VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

An independent review into the approach and behaviour of NHS South West in relation to the dismissal of John Watkinson by Royal Cornwall Hospitals NHS Trust

An addendum to the report

December 2010

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Appendix A Legal advice from David Lock to Royal Cornwall Hospitals NHS Trust

1. I have been asked to provide some advice to the Board of the Royal Cornwall Hospitals NHS Trust ("the Trust") about the proposals by the Cornwall and Isle of Wight Primary Care Trust ("the PCT") to cease commissioning upper gastrointestinal services ("upper GI services") from the Trust and to transfer commissioning of these activities to the Derriford Hospital, Plymouth. I will seek to keep this advice in a short form but am of course happy to supplement it with detailed advice on any aspect set out below if the Trust Board would wish me to do so.

2. The National Cancer Strategy published in December 2007 referred to centralisation of services as follows:

> "7.17 PCTs working together across a cancer network will wish to consider which diagnostic services should be centralised, taking account of National Institute for Health and Clinical Excellence (NICE) Improving Outcomes Guidance. They will also wish to consider what follow up services could be provided closer to peoples' homes, but with appropriate specialist monitoring"

3. This supports earlier work undertaken by the Department of Health which is explained on its website as follows:

> "Calman and Hine's 'A Policy Framework for Commissioning Cancer Services' (DH, 1995) proposed that cancer services should be based around Cancer Units and Cancer Centres, working together to create Cancer Networks involving NHS Trusts, Health Authorities, Primary Care Groups/Trusts, and the voluntary sector. This guidance manual on improving outcomes for upper gastro-intestinal cancers (affecting the oesophagus, stomach, and pancreas) notes that service provision in England and Wales has tended to be fragmented and disorganised. It sets out a specific service model which would make specialist care available to all patients, following the basic structure of the Calman and Hine model"

4. The Guidance was published back in 2001. I do not know what steps have been taken since 2001 but it does appear that this issue has been left on the back burner by local commissioners for a very long time. However the 2001 Guidance states:

"Minimum figures for the population base to be served by each team are specified below. These take the diverse geography of the different regions of Britain into account. Where possible, commissioners should work together to achieve numbers at the higher end of the ranges given, since the evidence shows that higher patient throughput is associated with better outcomes"

5. The "numbers" are explained as follows:

"Each team should aim to draw patients from a catchment area with a population of one to two million. (The minimum acceptable population size, for sparsely populated areas only, is 500,000.) A team with a population base of one million could expect to manage at least 100 patients with oesophageal cancer and 150 with gastric cancer who might require specialist treatment each year. Resections would be appropriate for about 100 of these patients. Adequate intensive care, high dependency facilities and specialist post-operative care (including out-of-hours consultant cover) must be provided to minimise peri-operative mortality"

6. Cornwall is, I understand, one of the most sparsely populated parts of the UK and has a population of just over 500,000. Parts of the county are extremley sparsely populated and just under half a million people look to Truro for acute services. It appears that some of the population in the East of the county look to Plymouth Hospital as its natural centre, rather than hospitals within the county. I understand that the Truro Hospital undertakes about 80 relevant upper GI operations a year and has good outcomes for upper GI surgery which is at least consistent with the national average (though these statistics need to be looked at carefully as there can be high variations with small numbers).

7. The PCT has proposed moving its commissioning of upper GI services from Truro to Plymouth, with the upper GI services in Exeter (where operation numbers appear to be slightly higher although the population served by that hospital appears slightly smaller) following possibly in 2010. There is considerable disquiet amongst local people at this proposed move but I understand that the clinicians have broadly accepted the case for change based on the clinical evidence that a larger catchment area will deliver more patients and thus produce a centre of excellence with better outcomes.

8. However, there are several aspects of the plans which have caused concern for local clinicians. In particular it appears, that there is insufficient political will to make the changes to move the service from Exeter to Plymouth. Co-incidentally (or maybe not) the local MP for Exeter is a Minister of State in the Department of Health.

9. The PCT have been very clear that they have not consulted about these changes. The Chief Executive has explained that, as the PCT considered that that they had little option but to make the changes, they would do so without public consultation. The PCT have therefore been undertaking a "public engagement" exercise to explain the changes to the public and seeking to allay fears. The justification for this appears in a letter dated 1841 July 2008 which was sent by the Chief Executive to the Chair of the Cornwall County Council Overview and Scrutiny Committee dated 18th July 2008 when she said as follows:

> "The PCT is being asked by the OSC to continue to commission a non-licensed service from a low volume centre, which does not meet Healthcare Commission requirements and cannot realise the improved outcomes we know are being achieved in most other parts of the country"

10. I am conscious that I may not have all the information available to the PCT, but it does seem to me that this slightly overstates the position. Ms James explains her case in the following paragraphs. However, as far as I am aware, there is no formal system of "licensing" surgery other than through the accreditation system of the Royal College of Surgeons which does not appear to be relevant to these facts. There is pressure from the National Cancer Action Team to centralise services and the letter refers to pressure from the Healthcare Commission. This puts pressure on the PCT, but does not amount to regulatory requirements.

11. I regret to have to advise the Trust, that the approach of the PCT to force through changes without consulting the public is plainly unlawful. The duty to consult the public is now grounded in section 242 of the National Health Service Act 2006 which provides:

> "Each body to which this section applies must make arrangements with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives, involved in and consulted on—

(a) the planning of the provision of those services,

(b) the development and consideration of proposals for changes in the way those services are provided, and

(c) decisions to be made by that body affecting the operation of those services"

12. The fourfold content of the duty of consultation is by now well established. Firstly, consultation must be undertaken at a time when proposals are still at a formative stage; secondly, sufficient reasons must be provided for particular proposals so as to permit those consulted to give intelligent consideration and response; thirdly, adequate time must be given; and fourthly, the product of consultation must be conscientiously taken into account when the ultimate decision is taken (see *R v Brent London Borough Council ex p Gunning* [1985] 84 LGR 168 approved in *R v London Borough of Barnet ex p B* [1994] ELR 357 and *R v North and East Devon Health Authority ex p Coughlan* [2001] 1 C)13 213).

