- Homeopathic treatment for CFS/ME
- Access to podiatry services (2 letters)
- Ongoing training and development of GPs
- Access to NHS dental treatment
- Care given to a deceased relative

In addition to these 5 letters, 2 e-mails and 5 telephone calls were received complaining about the lack of NHS dental provision in the Fareham and Gosport PCT area.

Family Health Service Practitioner (FHS) Complaints

During this period 2 letters were received relating to GP practices and 1 relating to a pharmacy working in the PCT area. In line with the NHS complaints procedure, correspondence was forwarded to the appropriate practice to be dealt with in accordance with in-house complaints procedures.

One Independent Review Panel took place to consider the care and treatment provided by a General Practitioner. The report is awaited.

One request for independent Review in relation to a GP complaint was received. The Convener has yet to reach a decision in respect of this request.

Complaints Reform

A document entitled NHS Complaints Reform 'Making Things Right' (DoH 2003) has been published. This document sets the Government's plans to improve the NHS complaints procedure. The key points from this are:

- Changing attitudes to complaints so they are valued for the focus they give to what needs to improve, leading to more positive relationships with patients
- Dealing with complaints and concerns positively as an integral part of service provision, so that problems don't escalate unless they need to.
- Radical reform to the Independent Review stage – placing responsibility for it with the new Commission for Healthcare Audit and Inspection (CHAI)
- Making information about complaints and their causes an integral part of the system to assure safe, high quality care with is constantly improving.

The programme for reform of the NHS complaints procedure is dictated by the need for primary legislation to establish CHAI and will therefore not be fully operational before April 2004. Further guidance will be issued in due course.

The Health Service Ombudsman has published a volume of Investigations Completed between August and November 2002. Many of the cases illustrate the ways poor communication contributes to problems, which may result in sub-standard care and treatment, being given to a patient. The lack of communication between medical and nursing staff and with patients and their carers are also featured. A summary of this is being prepared and will be circulated.

Ann Turner
Complaints Manager
11th April 2003

Quarter 4 Risk Event Statistics
1January – 30 April 2003

High Severity Incidents by Service and Type

Service	Patient Incidents	Staff Incidents	Property Incidents	Incident Details	Action
District Nursing			2	1. *Jubilee Surgery, Titchfield- 22.02.03* Theft of computer and monitor from District Nursing office. Cupboard broken into and 2 other unlocked and open.	Police informed and investigated. Locks were changed and pressure pad installed to HV room. Data protection co-ordinator informed.
				2. *Jubilee Surgery, Titchfield – 27.03.03* Theft of newly installed HV computer from DN/HV room. No entry made this time to locked DN room.	Still waiting to find out if cupboard locks to be changed or new cupboards to be supplied in the room following last theft. Awaiting Estates.
Learning Disabilities - Health	1			**Challenging behaviour – 01.02.03** A fight between two clients involved slapping, punching, and attempting to bite, with one client throwing a chair.	This is an on-going risk because of the client mix. Line manager informed and increased staff awareness will try to reduce the likelihood of future incidents.

		1		**Slip or trip – 26.02.03** Staff member tripped on chair resulting in a swollen ankle.	Staff member taken to QAH A&E Department – fracture to right ankle. Plastered from foot to knee.
			1	**Medication not available – 16.01.03** During review of medication care plan of client it was discovered that there was a discrepancy of 2 tablets missing. Despite exhaustive search of all records and of discarded medication, no apparent reason for discrepancy could be found.	Discussed with RN's 23.01.03 regarding the policy relating to controlled drug storage and recording. To be checked daily by RN on duty until further notice.
Learning Disabilities - Social			1	**Security – Property Missing <£1000 – 27.01.03** Front door was open. Staff member's handbag found to be missing from office.	Police informed of theft. Credit cards stopped and search made of local area. Everyone reminded to be extra vigilant.

Please note
There were no **high** severity incidents in this period recorded for: -
Community Hospitals, Physiotherapy, Occupational Therapy, Child & Family Therapy, Podiatry, CES, Learning Disabilities – Community/Health.

