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Investigation of Clinical Governance arrangements relating to medical staff employed by the Health and Social Services Department of the States of Jersey

Background

1. This investigation was undertaken at the request of Mr Colin Myers, Director of Health and Safety at the Health and Safety Inspectorate, on behalf of the Attorney General.

2. My involvement follows two Serious Untoward Incidents which occurred at Jersey General Hospital.

   2.1. The first involved the death of Mrs Elizabeth Rourke on 17 October 2006 as a result of massive blood loss following an elective hysteroscopy. Dr Moyano, a locum obstetrician and gynaecologist who had operated on Mrs Rourke, was charged with gross negligence manslaughter and was found not guilty at trial. An extremely long report following an external investigation by Verita was published in January 2010.[1] It made a number of criticisms of the hospital systems and processes, in particular in relation to the mechanism of appointing locum doctors, an underdeveloped culture of patient safety and governance, the relative lack of policies and procedures, an unwillingness to report serious incidents, a blame-oriented environment, a 'distant' senior management team which did not engage well with senior medical staff or provide sufficient leadership to the organisation, poor systems for induction, appraisal and job planning of medical staff, individual rather than team work and poor communication.

[1] http://www.verita.net/pages/our_work/119/verita.html

2.1.1. An addendum to the Verita report, based mainly on feedback from staff, indicated that there had been some improvement in some aspects of management, and in particular the blame culture, but that there was a perception that the senior hospital managers had to combine a central policy-making function with a hospital operational one. The hospital was isolated both geographically and organisationally, although it had strong clinical links with other hospitals. It was not part of a wider community of health organisations and did not easily benefit from developments in thinking and capacity elsewhere. Verita thought that it would be worth exploring whether a strong, formal 'twinning' arrangement with another healthcare provider could help, e.g. with staffing and the development of policies and procedures that meet modern standards while also taking account of Jersey's unique character and circumstances. The hospital had made progress on governance in the previous three years but more needed to be done to achieve a uniformly good standard.

2.2. The second incident was the death of Mr Joseph Vasse. He underwent surgery on 5 December 2008 for a suspected strangulated femoral hernia. Mr Narendra Pal, an associate specialist in surgery, performed the operation. The bowel which was present in the hernia was returned to the abdominal cavity. Postoperatively, Mr Vasse became very ill and underwent laparotomy on 7 December 2008. It was found that there was a perforated section of the bowel with a significant amount of dead tissue. This section of the bowel was resected but Mr Vasse did not recover, and died on 12 December 2008.

2.2.1. Mr Pal had noticed some deterioration in his eyesight, and on 2 September 2008, he referred himself to Mr Asim Shami, an associate specialist in ophthalmology. Mr Shami found cataracts in both of Mr Pal's eyes but did not conduct a formal near vision test. Mr Shami said that he did not give Mr Pal any advice about continuing to work, while Mr Pal said that Mr Shami told him that there was no need for any restriction on his practice. Arrangements were made for Mr Pal to undergo cataract surgery.

2.2.2. On 3 November 2008, Mr Pal carried out a varicose vein operation on Name removed . The femoral artery was mistaken for the saphenous vein, and excised.

2.2.3. On 4 November 2008, Mr Pal says that he informed his consultant, Mr Ingram, that he had a cataract which required surgery. Mr Pal says that Mr Ingram said that he was not concerned but that he specifically asked Dr Pal whether he had any problem operating. Mr Pal said that he had no difficulty in operating. Mr Ingram cannot recall that conversation but cannot deny that it took place.

2.2.4. Independent medical evidence was obtained regarding Mr Vasse's operation. It was reported that Mr Pal had bilateral cataracts. His left eye had an advanced cataract with poor vision, unsuitable for driving or carrying out surgical procedures. The right eye had better vision although 'just about substandard for driving and therefore problematical in relation to an ability to carry out surgical intervention'. His eyesight was compromised to 'a fair degree' but expert opinion was that there had been a failure of 'surgical technique and judgement'.

2.2.5. It was concluded that, if Mr Pal was aware of a visual deficiency, he should have had that attended to before resuming his career as a surgeon.

3. I have read the Verita reports relating to the death of Mrs Rourke and the report (and its appendices) of the Health and Safety Inspectorate dated 11 May 2010 relating to the incidents involving Mr Pal.