13. The bodies to who the section applies are both PCTs and NHS Trusts. See section 242(1). In *Smith v North Eastern Derbyshire Primary Care Trust & Anor* [2006] EWHC 1338 (Admin) Collins J explained the nature of the duty to consult in the context of a GP service that had failed and was being put out to tender where one option was that the service would be taken over by a • private company. The judge said:

"Thus I accept that a change of personnel or of contractual terms or of the form of a contract may not of themselves be covered by s.11. But the background is highly relevant. The need to replace a failed service should mean that the reasons for the failure are addressed and that may well, as was the case here, lead to a need to consider whether any different arrangements to deal with any problems which have manifested themselves are required. Thus public input may assist the PCT and will certainly help to allay concerns.

I have no doubt that the circumstances of this case did give rise to the s.11 duty. It can be said that any case where services have failed and must be replaced will amount to re-provision of those services. That merely underlines the point that the label 're-provision' does not give the answer in favour of the defendant and the Secretary of State. For the reasons I have indicated, a failure is often likely to require a consideration of its causes and so whether changes are indeed needed"

14. In this case there is a "re-provision" of a service in another part of the peninsular but there is no suggestion that it is a failing service (and the evidence appears clear that it was not a failing service). But the duty to consult the public before final decisions are taken about changes (let alone before they are implemented) arises even in circumstances where the medical professionals have reached a clear view that change is needed and there is no other viable option. The thinking behind the consultation requirements, is that these are public services which are paid for by the public through taxes and are relied upon by the public at times of crisis. It is important to maintain public confidence and support for such services. If changes are made to public services without involving the public then the public could react strongly against those changes and lose confidence in their health services. Thus, involving the public through consultation is a vital step in the process of change management in order to explain the technical case for change and to understand how it will impact on the public who use the services.

15. I therefore regret to have to advise that I consider that both the Trust and the PCT would be acting unlawfully if they attempted to move the upper GI services from Truro to Plymouth without prior public consultation.

16. In some sense of course it would be difficult for the Trust to consult on this because the Trust could not continue to deliver the service if the PCT were not prepared to commission it. Nonetheless there is a clear legal duty on the Trust to engage with the public about this and it is no answer to say that the administrative responsibility for the changes lay elsewhere. See *Fudge, R (on the application of) v South West Strategic Health Authority & Ors* [2007] EWCA Civ 803.

17. It seems to me that the PCT has not approached this in the most sensible way to date. They have taken specialist medical advice that the changes are required to be made and then sought to make final decisions without public consultation. This appears to have been driven by a number of factors, all of which in my view, slightly misunderstand the wider purposes of public consultation. First, it is perfectly lawful for the PCT to consult on just one option if the PCT considers that there is really only one viable option to put before the public. In R v Hillingdon Health Authority ex parte Goodwin [1984] ICR 800 Woolf J said at 809:

"Whenever there has to be consultation, there has to be an indication of what there is to be consultation about; and, although an authority must enter into the consultation without a closed mind, it seems to me that there is nothing objectionable in the authority having decided on a course it would seek to adopt, if after consultation it decided that that is the proper course to adopt."

18. See also *Nichol and ors v. Gateshead Metropolitan Borough Council* 87 LGR 435 where O'Connor LJ dealt with a consultation where there was only one promoted option. He said:

"When does the formative stage commence? I would be disposed to say that is when there is a provisional plan in existence. In the present case it would not be helpful to put before the parents all the original possibilities because the authority might then have to decide which of a variety of options, each with support, to accept. When does the formative stage end? In my opinion it ends when the details of the plan have been decided and no alterations can be made. In my opinion the action of the authority in this case was the most useful. The plan was outlined, the alternatives were mentioned as having been rejected but the plan was still at the formative stage because the council as a result of consultation was free to alter or reject the plan"

19. See also Kidderminster & District Community Health Council, R (on the application of) v Worcester Health Authority [1999] EWHC Admin 38. The argument that this was the PCT's preferred option and that, at this stage, they could not see any other acceptable course of action does not remove the duty to consult. The public are entitled to have the opportunity to seek to change the provisional mind of the PCT up to the point that final decisions are made.

20. Secondly the PCT appears to have confused the duty formally to consult the HOSC under regulations made under section 244 of the 2006 Act about substantial changes, with the general duty to consult the public. The duty to consult with HOSC is an entirely separate duty which leads to the right for the HOSC to refer a series of proposed substantial changes to the Secretary of State to prevent the changes taking effect. However, that duty is entirely independent of the general duty to consult the public on all aspects of healthcare under section 242.

21. Thirdly, even if the PCT were of a strong view about the main issues here, there a host of subsidiary issues which are likely to emerge in any consultation. These will include debate about what justifications the PCT is able to give for the staged movement of services where Truro loses its upper GI services two years before Exeter is required to follow suit. It could be thought that, given the excellent results of the GI services in Truro reported by the campaigners (assuming that these are correct), there is no need to rush to make the changes (though the Guidance has been around since 2001 so the PCT have hardly been rushing to date). More importantly, if the aim is to create a centre with a population of between 1m and 2m to allow for improved outcomes as envisaged in the Guidance, there is a good argument that the locality of services should not be given up before local patients have the benefit of such a centre. Local patients could say with some justification, that they are suffering all the local inconvenience of loss of services but not gaining the benefit of a regional centre of excellence. The resolution of these subsidiary issues is another reason why the public have a right to be consulted.