PCT's most frequently reported incidents (Low/Medium) – Community Services

Service	Low/medium incident trends	Comment	Action
CS/CH	1. Slips/Trips/Falls & Found on floor	Q4 shows a significant increase in the number of falls – Q1 = 57, Q2 = 77, Q3 = 49, Q4 = 77.	Continue to monitor.
CS/CH	2. Community Hospitals staff shortages on wards	Q1 = 6, Q2 = 22, Q3 = 3, Q4 = 5 (low), 3 (med) and 2 (low near miss).	Recruitment work on-going.
LD	3. Assaults – client on client and client on staff	Assaults have remained at about the same level compared to last quarter. Q1 = 35, Q2 = 69, Q3 = 50, Q4 = 51	Service model under review to address these issues and provide more appropriate support to the most challenging clients.
LD	4. Challenging Behaviour	There have been 50 reports of challenging behaviour in this quarter. Q1 = 20, Q2 = 20 Q3 = 28, Q4 = 50	Service model under review to address these issues and provide more appropriate support to the most challenging clients.

New Scoring matrix for Risk Events and Risk Assessments

Fareham and Gosport PCT, along with Portsmouth City and East Hampshire PCTs' were hoping for national guidance on scoring risks from the National Patient Safety Agency, but it has now been confirmed that there will not be any national guidance. Therefore the PCTs are now planning to re-launch the scoring process for Risk Events and Risk Assessments during 2003-04. New scoring will be launched in order to improve consistency of scoring all types of risks. This will be implemented with the launch of new forms for both incident reporting and risk assessments, supported by comprehensive training on the new scoring system.

Fareham and Gosport NHS
Primary Care Trust

AGENDA ITEM

BOARD SUMMARY PAPER

Title
Quality Team Performance Indicators **PART 2**

Background and Summary

Background and Summary

This report provides performance indicators for the Board in the areas of Legal Claims received, on-going and closed during quarter 4 (1 January – 31 March 2003).

Recommendations

To: Note

Date: 11 April 2003

Paper Prepared by

Caroline Harrington, Risk & Litigation Manager

LITIGATION CURRENT STATUS SUMMARY

11 March 2003

Employer's Liability Claims

Ref:	**FGEL003/03**
Letter of Claim Received:	18 January 2002
Date of Incident:	14 November 2000
Nature of claim:	HCSW injured back during SCIP Refresher Course
Current Position:	Liability denied April 2002 – awaiting response from Claimant's Solicitors
Estimated year of settlement:	2002/03
Estimated Quantum:	£9,000

Ref:	**FGEL006/01**
Letter of Claim Received:	29 July 2002
Date of Incident:	12 December 2001
Nature of claim:	Hand injury due to manual handling of elderly patient
Current Position:	Liability denied Nov 2002 – awaiting response from Claimant's Solicitors
Year of Settlement:	2002/03
Estimated Quantum:	£15,000

Ref:	**FGEL007/02**
Letter of Claim Received:	11 October 2002
Date of Incident:	12 April 2001
Nature of claim:	Shoulder and head injuries allegedly caused by faulty hydraulic lift
Current Position:	Liability denied, case referred to NHSLA
Estimated year of settlement:	2003/04
Estimated Quantum:	£13,000

Ref:	**FGEL008/04**
Letter of Claim Received:	15 October 2002
Date of Incident:	18 March 2002
Nature of claim:	Injury to (R) arm whilst restraining client
Current Position:	Initial investigation
Estimated year of settlement:	2003/04
Estimated Quantum:	Information not sufficient to estimate quantum

Ref:	**FGEL009/06**
Letter of Claim Received:	9 December 2002
Date of Incident:	14 March 2000
Nature of claim:	Back injury caused by challenging LD client
Current Position:	Liability denied March 2003, case referred to NHSLA
Estimated year of settlement:	2003/04
Estimated Quantum:	£8,500

Ref:	**FGEL010/07**
Letter of Claim Received:	8 January 2003
Date of Incident:	26 June 2002
Nature of claim:	Assaulted by LD client
Current Position:	Initial investigation, case referred to NHSLA
Estimated year of settlement:	2003/04
Estimated Quantum:	£9,000

Public Liability Claims

No Public Liability claims at present

Clinical Negligence Claims

No Clinical Negligence Claims at the present time but a *potential claim* has been received and the NHSLA have been notified.