4. The advice of Name removed was that there was insufficient evidence to prosecute Mr Pal in the criminal courts because it was not clear that his defective eyesight caused Mr Vasse's death, or that his knowledge of his defective eyesight amounted to a gross failing rather than a departure from good practice. Name removed indicated that there was *prima facie* evidence of an exposure of patients to risks arising from the absence of management and auditing of fitness to practise, that there was insufficient evidence that the absence of such management and auditing systems

represented a departure from well defined and established standards but that there was no evidence that such a breach was a substantial cause of the death of Mr Vasse.

5. Name removed recommended that an expert report should be sought to address the following issues.

   5.1. The system at the General Hospital in respect of the management and auditing of surgeons and medical practitioners, with particular reference to fitness to practise, self-referral to colleagues and the handling of issues of concern regarding individual clinical practice.

   5.2. How such systems compare with others in place in NHS Trusts in the United Kingdom.

   5.3. Whether the systems now in place at the General Hospital are sufficient to have addressed failings identified from the evidence obtained in his investigation and those identified in the Verita report.

6. I am Emeritus Professor of Anaesthesia at the University of Nottingham. I practised clinical anaesthesia from August 1973 until July 2010, and held consultant status from 1979. A summary of my Curriculum Vitae is attached as Appendix 2 (page 19). I have for many years had an interest in matters related to safety in medical practice. In addition, I have been a non-executive director of two NHS Trusts and have an intimate understanding of management systems within the NHS and of risk management and safety strategies. I was responsible for the implementation of the new consultant contract for all University clinical consultants in Nottingham and have a clear understanding of the details of that contract.

7. The following terms of reference were agreed for my investigation.

   7.1. To investigate the manner in which the Health and Social Service Department presently carries out the management of medically qualified staff working at the General Hospital, in respect of the duty owed by the States Employment Board, under Article 5 of the Health and Safety at Work (Jersey) Law, 1989, to patients undergoing treatment.

   7.2. The investigation should specifically address:

7.2.1. The arrangements for the performance, review and appraisal of medically qualified staff;

7.2.2. The manner in which both the initial and then the continuing medical fitness of medically qualified staff is determined;

7.2.3. The practice of staff seeking medical treatment within Health and Social Services, (commonly termed 'self-referral'); and

7.2.4. The arrangements available to Health and Social Services staff, who have concerns for the safety of patients by the actions or medical fitness of a colleague, by which they are able to raise their concerns.

7.3. The arrangements which are in place should be compared against best practice in the UK Health Service, with recommendations made to address any differences in management standards that are found.

8. In addition to reading the documents referred to above, I visited Jersey on 4 and 5 May 2011 and met Mr Richard Jouault (Deputy Chief Officer, Health & Social Services), Mr Andrew McLaughlin (Hospital Director), Dr Andrew Luksza (one of the two Medical Directors), Ms Rose Naylor (Director of Nursing and Governance), Mr Tony Riley (interim Director of Human Resources [HR]), Mr Brian Jones (Medical Staffing Manager) and Mr Jim Wagstaff (HR Consultant (Case Manager)), all of whom were extremely helpful and cooperative.

Medical staffing

9. The management of the medical staff has been reorganised. Formerly, there was a medical directorate and a surgical directorate. Now, eight clinical director positions exist, for Surgery, Medicine, Emergency Care, Paediatrics, Obstetrics and Gynaecology, Anaesthesia, Radiology and Support Services, and several of these posts have been advertised.

10. Consultants have a contract similar to that on the mainland in terms of the number of Programmed Activities (PAs) and basic salary. However, on the mainland, there is a competitive system of bonus payments (Clinical Excellence Awards; CEAs) based on demonstrated achievement in five domains (delivering a high quality service, developing a high quality service, managing a high quality service, contributing

through research and innovation and contributing through teaching and training), and then a national scheme for higher awards, again competitive and based on achievements. A prerequisite for CEAs is that the consultant has undergone annual appraisal. When the new consultant contract was introduced in Jersey, the agreement which was reached with the Local Negotiating Committee (LNC) was that the funds which would have been used to provide competitive CEAs would be distributed as, in effect, seniority payments. Consequently, in addition to the normal increments on the consultant salary scale, consultants in Jersey receive an automatic additional incremental payment for the first 17 years after appointment. There is, in theory, a competitive process for the final three payments (years 18-20) but I was told that no application had ever been denied. I was told by the Medical Director that these bonus payments would be made in future only subject to a satisfactory appraisal and agreement of a job plan, but I understand that this would be a variation in contract which could be implemented only with the agreement of the LNC. The CEA system in the United Kingdom is under review and may be withdrawn or modified. If it is not withdrawn, it will remain competitive. At present, consultants in Jersey have no financial incentive to maintain or improve their performance.