22. I would also note in passing that the PCT appear to have made a number of errors in the documents that the Chief Executive prepared for the Board. For example I note that the number of patients involved was quoted at 25 whereas the real number is about 80. Ann James is also noted as saying that the existing service was "outside of national clinical and Cancer Action Team guidance". If the Cornwall area is sparsely populated and has around 5000,000 persons then this may not be correct as this is within the Guidance. There are other errors but overall it seems to me that Ms. James has overstated her case for change.

23. It will take a considerable effort on behalf of the PCT to row back from its previous position and to agree with the need to consult and, during the consultation, to convince local people that the "proposals are still at a formative stage" and that, following consultation, "the product of consultation must be conscientiously taken into account when the ultimate decision is taken". It seems to me that if the local campaigners were to issue Judicial Review proceedings against both the Trust the PCT objecting to the changes, they would have a reasonably strong case for an injunction against the public bodies to prevent the changes taking effect until the PCT had discharged its legal duty to undertake public consultation.

24. In conclusion, I recommend to the Board that a firm but polite letter is sent to the PCT Board saying that the Trust considers that, whatever the strength of the technical case in

favour of change, both the Trust and the POT have a legal duty to consult the public about these changes before any final decisions are made. If the POT do not agree to do so, i consider that the Trust will have little choice but to undertake its own consultation because the duty under section 244 is on both the Trust and on the PCT.

25. The situation is of course complicated because the PCT are the commissioners of these services and, depending on the exact terms of the SLA between the PCT and the Trust, would have the contractual right to cease to commission those services at any time. This would mean that the Trust would no longer have the right to seek payment from the PCT for the provision of upper GI cancer surgery services. However the matter is not as simple as that because, in my view, in exercising the PCT's quasi-contractual powers under the SLA the PCT is required to act lawfully. Making a decision to stop commissioning these services without having engaged in prior public consultation would, in my view, be an unlawful act by the PCT.

26. I am mindful that the Trust Board almost certainly have no desire whatsoever to litigate against the PCT to assert their rights. However I consider that if the Trust attempted to cease to carry out upper GI cancer surgery services without consultation, the Trust would itself be acting unlawfully.

27. It would be theoretically possible for the Trust to issue Judicial Review proceedings against the PCT seeking a mandatory order they the PCT consults. However I assume that this is not a viable option. However, if the PCT does agree to go out to formal public consultation, all of the issues that concern the Trust about the details of these plans can be ventilated within the consultation. The overall picture can be reviewed by the Board at the end of the consultation period.

28. The Trust Board will have a much better knowledge than me of the ways in which pressure can be brought to bear on the PCT to modify their stance. One option may be to convene an urgent meeting at senior level between Chief Executives of the Trust and PCT with lawyers present on both sides at which the combined management and legal team could seek to persuade the PCT to row back from its present position and carry out a form of public consultation. If lawyers were present then the meeting could legitimately be considered privileged and thus the notes of the meeting and all documents surrounding it potentially would not be open to disclosure under the Freedom of Information Act 2000. it may be also

that the SHA have a role in plotting a way forward and should attend such a meeting. However I would suggest that the primary objective of the Trust Board should be to persuade the PCT to retreat back from its present position, to declare that it has not taken any final decisions yet and then agree to conduct a formal public consultation on the proposals (albeit with a very strong steer towards its preferred outcome).

29. I hope that this covers all matters upon which I have been asked to advise at this stage. If those instructing me would like to discuss the matter further please do not hesitate to contact me.

29th July 2008

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Appendix B Letter from John Watkinson to John Mills

Mr John Mills CBE
Acting Chairman
The Royal Cornwall Hospitals' Trust
Royal Cornwall Hospital
Truro
Cornwall TRI 3LJ

PERSONAL AND CONFIDENTIAL

30 September 2008

Dear Mr Mills,

I refer to our meeting on 25 September when you called me into your office.

You advised me that following the publication of a report into the financial management and governance at Bromley Hospitals NHS Trust that afternoon, a joint independent review into the RCHT had been announced by the Board and South West SHA.

I subsequently found that a press release had been issued that afternoon to that effect, and the reason given was that I and three former directors of Bromley are now employees at RCHT.

You informed me on 25 September that I was to be "informally" suspended, pending a meeting of the non-executive directors tomorrow when a formal suspension would be considered.

You asked me to take "special leave" up to tomorrow.

I was very taken aback by this request, but acceded to it at the time.

I have now had time for reflection, and also sight of the press coverage. Whilst I have no issue with an independent review being carried out at RCHT, subject to a fair review procedure being put in place, I believe the juxtaposition of the above comment in the press release by RCHT and action taken against me to be defamatory.

As a separate matter and independent of my employment by RCHT, it is a matter of record that I have pointed out the deficiencies in the review process at Bromley and rejected with written reasons the critical findings of me during my tenure at Bromley. I attach a copy of my letter to Mr Alderman, Chairman at Bromley, with comments on the draft report dated 10 April 2008. Subsequent press releases in respect of Bromley also contain unfounded and untrue allegations against me.

With regard to the meeting tomorrow, I can see no good reason for suspending me from my current role. Whilst suspension is not a formal disciplinary sanction, it gives rise to extreme negative suspicion and, given the tenor of the press release, can only cast doubt on my integrity. This is something I cannot allow.

I have done nothing wrong. Suspending me can not only damage my reputation, in breach of your legal obligations to me, but also that of the Trust and the good work carried out at the

Trust under my leadership. This is widely publicised in the press, and acknowledged both at Union and Government level.

If RCHT want a fair and proper review then I would have thought it of value that the review body should have my input and for me to be there to be interviewed. I would be able to facilitate the review. There can be no question of any interference by me. All the directors, non-executive directors and auditors will take part in the review, which provides for checks and balances. All records are kept securely and electronically and, whilst I would reject any suggestion that they might be at risk, this is not the case and cannot support a good reason for suspension.