Closed Claims

Ref:	**FGEL005/05**
Letter of Claim Received:	5 April 2002
Date of Incident:	17 September 1999
Nature of claim:	School Nurse injured knee lifting scales into car boot
Current Position:	Liability denied – no response from Claimant's Solicitors
Year of Settlement:	2002/03
Estimated Quantum:	£15,000
Outcome:	**CASE CLOSED 18/02/03 - Claimant out of time** **Damages: Nil** **Claimant's costs: Nil** **Defence costs: Nil** **TOTAL: Nil**

Ref:	**FGEL004/06**
Letter of Claim Received:	19 April 2001
Date of Incident:	October 1999 – November 2000
Nature of claim:	Back injury caused by inadequate sleeping facilities in community home
Current Position:	Closed
Year of Settlement:	2002/03
Estimated Quantum:	Reserve £16,000 (damages and costs)
Outcome:	**CASE ?WITHDRAWN 02/10/02** **Damages: Nil** **Claimant's costs: Nil** **Defence costs: £1650** **TOTAL: £1650**

Ref:	**CCFG/EL001**
Letter of Claim Received:	18 July 2000
Date of Incident:	18 November 1999
Nature of claim:	Back injury caused by LD client falling on her whilst they both descended the stairs
Current Position:	Closed
Year of Settlement:	2002/03
Estimated Quantum:	£10,000 (costs)
Outcome:	**CASE CLOSED (SETTLED) 26/06/02** **Damages: £1000** **Claimant's costs: £3,500** **Defence costs: £2,650** **TOTAL: £7,150**

Ref: **CCFG/EL002**
Letter of Claim Received: 5 April 2000
Date of Incident: 16 November 1998
Nature of claim: Cracked tooth while eating chicken & pistachio sandwich bought from staff canteen
Current Position: Closed
Year of Settlement: 2002/03
Estimated Quantum: £3000 (costs
Outcome: **CASE CLOSED (SETTLED) 05/07/2002**
Damages: £1,527.50
Claimant's costs: £1,132.50
Defence costs: £1,200
TOTAL: £3,860.00

Ref: **FGPL001/04**
Letter of Claim Received: 3 January 2002
Date of Incident: 29 November 2001
Nature of claim: Cracked two teeth on stone while eating curry prepared by Hospital
Current Position: Settled
Year of Settlement: 2002/03
Claimant's Damages & costs: £1000
Estimated defence costs: £1000
Outcome: **CASE CLOSED (SETTLED) 09/09/02**
Damages: £1000
Claimant's costs: included in damages
Defence costs: £1,800
TOTAL: £2,800

LITIGATION CURRENT STATUS SUMMARY

11 April 2003

Employer's Liability Claims

Ref:	**FGEL003/03**
Letter of Claim Received:	18 January 2002
Date of Incident:	14 November 2000
Nature of claim:	HCSW injured back during SCIP Refresher Course
Current Position:	Liability denied April 2002 – awaiting response from Claimant's Solicitors
Estimated year of settlement:	2002/03
Estimated Quantum:	£9,000

Ref:	**FGEL006/01**
Letter of Claim Received:	29 July 2002
Date of Incident:	12 December 2001
Nature of claim:	Hand injury due to manual handling of elderly patient
Current Position:	Liability denied Nov 2002 – awaiting response from Claimant's Solicitors
Year of Settlement:	2002/03
Estimated Quantum:	£15,000

Ref:	**FGEL007/02**
Letter of Claim Received:	11 October 2002
Date of Incident:	12 April 2001
Nature of claim:	Shoulder and head injuries allegedly caused by faulty hydraulic lift
Current Position:	Liability denied, case referred to NHSLA
Estimated year of settlement:	2003/04
Estimated Quantum:	£13,000

Ref:	**FGEL008/04**
Letter of Claim Received:	15 October 2002
Date of Incident:	18 March 2002
Nature of claim:	Injury to (R) arm whilst restraining client
Current Position:	Initial investigation
Estimated year of settlement:	2003/04
Estimated Quantum:	Information not sufficient to estimate quantum

