

3/1/02. CH1 steering Grp mtg.

\* Paid policy - 5 copies -> Eileen for 12pm Fri.

Clarify ~~round~~? A. Lord doing Tues / Thurs word round.

\* Penny Wells - phone to see if she wants to talk to Stone - Fri 4-5pm.

\* 9.30 pre-mtg in 'chapel' for steering grp/board.

(CH) \* ~~Sarnies~~ - 5.30pm -> chapel of rest Mon 7th

\* Copy of schedule to everyone - Fri/Mon.

? check whether interviewees can take pen + paper in i them.

Dr. Q Dyard Tues pm.

A. Lord Daed wed pm

Mathew Daed Thurs pm.  
Ruhel

## Schedule of times for ward rounds, meals, and handovers

### SULTAN WARD

GP visits - any time from midday - 2pm (come after their morning surgeries)

Meal times -    Breakfast    08:00  
                          Lunch            Midday  
                          Supper         17:45

Handovers -    07:30 Night staff to AM staff  
                          12:15 AM to PM staff but only those who work long shifts  
                          13:30 AM to PM  
                          14:15 AM to PM  
                          20:15 PM to night staff

Handovers confusing here due to ward having a large number of part time staff

### DRYAD WARD

Consultant round - Tuesday 13:30 - 14:00 start

Handover -    07:30 night staff to AM staff  
                          14:15 AM to PM staff  
                          20:15 PM to night staff

Meal Times - breakfast - 08:00  
                          lunch - 12:15  
                          supper - 17:30

### DAEDALUS WARD

#### Consultants rounds

Dr Lord - Mondays Multi-disciplinary Team meeting 14:00 until 14:45 followed by ward round.

Dr Holmes - Thursday Multi-disciplinary Team meeting 14:00 until 14:45 followed by ward round.

Meal Times - Breakfast - 08:30  
                          Lunch    - midday  
                          Supper - 17:45

Handovers    07:30 Night to AM staff  
                          13:00 AM to PM staff  
                          15:30 For part time staff  
                          20:15 PM to night staff

# Today's Priorities

- 1 CH1 - <sup>E-mail schedule to CH1.</sup> ~~Vanda Drapering~~
- 2 - Gill Hamblin - Sick
- 3 - Mick Conroy - ~~ok 20?~~
- 4 requested as interview. weds 9<sup>th</sup> 10.30 - 11.15.
- 5
- 6
- 7
- 8
- 9
- 10

~~Obs for 6.~~

E mail Julie Miller,

Change to Ward rounds w/c 7/1/02.  
The following are the ward rounds times + dates for Dryad + Daedalus.

Dryad 8/1/02 Tues Dr Quereshi ~~MD~~

Daedalus 9/1/02 Wed Dr Lord  
10/1/02 Thurs Dr Pullyel.

owing to Dr Lord's interview on the mon pm her ward round will now be on weds.

Carissie Turner

CHI review, but in addition included documents relating to the investigation and requests for specific audit reports on pathology services and human resource policies.

During the CHI site visit the investigation team split into two and secretarial or administrative support was crucial in the set-up and management of the rooms that were used for the interviews. As a number of matters emerged during the CHI incident team interviews, the original timetable needed rearranging and subsequent appointments had to be rescheduled. Specific administrative time for each room was essential in making this happen, sometimes at a few minutes' notice while managing the disappointment of those waiting. The learning point for us was to allocate separate administrative support to each room, with particular regard to the interpersonal skills of the administrative staff and their ready access to a telephone and telephone directory.

### **Brief the staff before, during and after interviews**

CHI provided briefing information, and we made sure that it was given to every member of staff who was to be interviewed by the investigation.

Personal contact with those about to be interviewed was also important and the director of nursing undertook this. In response to a request, a special incident team meeting was reconvened to allow those people invited for interview to talk about what type of questions CHI might ask and their fears and worries about being interviewed.