In addition, I require to be supported internally, given the detrimental treatment and adverse publicity to which I have been, and to which I am being, subjected. This is against a background where only two to three weeks ago I was given an extremely positive appraisal by you as the Acting Chairman.

Finally, I wish to place on record that I have very significant concerns that this activity of the SHA/Board is not for the reasons stated, but as a direct consequence of my support for the former Chairman, Peter Davis's, drive to retain cancer services at RCHT and his refusal to sign the joint statement on Upper GI cancer services which, given the position of the SHA, resulted in his resignation.

It has, up to now, been the clear desire of the Board, supported by the public, to retain cancer care services. This has been opposed by the SHA as it wishes to implement the plan to centralise such services outside Cornwall without consultation. Given the "competing" interests, on behalf of RCHT, I took advice from a specialist constitutional Counsel who advised RCHT would be in breach of their legal obligations if they failed to consult. I advised the Board of this opinion. My request for proper consultation to comply with our legal obligations and support for the initiative for the provision of better cancer care services to the local population supported by the doctors and public, but opposed by the SHA is, I believe, the real reason for the current action being taken against me.

Yours sincerely

John Watkinson
Copies to other Non-Executive Directors.

Appendix C Statement from PCT and letters to and from PCT and RCHT about the Griffin review (handling & publication)

10 September 2008

Statement from Ann James, Chief Executive, Cornwall and Isles of Scilly PCT and John Watkinson, Chief Executive, Royal Cornwall Hospitals Trust

The National Cancer Director, Professor Mike Richards, has strongly advised that an urgent review of the Upper Gastro-Intestinal (GI) service at the Royal Cornwall Hospitals NHS Trust (RCHT) be undertaken.

The review has been requested to help clarify how the service is currently being delivered in relation to national clinical requirements.

The Primary Care Trust (PCT) and RCHT have been facilitating the arrangements for the review, which is being undertaken by two of the leading Upper GI surgeons in the country and is ongoing.

The PCT and RCHT welcome the review as a helpful step, which will inform the consultation that the PCT has been asked to undertake in relation to Upper GI cancer surgery.

Notes to editors:

For more information contact Matt Lenny at the PCT on 01726 627867 or Greg Moulds at RCHT on 01872 252477

22nd September 2008

Strictly private and confidential
John Mills and John Watkinson
Chair and Chief Executive
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Dear John and John

Independent clinical review of Upper GI services, Royal Cornwall Hospitals NHS Trust

I am writing to confirm that the PCT has now received the final report from Professor Mike Griffin and Mr Bill Allum following their recent review of upper GI services. I am enclosing a copy of the report for your response. I note that your Board has already and quite properly received initial feedback following the external clinician's verbal summary of their visit to you and your colleagues.

The report is clear in a number of areas. It recognises that the current service is being provided by a committed and hard working team. The report also acknowledges that while the service is not described as unsafe it is not sustainable and should be discontinued as soon as practicable. There are a number of immediate steps required by the current service to address the critical gaps in current provision including:

Formal risk and fitness assessment programmes for patients undergoing oesophago – gastric cancer surgery should be instituted immediately

Immediate discussions should take place regarding the setting up of a video conferencing MDT between the Peninsula three units on a weekly basis to include patients considered both for radical and palliative therapies

There should be immediate discussions with the clinical governance process at RCHT about the short term future for performing this surgery. This is particularly pertinent as the report is clear 'improvements in the outcomes figures to reach currently acceptable standards will not be achieved with the present level of service at Royal Cornwall Hospital.'

It is important that RCHT has a clear process in place to address all of the above points. Since your Board has already had an opportunity to consider the feedback, I would like confirmation that the immediate actions are being implemented. Given the indication that there is a governance issue for the short term future of performing this surgery, I would welcome a response from you as Chair and Chief Executive before my Board meeting this Wednesday. In addition there is further work to do across the Peninsula and I will be working directly with the Peninsula Cancer Network Board to progress the issues raised.

The independent clinical review was welcomed by our two organisations and the patient groups and is attracting growing interest in its findings. In order to continue to be open and to help inform the Joint Overview and Scrutiny Committees work on consultation, I will be discussing this report on Wednesday at our public Board meeting. As you recall, this independent review was commissioned by the PCT and needs to formally report to the PCT. While timing is always difficult, I feel it would be unhelpful to discuss such a report either in private or until October when the PCT Board will next meet.

In terms of handling, Matt Lenny will work directly with Greg Moulds to ensure the local NHS works in a coordinated way. It is important that the report stays confidential until Wednesday when my Board will discuss the report.

The report is helpful is adding clarity to the way forward and will be used to inform any process for consultation.

I would like to discuss RCHTs response to the report before my meeting on Wednesday, specifically RCHTs response to the recommendations set out in this letter and the main body of the report.

Yours sincerely

Ann James
Chief Executive

STRICTLY PRIVATE AND CONFIDENTIAL
Mrs Ann James
Chief Executive
Cornwall & Isles of Scilly PCT
Peninsula House
Kingsmill Road
Tamar View Industrial Estate
Saltash PL12 6LE

23 September 2008

Dear Ann

Independent clinical review of Upper GI services, Royal Cornwall Hospitals NHS Trust

Thank you for your letter of 22 September enclosing Professor Griffin and Mr Allum's report.

We are very pleased to see the reviewers' confirmation that RCHT's current service is neither unsafe nor dangerous, thus endorsing the findings of last year's Peer Review. We are also pleased to note the positive comments in relation to the professionalism, hard work and commitment of those involved in delivering the service, and indeed in respect of the facilities here on site.