Ref:	**FGEL009/06**
Letter of Claim Received:	9 December 2002
Date of Incident:	14 March 2000
Nature of claim:	Back injury caused by challenging LD client
Current Position:	Liability denied March 2003, case referred to NHSLA
Estimated year of settlement:	2003/04
Estimated Quantum:	£8,500

Ref:	**FGEL010/07**
Letter of Claim Received:	8 January 2003
Date of Incident:	26 June 2002
Nature of claim:	Assaulted by LD client
Current Position:	Initial investigation, case referred to NHSLA
Estimated year of settlement:	2003/04
Estimated Quantum:	£9,000

Public Liability Claims

No Public Liability claims at present

Clinical Negligence Claims

No Clinical Negligence Claims at the present time but a *potential claim* has been received and the NHSLA have been notified.

Closed Claims

Ref:	**CCFG/EL005**
Letter of Claim Received:	5 April 2002
Date of Incident:	17 September 1999
Nature of claim:	School Nurse injured knee lifting scales into car boot
Current Position:	Liability denied – no response from Claimant's Solicitors
Year of Settlement:	2002/03
Estimated Quantum:	£15,000
Outcome:	**CASE CLOSED 18/02/03 - Claimant out of time** **Damages: Nil** **Claimant's costs: Nil** **Defence costs: Nil** **TOTAL: Nil**

Ref:	**CC/FGEL004**
Letter of Claim Received:	19 April 2001
Date of Incident:	October 1999 – November 2000
Nature of claim:	Back injury caused by inadequate sleeping facilities in community home
Current Position:	Closed
Year of Settlement:	2002/03
Estimated Quantum:	Reserve £16,000 (damages and costs)
Outcome:	**CASE ?WITHDRAWN 02/10/02** **Damages: Nil** **Claimant's costs: Nil** **Defence costs: £1650** **TOTAL: £1650**

Ref:	**CCFG/EL001**
Letter of Claim Received:	18 July 2000
Date of Incident:	18 November 1999
Nature of claim:	Back injury caused by LD client falling on her whilst they both descended the stairs
Current Position:	Closed
Year of Settlement:	2002/03
Estimated Quantum:	£10,000 (costs)
Outcome:	**CASE CLOSED (SETTLED) 26/06/02** **Damages: £1000** **Claimant's costs: £3,500** **Defence costs: £2,650** **TOTAL: £7,150**

Ref:	**CCFG/EL002**
Letter of Claim Received:	5 April 2000
Date of Incident:	16 November 1998
Nature of claim:	Cracked tooth while eating chicken & pistachio sandwich bought from staff canteen
Current Position:	Closed
Year of Settlement:	2002/03
Estimated Quantum:	£3000 (costs
Outcome:	**CASE CLOSED (SETTLED) 05/07/2002** **Damages: £1,527.50** **Claimant's costs: £1,132.50** **Defence costs: £1,200** **TOTAL: £3,860.00**

Ref:	**CCFG/PL001**
Letter of Claim Received:	3 January 2002
Date of Incident:	29 November 2001
Nature of claim:	Cracked two teeth on stone while eating curry prepared by Hospital
Current Position:	Settled
Year of Settlement:	2002/03
Claimant's Damages & costs:	£1000
Estimated defence costs:	£1000
Outcome:	**CASE CLOSED (SETTLED) 09/09/02** **Damages: £1000** **Claimant's costs: included in damages** **Defence costs: £1,800** **TOTAL: £2,800**

MINUTES OF THE FAREHAM & GOSPORT RISK MANAGEMENT COMMITTEE

HELD ON 9TH APRIL 2003 3 - 5PM

FAREHAM REACH BOARD ROOM

Present: Alan Pickering (Chair) (AP), Fiona Cameron (FC), Anne Hollis (AH), Derek Hayes (DH), Jane Parvin (JP), Ian Taylor (IT), Caroline Harrington (CH), Michael Croucher (MC)