Similarly, after the interview it was important that someone was available to meet with those interviewed to ask how it had gone, if there was anything they were still worried about and so on. Perhaps most importantly, as different interview slots were changed, it was important to tell people why the changes had happened, so that they still felt their contribution was valuable and so that their frustrations about spending a lot of time rearranging their clinical work in order to be interviewed by CHI were heard.

### **Be prepared to suggest what should appear in the report**

Each person interviewed by CHI was asked what they wanted to see in the report. Giving some consideration to what would benefit patients or what would assist others who need to carry

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out a similar exercise helped people to influence the final report in a meaningful way.

### **Conclusions**

No one can know whether the exploring of clinical concerns may unfold into a wide-ranging clinical incident necessitating the external scrutiny of a body like CHI. The suggestions above are those which were useful for a trust first undertaking such a review and then preparing for an investigation. Above all, the focus of any review or investigation undoubtedly has to be on what will make a difference to patients.

# Lessons from investigations by the Commission for Health Improvement

**Margaret Tozer**

*Investigations Manager, Commission for Health Improvement, London, email [margaret.tozer@chi.nhs.uk](mailto:margaret.tozer@chi.nhs.uk)*

- Locum doctors should be subject to the same system of clinical audit and performance monitoring as permanent doctor colleagues.
- In the evolving field of heart and lung transplantation, applying to a small number of very ill patients, the formal amendment of protocols and patient booklets regarding selection criteria is essential, and must be the subject of close multi-disciplinary audit.
- Effective complaints and whistleblowing policies are an essential feature of assuring the quality of patient care.

- Clinical governance is not designed to detect professional misconduct or criminal activity.

A function of the Commission for Health Improvement (CHI) is to investigate serious system failures in the NHS. Such investigations can stem from:

- a request from the Secretary of State for Health in England or the First Secretary in Wales;
- a request from an individual or an organisation;
- the receipt by CHI of information which merits an investigation.

A special process has been developed for the assessment of requests from the public or organisations for an investigation. Whether an investigation is made after such a request is decided by a subcommittee of CHI, on the basis of the following criteria:

- an incident is of great severity;
- there is evidence of high-risk activity;
- there is a pattern of service failure;
- a recurring problem has not been addressed;
- there is evidence of management

or organisation failure which goes beyond a single area or team;

- an investigation by CHI is likely to result in lessons for the whole of the NHS.

An investigation instigated by CHI should meet at least two of these criteria. To date, CHI has received over 350 enquiries or requests to consider an investigation and has recently appointed an enquiries officer to ensure these requests are dealt with in an appropriate and timely way.

CHI does not investigate:

- individual complaints, which should be taken through the NHS complaints procedure, including the Health Service Commissioner (Ombudsman);
- service changes that have been determined by the Secretary of State for Health;
- matters which have been determined by the courts;
- individual complaints about professional misconduct or fitness to practise, which should be referred to the professional regulatory bodies.

### Investigations to date

To date, CHI has completed and reported on five investigations. A sixth investigation, regarding breast screening at Charing Cross Hospital and managed by the Hammersmith Hospitals NHS Trust, is at the report writing stage, and a seventh, at the Gosport War Memorial Hospital, Portsmouth, is about to begin. Key areas for learning have been identified in all the investigations but some areas for learning across the whole of the NHS are outlined below from three of these.

#### The employment of locum consultants

CHI found that a reliance on locum consultants is frequently due to poor workforce planning, particularly in terms of arrangements for covering leave for permanent consultants and in the appointment of new consultants. In some fields such problems are compounded by a chronic national shortage of qualified consultants.

One CHI investigation pointed to a continuing failure by trusts to comply with Department of Health

rules about employing doctors and a duty of care to patients in employing doctors of proven ability to fulfil their responsibilities. This included obtaining references, checking career history, interviewing, and carrying out health checks and induction. CHI concluded that such processes must be reinforced by systematic audit for checking the quality and accuracy of clinical work.