We note in particular the thoughtful and valuable comments about the lack of agreement within the Peninsula Cancer Network about the process by which a single centre is achieved, and the recommendations for a comprehensive and inclusive approach to achieving this.

It is very good to see the explicit recommendation that there should be equivalent reviews of services at both Exeter and Plymouth to inform a decision about a single centre from 2010. As you know, we have always felt this to be essential in order to reassure patients – and public opinion – in Cornwall that a single centre, however it is achieved, will indeed improve patient outcomes and genuinely cover the 1-2 million population recommended within the Improving Outcomes Guidance. We look forward to hearing of your plans to take this recommendation forward within the Network. The end result can then be a genuine single centre within the Peninsula, based upon agreement, in which everyone should be able to have full confidence.

We look forward to discussing with you further how the findings of the review should be reflected in your planned consultation process. This will, in our view, clearly need to explore the option of the single centre being here in Cornwall, making best use of the investment there has been here in the excellent facilities at RCHT which received Professor Griffin and Mr Allum's approbation.

You have asked for early confirmation of steps being taken to address the gaps in current service provision identified in the review and I can confirm that Dominic Byrne has already written to lead surgeon Paul Peyser formally requesting that the MDT is linked across the three units by way of a weekly teleconference as soon as possible. Dominic will be working with Paul on the introduction of formal risk and fitness assessment programmes.

We will also convene, at the earliest opportunity, a special meeting of the Governance Committee in order to discuss the clinical governance implications of the review in detail. Feedback from the proposed external reviews of the other two centres in the Peninsula will clearly be important in informing this process in due course.

Yours sincerely

Sent by e-mail
John Mills CBE
Acting Chairman

Sent by e-mail
John Watkinson
Chief Executive

Appendix D Letter from Bill Shields to John Watkinson

12 September 2008

John Watkinson
Chief Executive
Royal Cornwall Hospitals NHS Trust
Trust Head Office
Bedruthan House
Truro

Dear John

Royal Cornwall Hospitals NHS Trust Performance Issues

I am writing to set out the concerns of the South West Strategic Health Authority over current performance at Royal Cornwall Hospitals NHS Trust. These concerns were not abated by the discussion at the performance meeting on the 11 September 2008. In particular the South West Strategic Health Authority is concerned with performance in the following areas:

- financial performance
    - as at Month 4, a variance of £1.7 million against plan and a projected outturn of between £1.5 million and £8 million adverse as evidenced in your NHS Trust Board report;
    - if Royal Cornwall Hospitals NHS Trust does not deliver its planned control total, it will default on the loan agreed with the Department of Health and the Financially Challenged Trust plan;

- accident and emergency four hour wait performance;
    - although year to date performance is on, there have been sePittl dips in performance in recent weeks;

- 18 weeks Referral to Treatment;
    - performance over recent weeks tends to suggest that Royal Cornwall Hospitals NHS Trust is struggling to sustain performance on the admitted target. The increasing size of the orthopaedic backlog would also suggest that achievement of 13 weeks Referral to Treatment by December 2008 is at risk especially, considering the current performance of 37% in orthopaedics;

- MRSA;
    - against an annual target of 24 cases, Royal Cornwall Hospitals NHS Trust had experienced 23 cases in the first quarter with a further four cases in
      August 2008 and September 2008 to date meaning the annual target has already been breached.

Overall, therefore, this presents an extremely worrying picture and leads us to think that Royal Cornwall Hospitals NHS Trust is in significant risk of breaching its statutory financial duties, and failing to meet national targets.

It is exceptionally disappointing that I need to write to you, and I believe that you need to brief your Chairman; as this discussion will need to be escalated.

Yours sincerely

BILL SHIELDS
DIRECTOR OF FINANCE AND PERFORMANCE

Copy to:

Sir Ian Carruthers OBE, Chief Executive, South West Strategic Health Authority
Lisa Manson, Associate Director of Performance, South West Strategic Health Authority Bill Boa, Associate Director of Finance, South West Strategic Health Authority
Ann James, Chief Executive, Cornwall and Isles of Scilly Primary Care Trust

Appendix E Extract from email to John Watkinson dated 4 August 2008

Email explains that John Watkinson had five days to reply.

Dear John

Following completion of your core standards inspection, I am writing to invite you to consider your draft inspection reports and provide any comments on their factual accuracy. I apologise that you did not receive these last week as anticipated. I have extended the deadline for return of your comments to reflect this delay.

I would be grateful if you would review the attached report(s), and submit your comments to me by 5.30pm on Monday 11th August 2008. Comments received after this date will not be considered.

You must ensure that your comments are recorded in the following format:

· page number and location (line of enquiry reference) of factual inaccuracy;
· why you believe that the record is factually inaccurate;
· what evidence (including references) demonstrates the accurate record (page number and reference to wording).

You may wish to use the template table attached to record your comments. Please use a separate template for each standard commented on.

You may wish to review whether each inspection report is an accurate reflection of the evidence you informed the Healthcare Commission you relied upon when making your declaration.

All comments must relate to factual accuracies recorded in the report(s) and to documentation removed during the inspection or sent two working days after the inspection. Please note that this is not an opportunity to submit new documentation to the Healthcare Commission. In circumstances where new docum...

Appendix F HCC draft infection control report

Inspection Guide 2007/2008

Core standard: C4a infection control

Domain: Safety

Sector: All sectors

Region/area	South West/Cornwall, Devon, Dorset and Somerset	
Trust code and name	REF	Royal Cornwall Hospitals NHS Trust
Type of inspection:	Risk-based	
Lead assessor	Elizabeth Seale	
Other assessors		
Date of inspection	8 July 2008	
Area manager		
Trust declaration	Compliant	
Assessed assurance of compliance		

This inspection guide is a resource for the Healthcare Commission's assessors to use when carrying out selective inspections for the assessment of core standards. The guide does not add any additional requirements to those published in: *www.healthcarecommission.org.uk/healthcareproviders/serviceproviderinformation/annualhealthcheck/nextyearsannualhealthcheck/criteriaforassessingcorestandards.cfm*

Core standard: C4a infection control

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).