		Action/ Attachment
1.	**Apologies** Diane Wilson, Rachael Boyns, Lucy Docherty, Sue Pittam **Non attenders** Dr Garratt	
2.0	**Minutes of previous meeting**	
2.1	The previous meeting's minutes were agreed as an accurate record.	
2.2	CH stated that the date should read 5th February 2003 rather than 2002.	
2.3	MC stated that he had sent his apologies prior to the February meeting.	
2.4	AP/CH confirmed that the Risk Management Strategy had been formally ratified by the PCT Board at the March meeting (Item 3.3).	
2.5	AP confirmed that he will be addressing the issue of funding for Health and Safety risks during the 2003-04 allocations (Item 10.5)	
2.6	CH stated that Sue Pittam, Practice Manager at Fareham Health Centre has kindly agreed to attend the Risk Management Committee, although had to give apologies for this meeting.	
3.0	**Controls Assurance**	
3.1.1	Controls Assurance Board Report CH presented the first draft Controls Assurance Board Report, which sets out the PCT's position regarding Controls Assurance scores, and the methodology used to assess each Standard.	
3.1.2	The report was discussed and Standards scoring less than 75% were looked at in detail (see attached). It was agreed that generally there were no surprises, and that many of the scores would have improved already, for example Risk Management/complaints and Data Protection training has now commenced (part of the induction programme), but was not in place as at 31 March 2003 and was therefore not able to be counted in the scores for those Standards.	BLUE
3.1.3	It was decided that in order for the Committee to present recommendations to the Board regarding the PCT's top ten highest risks, any total risk score 10 or more would be discussed at the June Risk Management Committee in order for the recommendations to be agreed and incorporated into the annual Risk Management Report, which is planned to be submitted to the June Board.	

3.2 Internal Audit Report
CH confirmed that AP and CH have commented on Internal Audit's discussion document which suggested 4 recommendations to improve implementation of Controls Assurance.

3.3 Monitoring and review of action plans
It was agreed that the Lead Directors would be responsible for updating the Committee on actions completed/on-going relating to the Action Plans resulting from the Controls Assurance assessments. This monitoring will occur on a 6 monthly basis, CH will distribute an amended action plan to each Director in August, ready for feedback to September's Risk Management Committee.

4.0 Clinical Negligence Scheme for Trusts (CNST)/Risk Pooling Scheme for Trusts (RPST)

4.1 Excesses and delegated limits within the RPST
AP updated the group on the new excesses and delegated limits within the RPST, which take effect from April 2003.

4.2 NHSLA PCT Bulletin
CH mentioned that the NHSLA PCT Bulletin may be of interest to members. See attached.

4.3 NHSLA 'homework'
CH informed the group that the next NHSLA workshop was due to be held in London on 28 May 2003. The NHSLA workshop 'homework' was discussed and it was agreed that CH would represent the PCT at the May workshop. — **CH**

5.0 Emergency Planning

5.1 Health Protection Agency – CH informed the group that the new Health Protection Agency had been established as from 1 April 2003. The HPA will have responsibility for a range of health protection functions that were previously performed by the Public Laboratory Service, the Microbiological Research Authority, the National Focus for Chemical Incidents, Regional Service Provider Units and the National Poisons Information Service, Consultants in Communicable Disease Control (CCDC) and other health protection staff and regional health emergency planning advisers and their staff.

5.2 Black Knight – AP/CH gave feedback on the Black Knight Exercise in February. This was a multi-agency exercise planned by Hampshire Police to test all organisations' preparedness to respond to a major incident. This 48 hour exercise specifically tested ability to respond to CBRN (Chemical, Biological, Radiological, Nuclear), hostage, and mass casualty incidents.

Feedback from both Police and Strategic Health Authority colleagues confirms that although there are a number of lessons, the Health input (JHAC – Joint Health Advisory Cell) worked extremely well.

5.3 Directors workshop – CH confirmed that the actions arising from February's pan-PCT Directors workshop were in hand. The EPLO's (Emergency Planning Liaison Officers) had met and were taking the actions forward.

6.0 Risk in Primary Care

6.1 Risk Assessment Training – CH stated that one Risk Assessment Training session for Primary Care (attended by Practice Managers) had been held at Fareham Reach with good attendance, and another one is planned.