11. The performance of doctors is assessed at appointment on the basis of references from past employers, including the current employer. A Criminal Records Bureau check is performed for all medical staff and evidence of effective hepatitis B vaccination is required. In addition, newly appointed medical staff are assessed by the an external Occupational Health agency.

Appraisal

12. Apart from Foundation Year (FY) 1 and 2 trainees, who are appraised by the Wessex Deanery, appraisal of medical staff in Jersey has been sporadic. In hospitals in the United Kingdom, there has been mandatory annual appraisal for several years. Appraisal is important for, principally, two reasons. First, the hospital is able to obtain reassurance that the consultant has an acceptable clinical record, has been keeping up to date and has been participating in audit, and compliments or complaints from patients are considered. Health and probity are also explored. In the absence of regular appraisal, the hospital cannot know whether its consultants are acting within acceptable boundaries. Second, revalidation by the General Medical Council (GMC)

is scheduled to start towards the end of 2012, and to be complete by 2015. Revalidation will be a requirement for doctors to maintain a Licence to Practise. The current advice from the GMC[2] is that, for the first round of revalidation, a recommendation on revalidation can be made to the GMC by the Responsible Officer (a local senior doctor trained by the GMC to assess whether criteria for revalidation have been met by each doctor) on the basis of at least one strengthened appraisal. Subsequent rounds of revalidation will occur every five years, and will be based on five annual appraisals.

13. At present, mandatory annual appraisal at the General Hospital is planned to start towards the end of 2011. This means that every doctor should have had at least one appraisal in time for revalidation starting at the end of 2012. At the time of my visit, no Responsible Officer had been appointed. It is important that an appointment is made soon, because the appointee will need to be trained by the GMC.

14. Currently, there is no formal training of appraisers. An appraiser training package was purchased about 3 years ago, but with a much more formal appraisal system being introduced to support revalidation, consideration should be given to repeating the training. It is proposed that the Medical Directors will appraise the Clinical Directors, and the Clinical Directors will appraise medical staff in their Directorate. The Medical Directors will also need to be appraised.

Consultant job planning

15. Job planning has been rudimentary and medical staff do not have Personal Development Plans, which are necessary as part of the appraisal process as a means of ensuring the Continuing Professional Development objectives are met. The Zircadian suite of software which facilitates job planning and appraisal has been purchased but there is currently no timetable for its implementation. All consultants are allocated 10 Programmed Activities (PAs; 4-hour periods of work) but currently the HR Department does not know how many PAs are actually being worked, or the split between PAs for Direct Clinical Care and those for Supporting Professional Activities (e.g. audit, teaching, learning, committee work). On-call duties are rewarded by time off in lieu, which is an inefficient method of using consultant time. On the mainland,

[2] *Blueprint for Revalidation* V1.0, 7 March 2011. General Medical Council.

on-call commitments are rewarded by a percentage of salary which is determined by the frequency and intensity of on-call work; in most specialities, this results in consultants undertaking their daytime activities every week.

'Middle grade' doctors

16. Because there are very few trainees, the General Hospital relies heavily on 'middle grade' medical staff, who are currently on old staff grade or associate specialist contracts. A new contract for these non-consultant career grade (NCCG) doctors, based on the contract used in the United Kingdom, has been under negotiation with the British Medical Association for 2½ years. I was told that an offer was to be made by the end of May, but further negotiations will be needed to agree a pay scale. The NCCG doctors have not been appraised at all. The NCCG doctors work up to the equivalent of 15-16 PAs per week, and are not restricted, as they are in the UK, by the European Working Time Directive. Current job plans do not include prospective cover for leave; the additional work is covered mostly by other staff, but sometimes locums are required.

Exclusions/restricted practice

17. There are currently four doctors on restricted practice following a variety of incidents. No doctors are currently suspended. If remediation fails, then capability hearings will take place with external assistance.