Summary of conclusion for level of overall assurance of compliance with the standard

Assessed level of assurance of compliance	Justification

Summary of conclusions for the elements

Table 1.0

Element 1 conclusion	Justification

Core standard C4a infection control

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).

All organisations

Element 1:

The healthcare organisation has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006).

Table 1.0 Element 1 conclusion – see page 3

Table 1.1 Element 1 summary of findings

	I: Lines of enquiry	II: Evaluation of evidence and findings
a	The Hygiene Code requires healthcare organisations to have in place appropriate management systems for infection prevention and control which must include the following:	Evidence referred to in the evaluation against this line of enquiry was provided, on behalf of the healthcare organisation, by the following post holders: Director of organisational development, nursing and therapies Deputy director of nursing: practice development Evaluation: Trust representatives explained that although they did not meet their target of 24 (50%) reductions in MRSA for 2007/2008, the number overall had reduced by 25%. There was a rise in the number of cases in March 2008. The trust's local target for the reduction in cases of *C difficile* by 25% was not achieved. There was an actual increase in the number of cases of in 2007/2008. Although there were reductions in the second half of the year, the trend increased towards the year end. The trust reported a number of examples of actions taken during the year to ensure compliance with the Health Act and to reduce the occurrence of HCAI, such as the introduction of bedpan macerators, purchase of 85 commodes, root cause analyses carried out on all cases of MRSA bacteraemia and training for cannulation using a non-touch

	I: Lines of enquiry	II: Evaluation of evidence and findings
		technique *(interview recording form C4a* (July 2008*), trust story board C4a).* The board does not have a formal board level agreement; however evidence demonstrated that the board is aware of its collective responsibility. For example, the responsibilities of the director of infection prevention and control (DIPC), medical director and deputy director of nursing are set out in the DIPC's 2006/2007 annual report, together with those of the infection control team. The trust's committee and reporting structure for infection control is also described in this report. Infection control became a standing item on the governance committee agenda in December 2007 *(annual report 2006/2007 and action plan* (June 2008), *reducing healthcare associated infections action plan* (February 2008), *interview recording form C4a* (July 2008).
	a board level agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks (Duty 2 a)	The trust updated its infection control policy during the year and a new version was formally launched in February 2008. The earlier version makes no reference to responsibilities or accountability arrangements. The January 2008 version makes explicit reference to the responsibilities of the trust board and chief executive, including the need to identify a board lead. It also clarifies the roles of all other members of trust staff. Other evidence seen provided assurance that the board is aware of its collective responsibility for infection control, for example minutes of the board and sub-committees and the trust assurance framework (*infection control policy* (July 2006), *infection control policy* (December 2007)*, governance committee minutes* (March 2008), *RCHT assurance framework* (February 2008), *executive visits re the Health Act* (August 2007), *hospital infection control committee minutes* (January 2008), *patient safety strategy meeting* (December 2007), *board minutes* (2007/2008), *reducing healthcare associated infections* (November 2007 and February 2008).

	I: Lines of enquiry	II: Evaluation of evidence and findings
	the designation of an individual as director of infection prevention and control (DIPC) with the role as defined in the Code and accountable directly to the board and, from January 2008 directly to the Chief Executive. (Duty 2b, Annex 1)	The trust's infection control policy, effective from January 2008 clearly sets out the responsibilities and duties of the DIPC. Trust representatives explained that the previous director of nursing was designated as the DIPC until September 2007. From September to January 2008 the trust did not have a designated DIPC, although the interim director of organisational development had executive responsibility for infection control. In January 2008 the interim director of organisational development formally adopted the role of DIPC. The post holder does not hold a qualification in infection control and obtains technical advice and support from the trust's two microbiologists, who provide 24-hour telephone cover on a rota basis. Although the trust did not have a DIPC in place for the full year, the board took a responsible and pragmatic approach to resolving this issue *(infection control policy* (December 2007), *interview recording form C4a* (July 2008)*, governance committee minutes* (January 2008), *trust board minutes* (February 2008)*.* Trust representatives explained that compliance with the Health Act 2006 had been assessed and priorities identified have been incorporated into an action plan. A number of actions remained incomplete at the end of 2007/2008. Some of the delays are due to the need to increase resources to improve the infection control infrastructure. For example, the trust has identified the need to agree and implement an infection control education strategy. During February 2008, it was reported that the strategy was to be adopted by June 2008, following agreement to increase resources. The DIPC's annual report had not been completed at the time of the inspection *(interview recording form C4a, reducing healthcare associated infections action plan* (November 2007 and February 2008), *governance report to board quarter 4* (April 2008). The trust is aware that the capacity of the infection control team to maintain and implement up to date policies, and change practice, is an issue. This was commented on in the Healthcare Commission intervention report April 2008, which the trust confirmed they had considered as part