A major problem is that when concerns about the performance or conduct of locum doctors arise, all too often trusts simply terminate contracts or do not re-employ them, without alerting other employers to the problem. There is no system for tracking locum doctors around the NHS to enable employers to check on career history and performance records.

Among other recommendations, CHI proposed that:

- the Department of Health's code of practice on the employment of locum doctors should be strengthened and clarified through greater detail about induction, performance monitoring, occupational health checks and examples of best practice;
- a central system should be established for recording concerns about locum doctors' career history and performance, and this information should be accessible to all employers.

The Department of Health has responded with an initiative for a central agency to support doctors working outside managed organisations. The Royal College of Pathologists has responded with a new protocol for supporting and advising trusts on the performance of consultant pathologists. In response to CHI's concern that trusts fail to report concerns about locums to the General Medical Council, the Council will encourage them to do so through clearer publicity about its services.

**Heart and lung transplantation at St George's Healthcare NHS Trust**  
While written criteria for the selection of patients for heart and lung transplant were broadly in line with those developed by the other six such units in the country, CHI found that in practice patient selection for heart and lung transplant at St George's frequently deviated from

the criteria in a way that was unclear and idiosyncratic.

No formal amendments were made to the transplant protocols to reflect the changes in patient selection nor was there a documented audit of the process for assessing patients for transplant. In addition, CHI found:

- no written documentation on whether or not patient booklets were given to patients or relatives;
- inadequate documentation of risks discussed with patients and relatives, including those patients with increased risk such as serious kidney problems – which did not comply with NHS guidelines on patients' consent for examination and treatment.

Because heart and lung transplant is a constantly evolving field applying to a small number of very ill patients, CHI emphasised that heart and lung transplant programmes must ensure a transparent approach to any changes in selection criteria. This transparency would involve:

- recorded multidisciplinary discussion and agreement of any changes;
- formal amendment of protocols and patient booklets regarding selection criteria, and any changes to these to be the subject of close multidisciplinary audit;
- regular audit and review of outcomes, and the resulting information to be given to patients and relatives.

Additionally, CHI proposed the development of a national format for written information for patients and relatives, such information to be developed with the involvement of patients, relatives and representative organisations.

#### The case of a general practitioner in Loughborough

This investigation highlighted the importance of effective whistle-blowing policies and reported on a culture that did not listen to or treat complaints inquisitively. This was evidenced by a systems failure when, between February 1985 and January 1997, there were 23 occasions when an individual or organisation was aware of a concern or a complaint involving the practitioner involved.

CHI found that the current NHS complaints procedure contributes to a disempowering system for patients and places unreasonable restrictions on them. It lacks independent lay input into the investigation and analysis, and assumes an ability to articulate concerns with a degree of knowledge and perseverance that is unreasonable.

In reviewing clinical governance arrangements in place locally, CHI reported that the primary care group had pushed the boundaries of clinical governance beyond what many may have achieved, evidenced by the willingness of many to learn from the experience of the unacceptable events. Nonetheless, a clear distinction between unintentional poor performance (which clinical governance arrangements should address) and professional misconduct and criminal activity (which clinical governance is not designed to address) is required. CHI concluded

therefore that there remained the potential for professional misconduct to go undetected.

To reduce this risk therefore CHI proposed:

- A clear commitment that patients' interests are central to all activities in the NHS should be demonstrated by the introduction of one complaints system with explicit standards to which all NHS staff must work, and which is clearly understood by those wishing to make a complaint. The system should include lay input into the audit of complaints, and the logging and tracking of anonymous and informal concerns which may be held separately but should be reported in tandem with complaints information.
- Mechanisms for auditing what happens behind the consulting room door – for example, auditing organisation and clinical practice

– should include the patient's perspective.