18. Although some members of staff told me that there was pressure from politicians and the press not to exclude a doctor following a serious untoward incident, I was assured by the Hospital Director and the HR Department that, if appropriate, exclusion would take place, although every attempt would be made to resolve the situation as rapidly as possible. The Occupational Health agency is able to support doctors who have been excluded, and a mentor is appointed for additional support.

Locums

19. There is currently only a small number of locums in post, as a result of some doctors being on restricted practice, inability to fill substantive posts in some specialties and to cover leave of NCCG doctors.

Good Medical Practice

20. The General Medical Council document *Good Medical Practice*[3] summarises the duties of a doctor as follows. 'You must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
  - Keep your professional knowledge and skills up to date
  - Recognise and work within the limits of your competence
  - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
  - Treat patients politely and considerately
  - Respect patients' right to confidentiality
- Work in partnership with patients
  - Listen to patients and respond to their concerns and preferences
  - Give patients the information they want or need in a way they can understand
  - Respect patients' right to reach decisions with you about their treatment and care
  - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession.'

21. At the General Hospital, the budget for both consultant and NCCG doctors is more generous than in most hospitals in England, enabling them to keep their knowledge and skills up to date. There are weekly local meetings for teaching of FY1 and FY2 trainees, and multidisciplinary meetings. Days are set aside for presentation of audits and multidisciplinary morbidity and mortality meetings are to be arranged at 3-monthly intervals. There is mandatory training for medical staff in dealing with fires and manual handling. There is mandatory training in Basic Life Support for all doctors, and in Advanced Life Support for all anaesthetists and for all doctors working in the Emergency Department. Formal courses in Advanced Life Support, Advanced Trauma Life Support and Advanced Paediatric Life Support are undertaken

[3] http://www.gmc-uk.org/guidance/good_medical_practice.asp

in Jersey by appropriate doctors. Audit has been sporadic, but is now being organised more formally through the Care Quality Group (see paragraph 36). Once these are in place, it is my opinion that provision for Continuing Professional Development and audit of clinical practice will achieve the standard which pertains in comparable hospitals in England.

22. The quality of care at the General Hospital is compared with mainland hospitals through the Picker Institute, which conducts patient satisfaction questionnaires. The General Hospital fares well in comparison to other hospitals except (entirely understandably) in respect of choice of hospital for operation or childbirth. In addition, when appraisal is implemented, compliments and complaints relating to individual members of medical staff will be considered.

23. There is a Whistleblowing Policy which applies to all States' employees, although a more specific policy relating to Health & Social Services is being developed. All policies and procedures are available on the intranet. There is clear guidance about reporting actions by others which might be putting patients at risk.

24. Probity, health and behaviour will be assessed when appraisal is implemented.

25. Assessment of clinical performance of consultants is difficult in any hospital. It is generally easier in the case of surgeons, because outcomes and the frequency of need for re-operation can be identified. However, for most other specialties, there are no clear indicators of performance. Length of hospital stay has been used, but is not a robust indicator of performance because case-mix may be different for individual consultants. This is a problem which exists in all hospitals. Appraisal will assist in identifying poor performance if, for example, an individual attracts multiple complaints from patients, and information should be available from clinical audits. However, because consultants work autonomously, assessment of their performance will remain difficult and appraisal may fail to detect underperforming consultants. In this respect, the General Hospital is no different to hospitals in England.

26. Assessment of the performance of NCCGs and trainees is easier because their work and the outcomes of their patients are supervised by consultants.

Self-treatment

27. The document *Good Medical Practice* sets out the following guidance in relation to self-treatment.

- You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

- You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

- If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

28. In addition, the General Medical Council document *Good Practice in Prescribing Medicines*[4] indicates that:

- Doctors should, wherever possible, avoid treating themselves or anyone with whom they have a close personal relationship, and should be registered with a GP outside their family.

29. At Jersey General Hospital, self-referral to colleagues is discouraged. This is also the case in the United Kingdom. Self-referral is not proscribed by the General Medical Council and does occur, but full records must be kept and, unless the self-referred doctor refuses, his or her general practitioner should be informed of the results of the consultation. The situation in Jersey is slightly different to that in England because consultation with a general practitioner is not free in Jersey.