	I: Lines of enquiry	II: Evaluation of evidence and findings
	the mechanisms by which the board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI. These should include implementing an infection control programme and infection control infrastructure (Duty 2c)	of their assurance process. The trust is reviewing its arrangements in relation to the hygiene code, including the availability of resources. The trust has not had strong leadership of the infection control team for some time, compounded by several years without an infection control doctor. The team is small and has extensive responsibilities, including community hospitals and the three Royal Cornwall hospital sites. These are situated over a wide geographical area. It is understood that a business case has now been prepared to expand the team during 2008/2009. In the absence of an infection control doctor, the trust has access to just two medical microbiologists, whose ability to visit wards is restricted. They are however accessible by telephone. The trust is trying hard to appoint a substantive director of infection prevention and control, but reported that they have experienced some difficulty in attracting applicants. The trust has link nurses, located at each of the hospital sites, who were described as key in taking the infection control agenda forward. Trust representatives explained that they meet quarterly to update and develop their skills. It was not entirely clear from the evidence reviewed what their role was in practice and the trust recorded that their competencies had not been identified during the year. There was no evidence that the infection control team receives analytical support including adequate information technology. The trust plans to replace the pathology IT reporting system and introduce an infection control surveillance system in 2008/2009 (*Healthcare Commission intervention report* (April 2008), *reducing healthcare associated infections* (February 2008), *line care month ward activities, activity form IV awareness month, interview recording form C4a* (July 2008)*, link nurse group minutes* (June 2007). As part of its infection control programme, the trust carried out a number of audits during 2007/2008 which included *saving lives* audits. In addition to this programme, audits of patient areas were carried out by the trust's patient and public involvement forum (PPIF) as well as cleaning audits and audits of ward kitchen areas *(RCHT PPIF ward survey report* (February 2008), *saving lives hand hygiene results November to May 2008* (May 2008), *ward kitchen audit*

	I: Lines of enquiry	II: Evaluation of evidence and findings
		report (May and June 2007), *ward weekly cleaning schedule template, hospital infection control committee minutes* (January 2008), *medical group joint cleaning audit July–December* 2007, *cleaning audit results January–June 2008*). The trust is aware that improving the physical environment is an ongoing challenge. The Healthcare Commission report confirmed that the trust has identified the risks associated with a backlog of maintenance work, including repairs to flooring in order to reduce the risk of infection. Good progress was being made towards completing this work by the end of the year. The trust did not provide evidence that it has a planned preventive maintenance schedule in place. Evidence provided showed that the second highest number of reported incidents relate to environmental matters. A high proportion of which involved clinical waste and an unsafe/inappropriate clinical environment, including damaged flooring and fixtures and fittings falling to the floor *(reducing healthcare associated infections action plan* (April 2008*), Healthcare Commission intervention report* (April 2008*), interview recording form C4a* (April 2008), *governance report quarter 4* 2007/2008, *RCA review meeting – renal* (December 2007)*)*. The infection control policy in place until the launch of a new policy in February 2008 did not contain up-to-date advice on the admission, transfer, discharge and movement of patients. Although the new policy does not address the points set out in this line of enquiry, it is supported by other procedures and guidance, which were launched at the same time. These documents include advice on how the transfer and discharge of patients should be managed. There is no reference to admissions or screening of patients but trust representatives explained that all elective orthopaedic patients are now screened for MRSA prior to admission. The trust did not provide evidence that satisfactorily demonstrated how the infection control policy and supporting procedures had been shared with staff but explained that they are available on the trust's intranet

	I: Lines of enquiry	II: Evaluation of evidence and findings
		document library. Evidence of assurance reviewed demonstrated that the trust is aware that inconsistencies in the application of relevant policies occurred in some areas during the year, for example ward closure procedures *(infection control policy* (July 2006), *infection control policy* (December 2007), *source isolation policy and procedure* (December 2007), *C. difficile guidance* (December 2007), *Healthcare Commission intervention report* (April 2008*), interview recording form C4a* (July 2008), *governance report quarter 4 2007/2008) .* The trust introduced a patient transfer/discharge form that includes a section on healthcare associated infection (HCAI) during the year. It was not clear from the evidence provided whether the form was available across the trust by the end of March 2008, or how consistently it was being used for inter-hospital and ward transfers. An audit of the usage of the form was to be completed by February 2008, but the evidence provided did not clarify if this was achieved *(patient transfer form template* (December 2007), *reducing healthcare acquired infection action plan* (February 2008), *interview recording form C4a* (July 2008). The trust is utilising single rooms to isolate infected patients and microbiologists are available to give further advice on a 24-hour rota basis. The trust introduced a bed management policy in February 2008, setting out the arrangements for joint planning and liaison between the infection control team and bed managers. There was no evidence of the involvement of ambulance trusts *(side room matrix, microbiologist 24-hour rota, interim operational policy for bed management and clinical site management* (January 2008).

	I: Lines of enquiry	II: Evaluation of evidence and findings
	a policy addressing, where relevant, admission, transfer, discharge and movement of patients between departments, and within and between healthcare facilities (Note: for ambulance trusts, this should reflect the transfer of potentially infectious patients between facilities) (Duty 2f)	

	I: Lines of enquiry	II: Evaluation of evidence and findings
	(See Points of Information 1-6)	
b	The healthcare organisation should have in place appropriate management systems for infection prevention and control, including the following: An appropriate assurance framework (Duty 2c);	Evidence referred to in the evaluation against this line of enquiry was provided, on behalf of the healthcare organisation, by the following post holders: Director of organisational development, nursing and therapies Deputy director of nursing: practice development Evaluation: The trust described the process for monitoring and reporting on progress towards achievement of infection control action plans. A document produced to report on progress towards reducing healthcare associated infection and the trust's assurance framework are used to report progress to the board. The board receives a performance report that includes the number of MRSA and *C. difficile* cases, but does not include a trend analysis or comparative data for benchmarking purposes. The governance report for the final quarter of 2007/2008 which includes an analysis of complaints and incident data showed that the second highest number of reported incidents related to infrastructure or resource issues. It was noted from a review of the evidence of assurance that the presentation of information in board reports was not always consistent and lacked clarity on some occasions. The Healthcare Commission intervention report, provided as evidence of assurance, gave examples of inconsistency and lack of clarity in board reporting in relation to infection control. The trust accepted the need to agree a revised format to improve board reporting. It was not clear from the evidence whether the necessary agreement had been