- Regular audit of critical incident and near-miss reporting should maximise feedback from patients, practitioners and managers.
- There is a need for mechanisms for auditing trust and health authority compliance in establishing whistle-blowing policies.

Discussions are currently taking place with the Department of Health and others in response to these proposals.

## Conclusions

Although at an early stage of its development, CHI has been able to identify system failures which need to be addressed at a national level. Addressing the issues at this level should enable the NHS to develop approaches to assure the quality of patient care.

# The audit of cervical cancer: a door to openness and honesty in the NHS

**David Slater**

*Consultant Histopathologist, Royal Hallamshire Hospital, Sheffield S10 2JF, and Director of Quality Assurance for the NHS Cervical Screening Programme (Trent), Quality Assurance Reference Centre, Northern General Hospital, Sheffield S5 7AU, email David.Slater@sth.nhs.uk*

- All screening is 'low risk' and not 'no risk'.
- Good quality assurance always discovers problems.
- Audit of cervical cancer has resulted in screening recommendations in the NHS Cancer Plan (all women should receive a national information leaflet and informed choice on screening must incorporate an understanding of the potential benefits and harm).
- Following a cultural change, there is now public education that no screening programme will achieve a zero error rate.

In the NHS Cervical Screening Programme, a major way to monitor performance, including both effectiveness and quality, is the audit of invasive cervical cancer. Indeed, since 1996, a mandatory national standard has existed to audit 100% of cases and the findings can be used for both quality assurance (QA) and

quality improvement. An early audit identified system errors (other than women failing to attend for a cervical smear), including incorrect laboratory reporting and inappropriate clinical management<sup>1</sup>.

## The Leicestershire audit of invasive cervical cancer

The results for this important audit span the period 1992–2000 and relate to over 300 women. Discrepancies in laboratory reporting were identified in over one-third and included both missed abnormalities and inappropriately graded smears. Because of numerous well publicised 'blunders' in cervical screening, there were immediate fears of another failing laboratory. This had to be quickly responded to by the Trent Quality Assurance Reference Centre, as the audit had not identified any one specific causative factor or individual. Furthermore, internal and

external QA spread over several years, backed up by a QA visit, provided no proof of substandard performance. Although numerically high, the percentage and nature of errors were comparable to those already published<sup>1</sup> and known to be occurring elsewhere in the UK.

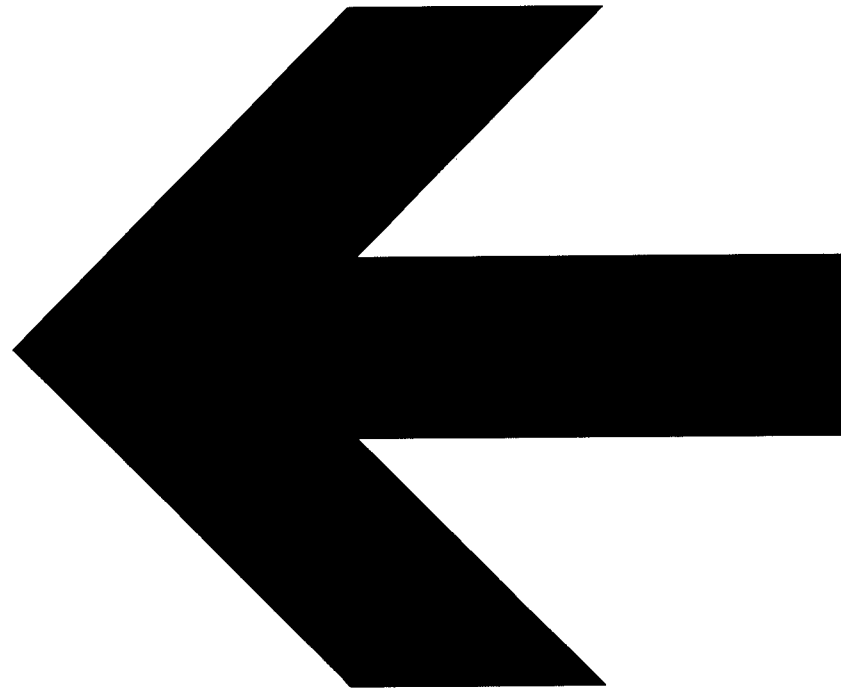
Despite these errors, it is significant that the death rate from cervical cancer in Leicestershire has fallen by over 33% in the last decade and the errors can account for only 5–10% of overall deaths from cervical cancer.