[4] http://www.gmc-uk.org/guidance/ethical_guidance/prescriptions_faqs.asp

30. At the General Hospital, doctors are not allowed to prescribe medicines for themselves, and this is monitored by the Chief Pharmacist.

Medical staffing issues

31. There are, at present, 106 doctors working at the General Hospital per 100,000 population. The average number of doctors working in comparable District General Hospitals in England is 181 per 100.000 population. These English hospitals may not be directly comparable to the General Hospital because, probably, more patients are evacuated to England from Jersey that are transferred from District General Hospitals in England to tertiary referral units. There is a higher proportion of attendances at the Accident and Emergency department in Jersey per size of population than in Singapore, Tasmania, England, Guernsey, Scotland or the Isle of Man (0.40 compared with an average of 0.25), which is, I understand, attributed to the fact that attendance at a general practitioner's surgery in Jersey is not free.

32. It has been calculated that 60% of hospital consultants in Jersey are eligible to retire within the next 10 years. The training systems on the mainland no longer produce consultants who have the ability to act as general physicians or surgeons; 'superspecialised' individuals are being trained. This is likely to impact on the ability to recruit appropriately trained consultants to Jersey when the current consultants retire. In my opinion, it will be necessary to increase the number of consultant posts significantly if the current level of care is to be provided at the General Hospital, unless, as was suggested in the Verita report, a 'twinning' arrangement with another centre can be arranged.

Risk management

33. In England (similar arrangements exist in Scotland, Northern Ireland and Wales), risk management has been driven by the Clinical Negligence Scheme for Trusts (CNST) which pools financial risk for NHS Trusts in relation to litigation. The CNST has developed a system of risk assessment in which four levels of risk management can be achieved (0-3, 0 being an organisation which must be placed under improvement measures). The higher the level achieved, the greater is the reduction in the Trust's contribution to the fund pool. There is therefore a strong financial incentive (in addition to a wish to achieve high standards of safety) for Trusts to achieve the

highest levels of risk management. Formal CNST risk assessments have not been undertaken in Jersey because the General Hospital is not part of the NHS. However, the criteria for each level of risk management are available to external bodies. There are separate criteria for acute hospitals[5] and maternity units.[6]

34. At Health and Social Services, there is an Integrated Governance Committee (see Appendix 1, page **Error! Bookmark not defined.**) chaired by the Chief Executive Officer. Its objectives are:

> To develop an Integrated Governance Strategy.
>
> To ensure that appropriate strategies, assurance, frameworks, structures and policies are in place, and to monitor and evaluate progress, in the following areas:
>
> - Clinical governance
> - Corporate governance
> - Risk management
> - Information governance
> - Research governance
> - Staff governance
> - Organisational development
> - Safeguarding adults and children
> - Health and safety
>
> To monitor and facilitate compliance against external standards, good practice guidelines and legislation.
>
> To receive assurance that appropriate systems are in place for the development and review of care pathways, clinical policies and the implementation of NICE (National Institute for health and Clinical Excellence) guidelines.

[5] NHSLA Risk Management Standards for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Independent Sector Providers of NHS Care. See www.nhsla.com/RiskManagement/

[6] Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards. See www.nhsla.com/RiskManagement/

To monitor the Corporate Risk Register, ensuring that risks are appropriately prioritised and adequately controlled and that all high and extreme risks are communicated to the Corporate Management Executive (CMEX).

To ensure that key performance indicators for clinical quality, efficacy, patient safety and risk management are developed and monitored for all commissioned and directly provided services.

To ensure that effective monitoring of near misses, incidents, accidents, complaints, claims and Serious Untoward Incidents (SUIs) is undertaken and that appropriate management action has been taken promptly.

To receive reports from the Care Quality Groups from the General Hospital and Community and Social Services.

To receive reports from the Jersey Child Protection Committee.

35. I was told by the Deputy Chief Officer that he usually chairs SUI investigations. There are clear terms of reference for investigation of SUIs. The investigation team usually includes the two Medical Directors, the Risk Manager and the Director of Nursing and Governance. A total of 80 staff have been trained in Root Cause Analysis. SUI reports are not made available on the hospital intranet or on the internet for reasons of confidentiality.