6.2	Incident Reporting – CH reported that one of the Fareham Practices had asked for information on reporting an incident to the PCT. CH is liaising with the Practice to take this forward.	
7.0	**Assurance Framework Guidance** DH gave a brief outline of the recently issued DoH document 'Building the Assurance Framework: *A Practical Guide for NHS Boards*'. FC/AP stated that Fred Bendall, Audit Commission had been invited to give a presentation on this document to Board members on 10 April.	
8.0	**Clinical Governance** The minutes of the meeting held on 12th March 2003 were not available.	
9.0	**Health and Safety** The minutes of the Trust-wide Health & Safety Committee held on 20th March 2003 were noted.	WHITE
9.1	CH confirmed that following January's Health & Safety Committee which highlighted poor communication/performance by the Estates Department, at the March meeting 2 representatives from Estates attended, and Service issues were discussed in depth.	
9.2	CH stated that the Health & Safety Committee seemed to be working well, and AH who also attends, agreed. JP reported that Union representatives had commented that the Committee is working well.	
10.0 **10.1**	**Any other business** Learning Disability Safety Harness – CH reported that the Learning Disability Service had been looking into a harness to be made for a client who is unable to sit or stand, to minimise risk of injury whilst out in the house vehicle. Although the PCT has taken advice from the PCT's Solicitors and the fleet insurers have agreed that this is covered by the fleet insurance, there is a higher risk than usual due to the fact that the harness will not be crash tested. It was requested that the Risk Management Committee acknowledge the risk to both the client, and the PCT if there is an accident resulting in injury to the client. FC commented that a Risk Assessment would need to be completed, including a focus on staffing levels when taking this client out in the Trust vehicle. The Committee agreed that the risk was one the PCT was willing to take in order to allow this client to go out of the house. CH to confirm this with Nicola Hepple, Mike Drake, Diane Wilson.	
10.2	Audit of District Transport – This issue was discussed under Controls Assurance (Fleet management Standard). Adapted vehicle group to liaise with AP regarding concerns relating to the performance of District Transport.	
13.0	**Date and Time of next meeting** Wednesday 4th June 2003 **9 – 11am**, Board Room, Fareham Reach – **please note earlier time**	

Future meeting dates are :

Wednesday 6th August 2003 **9 – 11am**, Board Room, Fareham Reach
Wednesday 8th October 2003 **2 – 4pm**, Board Room, Fareham Reach
Wednesday 10th December 2003 **2 – 4pm**, Board Room, Fareham Reach

Distribution	For Information
Michael Croucher	Code A, Prescribing Adviser
Alan Pickering	Ann Turner, Complaints Manager
Derek Hayes	Nicky Heyworth, Clinical Governance Manager
Fiona Cameron	Clinical Governance Committee
Anne Hollis	Fareham & Gosport PCT Trust Board
Ian Taylor	Chief Executive, East Hants PCT
Diane Wilson	Chief Executive, Portsmouth City PCT
Dr Garratt	Lucy Docherty
Rachael Boyns	Code A Numerica (Internal Audit for Controls Assurance)
Jane Parvin	Code A IOW, Portsmouth & SE Hants Health Authority
Caroline Harrington	Fareham & Gosport PCT Audit Committee

Nicola Hepple and Code A re. Items 10.1 and 10.2

NB. Attachments distributed during meeting are only attached for Apologies/non-attenders only.
Information available from upon request.

Attachment E

Infection Control Accountability Chart

PCT Board

PCT Chief Executive

Director Public Health

Risk Management Committee

Clinical Governance Committee

Operational Management Group / Primary Care Development Group

Joint Trusts Infection Control Group

Accountable to

Links with

PHT Infection Control Committee

Infection Control Link Persons

Health Protection Agency (HPA)

PHT Infection Control Team (ICT)

Provides services to:
Independent contractors:
General Practitioners
General Dental Practitioners
Optometrists
Community Pharmacists

Provides services to:
Elderly Medicine
Elderly mental health
Community Hospitals
Health Centres
Community Services
(Dental, podiatry, etc)