Fareham and Gosport NHS
Primary Care Trust

CHI IMPLEMENTATION STEERING GROUP MEETING HELD AT GOSPORT WAR MEMORIAL HOSPITAL

Notes of the Meeting held on Friday 31 October 2003

Present: Fiona Cameron
Judith Goodall (for Paula Turvey)
Lesley Humphrey (for Neil Stubbs)
Ian Reid
Jane Parvin
Hazel Bagshaw
Jeff Watling
Ann Stewart
Nigel McFettridge
Kathryn Rowles (Chair)
Noreen Kickham

		Action
1	**Notes of Previous Meeting** Agreed as correct record	
2	**Matters Arising** **2(i) Collation of Evidence** Kathryn indicated that the collation of evidence was progressing well and that the outstanding issues would be picked up in the Progress Report (item 4 below) **2(ii) Co-ordination/Monitoring of Implementation Plan** There was brief discussion of how best to sustain the CHI Action Plan Implementation process. Kathryn indicated that responsibility for monitoring the sustained implementation of the Plan would pass to the PCT's Clinical Governance Committee. Group members agreed that the timing for this handover should be reviewed after progress reporting (see item 4)	
3	**Serious Unexpected Incident (Gosport Ward Memorial Hospital – 22 October 2003)** Kathryn suggested it would be appropriate to provide a brief report to the group about the Serious Unexpected Incident at Gosport War Memorial on 22 October 2003. Members of the Group discussed the linkage/relevance of the incident to the wider Gosport War Memorial CHI Implementation Agenda. It was agreed that the Serious Unexpected Incident was relevant to the drugs administration issue highlighted in the wider Implementation Plan.	

Fiona reported an outline of the incident to the Group

- Incident occurred on 22 October 2003 at Gosport War Memorial Hospital
- Incorrect administration of dose of diamorphine to a terminally ill patient
- Error was immediately identified and reported to Doctor and Manager by the two nursing staff involved
- Relatives were immediately offered reversal drug, this was declined
- Critical Incident Form was completed
- Two nurses involved have been placed under supervision
- Police interviewed staff involved. Case referred to CPS
- Issues were identified around the competency and training provided to the nurses that need to be addressed
- Serious Unexpected Incident reporting to the Strategic Health Authority had not been implemented. This was now being completed. Nigel requested that this be submitted as soon as possible
- A review of the process for Serious Unexpected Incident reporting within the PCT and reporting up to the Strategic Health Authority was being undertaken as a matter of urgency

It was agreed that the Incident has tested Fareham and Gosport PCT systems. The Critical Review report would provide verification of systems that had worked well and areas where further improvement was needed.

4 Progress Report – Implementation Plan

The Group went through the Implementation Plan and progress as at 31 October 2003 is outlined in the report attached.

5 Transition Arrangements to Clinical Governance Committee

The Group discussed the transition of responsibility for monitoring implementation of the Action to the PCT's Clinical Governance Committee. Nigel indicated that there was still more progress to be achieved on Recommendations 3 - 6. It was agreed that a small group be set up as a matter of urgency to conclude these recommendations.

Members would comprise:

Ian Reid
Jeff Watling
Fiona Cameron
Sue Chan
Hazel Bagshaw
Nigel McFettridge
Kathryn Rowles / Noreen Kickham

Responsibility for progressing/sustaining implementation around Recommendations 1 and 7 - 22 would be formally handed over to the Clinical Governance Committee.

Members of the Group were thanked for their contributions to the Implementation Steering Group.

Please note the meeting scheduled for the 28th November 2003 is therefore cancelled.