36. Risk management at the General Hospital is overseen by a Care Quality Group (CQG; see Appendix 1, page **Error! Bookmark not defined.**). The Director of Nursing and Governance is in charge of risk management on a day-to-day basis. The overarching aim of the CQG is to oversee the delivery of all aspects of quality, including safety and risk, patient experience, and effectiveness and outcomes in the General Hospital, and to drive developments and improvements in all areas. The Group is expected to ensure delivery of the following:

A Hospital Risk Register to review new risks, changes in risk ratings or mitigation plans prior to updating the Health & Social Services overall risk register.

Monitoring and facilitation of compliance against external standards, good practice guidelines and legislation, and to highlight areas for action to assure compliance.

Service area reports covering all aspects of governance, which will result in higher level assurance reports being provided to the IGC. This will include monitoring of near misses, incidents, accidents, complaints claims and SUI reports, and provide assurance that appropriate management action has been taken promptly.

Assurance that appropriate systems are in place for the development and review of care pathways, clinical policies and the implementation of NICE guidelines.

Regular reports in relation to infection prevention and control matters, to include key infection rates and performance, audits and hygiene reports.

37. Alerts from the National Patient Safety Agency (NPSA) and the Medicines and Healthcare products Regulatory Agency (MHRA), and advice from the National Institute for health and Clinical Excellence (NICE), are obtained regularly, but, unlike hospitals on the mainland, these are not sent directly to the General Hospital. Alerts and advice are sent to appropriate staff by e-mail and also displayed on notice boards in appropriate departments. The MHRA has accepted reports of incidents from the General Hospital, but the NPSA incident reporting system is open only to organisations which are part of the NHS.

38. The World Health Organisation checklist, which is intended to minimise the risks of errors in identity of patients undergoing surgery and errors on the site or side of surgery, has been implemented in the operating theatres at the General Hospital. This has been demonstrated elsewhere to improve safety of surgical patients.

39. There is an on-line incident reporting system within the General Hospital. It is not anonymous. However, in a small organisation, it is often difficult to provide full anonymity to individuals who report incidents. The incident reporting scheme is supported by most staff, including most medical staff. Reports are screened by the Risk Manager, who flags up any which cause major concern. Incident reports are also reviewed by hospital managers and ward managers.

40. Complaints are dealt with by a Complaints Officer who reports to the Deputy Chief Officer of Health & Social Services.

41. There is a multidisciplinary Risk Management Committee in the Obstetrics and Gynaecology directorate. Following incidents, statements are taken from staff in case of future complaints or litigation. The incidents are analysed and a summary is provided to the Care Quality Group.

42. The 'blame' culture which existed at the General Hospital appears to have improved significantly, in respect of both medical and nursing staff. Managers have a much clearer understanding of the fact that most errors and incidents occur as a result of system failures as well as human error.

43. In my opinion, all of these measures should ultimately achieve clinical governance standards equivalent to best practice in District General Hospitals in the United Kingdom. However, in my opinion, that will take several years. The Director of Nursing and Governance estimates that the General Hospital is about 8 years behind comparable hospitals on the mainland in developing a risk management strategy. Risk registers, which were developed in mainland hospitals many years ago, are only now being set up at the General Hospital. The Hospital Director considers that the current CNST risk level at the General Hospital is 1-2 in the maternity unit and 0 (i.e. *very* poor) elsewhere. His aim is to achieve level 3 in the maternity unit as soon as possible, and, in the rest of the hospital, to achieve level 1 by 2012 and level 2 by 2013-4. It is his view that the current low level of resources available for management at the General Hospital is impairing the rate of improvement of safety. Management costs are 3.6% of total income at the General Hospital, compared with an average of 4.6% at comparable hospitals on the mainland.

Leadership

44. With regard to the management of medical practitioners, the Hospital Director, senior members of the HR department, the Medical Directors and the Director of Nursing and Governance have, in my opinion, developed plans which would bring the General Hospital up to the level of best practice in the United Kingdom if implemented and achieved over the next few years. However, the Hospital Director and the senior members of the HR department are individuals who have been recruited from the

mainland on temporary contracts. It was not clear to me that, when these contracts expire, there would be remaining managers of sufficient ability to maintain delivery of the changes which are planned, and which are, in my opinion, necessary.

Conclusions

45. On the basis of the information available to me, the importance of clinical governance has been recognised at the General Hospital and steps have been taken to manage it effectively.