## To tell or not to tell? That was the question

A request to local management for permission to publish the audit findings focused attention on this important question.

Informed members of the medical profession had no doubt as to the preferred way forward<sup>2,3</sup>. Specifically,

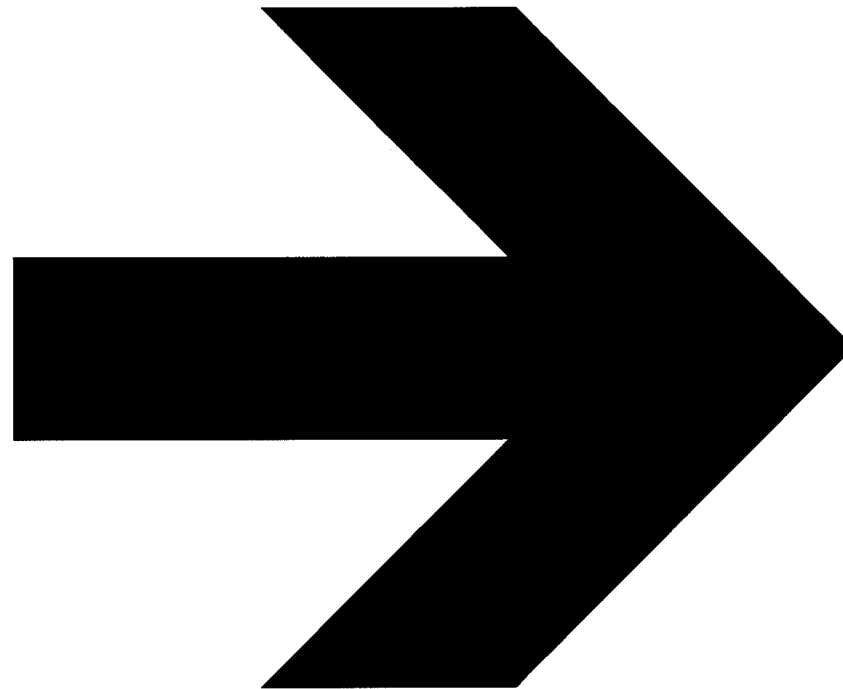
# **COMMISSION FOR HEALTH IMPROVEMENT**



**THIS WAY PLEASE**

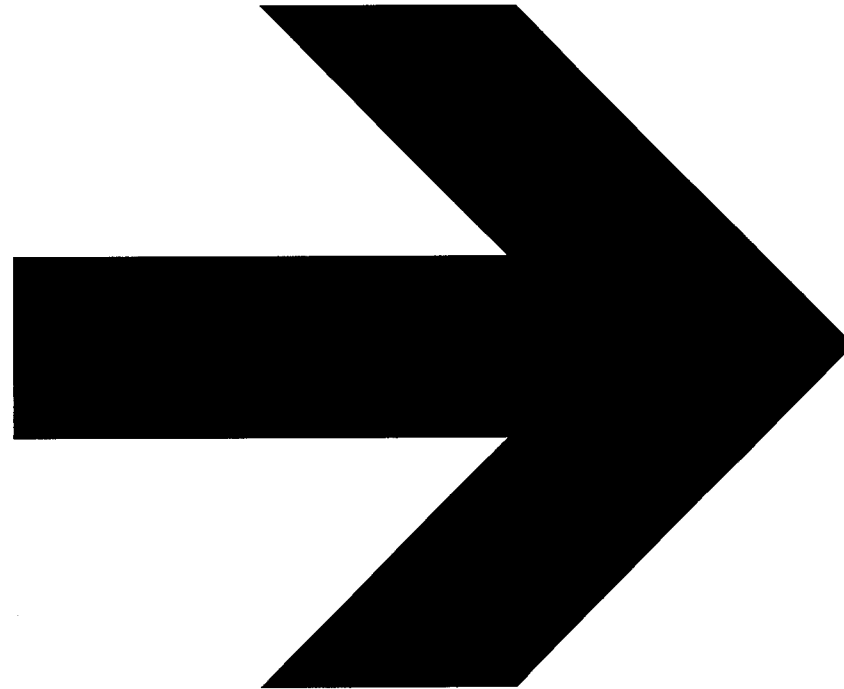


# **COMMISSION FOR HEALTH IMPROVEMENT**



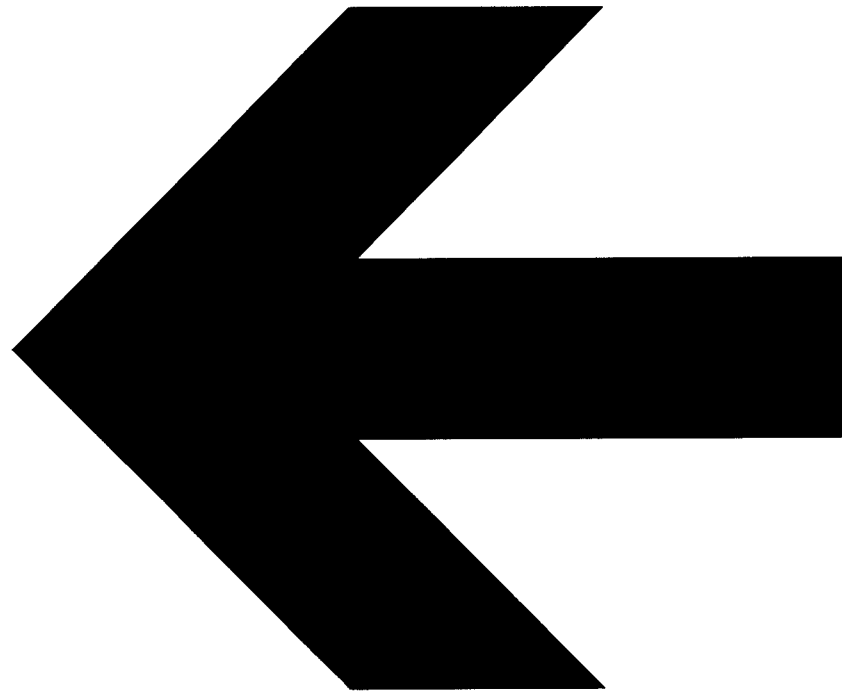
**PLEASE REGISTER HERE FOR  
YOUR 'CHI' INTERVIEW**