46. However, safety in most clinical areas at the General Hospital is currently below the minimum standard found in England. Managers have developed commendable structures and plans which will improve safety significantly over the next few years, but, in relation to medical staff, most have not yet been implemented.

47. In my opinion, the most important issue in relation to medical staff is the introduction of mandatory annual appraisal which will provide reassurance about many aspects of doctors' performance and which will be essential if doctors are to retain their licence to practise medicine.

48. There is currently a team of highly skilled senior managers whose plans should lead to greater safety at the General Hospital. However, a number of key players are on temporary contracts and there is a risk that the implementation of their plans may falter when they leave.

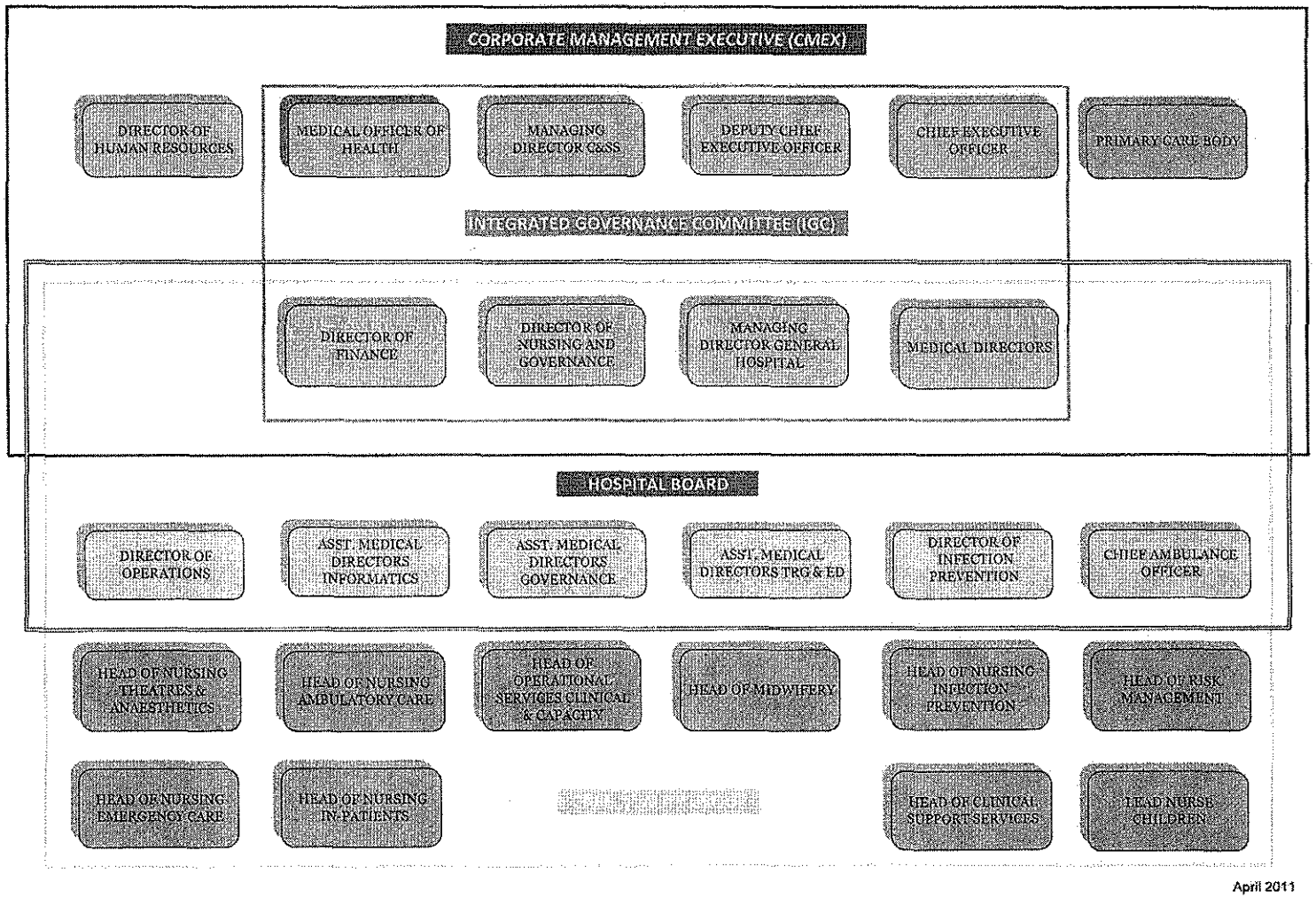
49. In my opinion, the situation regarding implementation of the plans should be reviewed towards the end of 2011 (because of the importance of introducing mandatory appraisal), and then probably annually.

21 July 2011

Alan R Aitkenhead BSc MD FRCA
Emeritus Professor of Anaesthesia

HOSPITAL CORPORATE GOVERNANCE STRUCTURE

Appendix 1



April 2011

Appendix 2

ALAN ROBERT AITKENHEAD

Summary of Curriculum Vitae

QUALIFICATIONS	BSc (Med Sci), MB, ChB, MD, FRCA
GMC REGISTRATION	Full registration, No. 1331851. Specialist register (anaesthetics)
PRESENT APPOINTMENT	Emeritus Professor of Anaesthesia, University of Nottingham
PREVIOUS APPOINTMENTS	Professor of Anaesthesia, University of Nottingham and Honorary Consultant, Nottingham University Hospitals *(January 1989 – July 2010)*
	Senior Lecturer in Anaesthesia, University of Leicester and Honorary Consultant, Leicestershire Health Authority *(November 1979 - December 1988)*
	Senior Registrar, Nuffield Department of Anaesthetics, Oxford *(April 1978 - October 1979)*
	Research Fellow and Honorary Senior Registrar, Shock Study Group, Department of Surgery, University of Glasgow *(February 1977 - March 1978)*
POSITIONS HELD RECENTLY	*National*
	Member of Council, Medical Defence Union
	Member, NHSE Mediation Working Party, representing Academy of Medical Royal Colleges in the UK
	Member, Clinical Negligence Working Group, Lord Chancellor's Department
	Member, Resuscitation Council (UK)
	International
	Industrial Liaison Officer, European Society of Anaesthesiologists
	Chairman, Editorial Board, European Academy of Anaesthesiology
	Regional
	Member, Trent Regional Anaesthetic Training Committee
	Member, Regional Advisory Specialty Committee in Anaesthesia
	Local
	Admissions Sub-dean, University of Nottingham School of Medicine
	Member of Nottingham University Hospitals External Reference Strategy Group

LITERARY ACTIVITIES

Member of Editorial Board, *Baillière's Best Practice & Research: Clinical Anaesthesiology*

Joint editor of *Foundations of Anaesthesia and Acute Medical Care* series

Chairman of Editorial Committee, *European Journal of Anaesthesiology*

Co-editor of *Textbook of Anaesthesia* (six editions)

Co-editor of *Clinical Anaesthesia*

Co-author of *Essential Anaesthesia for Medical Students*

Co-author of *MCQ Companion to Textbook of Anaesthesia*

Co-author of *Essay Plans in Anaesthesia*

POSITIONS HELD FORMERLY

President, European Society of Anaesthesiologists

Chairman, Association of Professors of Anaesthesia

Examiner, Royal College of Anaesthetists

Secretary, Anaesthetic Research Society

Secretary, Research Subcommittee, Intensive Care Society

Secretary, Association of Professors of Anaesthesia

Vice-President and Member of Council, Association of Anaesthetists of Great Britain and Ireland (AAGBI)

Chairman, Education and Research Committee, AAGBI

Vice-dean, Faculty of Medicine and Health Sciences, University of Nottingham

Member, University Hospital Executive Committee

Non-executive director of Nottingham Healthcare NHS Trust

Non-executive Director, Queen's Medical Centre University Hospital NHS Trust

Head of School of Medical and Surgical Sciences, Faculty of Medicine and Health Sciences, University of Nottingham

Chairman, Nottingham and East Midlands School of Anaesthesia

AWARDS etc.

Featherstone Award for services to anaesthesia, awarded by the Association of Anaesthetists of Great Britain and Ireland 2003

MAIN RESEARCH INTERESTS

Awareness during anaesthesia

Measurement of depth of anaesthesia

Effects of anaesthesia on the colon

Pharmacokinetics of opioids

Pulmonary and laryngeal function during anaesthesia

Safety during anaesthesia