# **COMMISSION FOR HEALTH IMPROVEMENT**



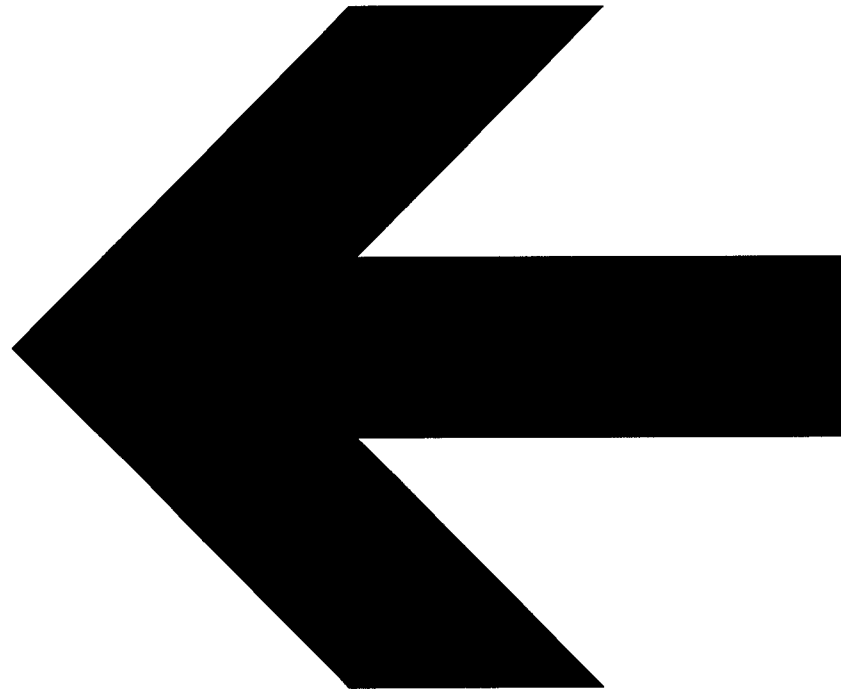
**THIS WAY PLEASE**

# **COMMISSION FOR HEALTH IMPROVEMENT**



**THIS WAY PLEASE**

# **COMMISSION FOR HEALTH IMPROVEMENT**



**PLEASE CONFIRM THAT YOUR INTERVIEW HAS FINISHED**  
*THANK YOU*

Portsmouth HealthCare



NHS Trust

## Commission for Health Improvement

### Gosport War Memorial visit 7th - 11th January 2002

Please find attached two maps, one showing the layout of the ground floor rooms you will be using, and the other showing the rooms you will be using on the first floor.

Please note, the 'Seminar room' on the ground floor is where your refreshments will be served, this room will be available to you for the whole week. Also marked are the lavatories and Fire Exits.

If you require any additional refreshments the hospital restaurant is open from x until y every day. The restaurant is marked on the ground floor map.

Also attached is a schedule of interviews detailing the day, time and precise location of each interview so that you will know who to expect in your interview room.

#### Useful telephone numbers:

Max Millett, Chief Executive - **Code A**

Dr Ian Reid, Medical Director - **Code A**

Dr Eileen Thomas, Nursing Director - **Code A**

If you require assistance of any kind during your visit please telephone *Caroline Harrington, CHI visit co-ordinator* on Ext. **Code A** or Ext. **Code A**

**Portsmouth HealthCare**

NHS Trust

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Max Millett, Chief Executive - **Code A**

Dr Ian Reid, Medical Director - **Code A**

Dr Eileen Thomas, Nursing Director - **Code A**

If you require assistance of any kind during your visit please telephone *Caroline Harrington, CHI visit co-ordinator* on Ext. **Code A** or Ext. **Code A**

**MESSAGE**

Phone conversation

Date: 19/12/01 12:15

To: Caroline

**WHILE YOU WERE OUT**

Mr. Deborah Hunt

of: until 6th

Telephoned	<input checked="" type="checkbox"/>	Please Phone	<input checked="" type="checkbox"/>
Called	<input type="checkbox"/>	Will call again	<input type="checkbox"/>
Wants to see you	<input type="checkbox"/>	Urgent	<input type="checkbox"/>

Callers Phone No.

**Code A**

K. 22/01

**MESSAGE:**

Around 12.30 please kinsmol if not able to today. Ref: CHI interview.

leaving Sun 6th  
Job S'ton - 7th

3 m-w. - course in Bournemouth.

See or Telephone conversation - what's best for you? Signed: Nita

WSG0556

2nd early 7.30 - 1

Thurs Late 12<sup>15</sup> - 8.30.

Fri late.

Sat late.

Sun 7.30 - 1

31/12/01

Spoke to Julie Miller -

pass on info re. phone

no + shift times.

Julie to talk to Debbie  
direct to organise a

convenient time to talk.