	I: Lines of enquiry	II: Evaluation of evidence and findings
		reached by 31 March 2008. Matters relating to infection control are discussed at the hospital infection control committee, which reports to the board via the governance committee. Infection control became a standing item on the governance committee agenda in December 2007. Review of the minutes of the infection control committee showed that the terms of reference had not been revised since October 2005 and did not therefore take account of the requirements of the Health Act 2006. The committee is chaired by the DIPC and has an appropriate complement of members, including a non-executive director. In practice however, meetings are not well attended, particularly by medical staff *(RCHT assurance framework* (February 2008), *reducing healthcare associated infections action plan* (November 2007 and February 2008), *reducing healthcare associated infections – evidence and achievements* (November 2007), *governance committee minutes* (March 2008), *governance report to board quarter 4* (April 2008), *interview recording form C4a* (July 2008), *hospital infection control committee minutes* (May and June 2007, and January and February 2008), *Healthcare Commission intervention report* (April 2008). Evidence provided by the trust showed that attendance at mandatory infection control training was poor in the first six months of the year. It was reported that some pre-arranged sessions were not being attended and that doctors were a particular problem. This had improved by 31 March 2008, by which time 81% of staff had received some training in prevention and control of infection. An analysis of the mandatory training figures for the year showed the gaps in attendance related mainly to doctors and healthcare assistants, with numbers in some groups as low as 17%. Evidence showed that half-day mandatory training sessions took place in March 2008 for senior medical staff that included a 20-minute session on infection control. Although attendance figures improved in the second half of the year, the poor attendance by some staff groups and the approach to training for medical staff does not demonstrate that the trust is giving the prevention and control of infection sufficient priority *(e-mail to group general manager re Lowen ward infection control mandatory training* (October 2007), *e-mail re infection control figures*

	I: Lines of enquiry	II: Evaluation of evidence and findings
	Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection (Duty 2d);	*April 2007 to March 2008* (July 2008)*, final year-end 2007/2008 mandatory training activity profile* (April 2008)*, ward based infection control training August and September 2007, patient safety strategy – pocket guide for staff, interview recording form* (July 2008). Board and governance committee papers recorded a massive reduction in central line infections due to targeted training delivered during September 2007 by the infection control team. There were concerns raised however in March 2008 in root cause analysis (RCA) reports that peripheral lines and IV sites continued to be a concern (*governance committee minutes* (January 2008), *trust board minutes* (August 2007)*, root cause analysis example* (March 2008), *RCA meetings – eldercare* (February 2008), *RCA review meeting – renal* (December 2007). Two satisfactory examples of agency staff having received infection control training from their employers were provided. No evidence of assurance was provided relation to the supervision of staff, but trust representatives interviewed explained that outbreak meetings take place that follow a set agenda, and that supervision is included *(CSCI report* (April 2007), *nursing agency report, interview recording form (July 2008)*. Monthly training sessions for contractors working in clinical areas were to be developed with the infection control team by 31 March 2008. It was not clear from the evidence provided if this was achieved *(reducing healthcare acquired infections action plan* (February 2008). The trust had an audit programme during 2007/2008 which included *saving lives* audits. Audit

	I: Lines of enquiry	II: Evaluation of evidence and findings
		results highlighted a number of areas for improvement and did not demonstrate that key policies and practices were being implemented appropriately. One example was an ongoing waste issue at West Cornwall hospital, one of the trust's three sites. This resulted in clinical and domestic waste and dirty linen being piled high in one room, awaiting collection. This was considered to present a risk of cross-contamination of waste and contamination of the storage area. Other examples included a dirty infusion pump, breast milk stored in a dirty fridge, condemned items and surplus equipment taking up storage space and the absence of sinks for hand washing *(audit programme 2007/2008, infection control audit MAU* (July 2007)*, infection control audit Wheal Fortune* (October 2007*), infection control audit Wheal Rose* (October 2007*), Godolphin environment audit dirty utility* (January 2008), *Wellington environment dirty utility* (January 2008). A number of other audit results were provided as evidence of assurance. For examples, audits carried out by the trust's patient and public involvement forum (PPIF) in June and October 2007 and hand hygiene audits from November to March 2008 carried out by trust staff. Concerns raised related to inadequate storage space and clutter, with bathrooms used as equipment stores and repositories for out of date equipment, poor maintenance of the environment, low use of alcohol gels at trust entrances and some low levels of hand washing *(RCHT PPIF ward survey report* (February 2008), *saving lives hand hygiene results November to May 2008* (May 2008). Audits of ward kitchens were carried out during the year and regular cleaning audits across the trust were introduced in January 2008, based on national cleaning standards. Common issues raised were in relation to cleanliness of kitchens, food expiry dates and fridge temperature records not being kept. The trust continues to implement actions and dedicate resources to improve its cleaning regime *(ward kitchen audit report* (May and June 2007), *ward weekly cleaning schedule template, hospital infection control committee minutes* (January 2008), *medical group joint*

	I: Lines of enquiry	II: Evaluation of evidence and findings
	A programme of audit to ensure that key policies and practices are being implemented appropriately (Duty 2e). Trusts who are able to demonstrate NHSLA Level 2 should not be assessed for this LoE. (See points of information 1, 2, 7 & 8)	*cleaning audit July–December* 2007, *cleaning audit results January–June 2008*). In addition to the audit programme, the trust provided evidence that members of the executive team had visited wards from time to time to assess the environment and discuss the Health Act 2006 with staff. Following these visits, issues were recorded, together with action planned to address them, which is considered to be a very positive approach. Trust representatives interviewed explained that action plans are monitored at executive team meetings but they declined to provide the notes of these meetings as evidence due to their confidential nature (*executive visits re the Health Act* (August 2007), *director visits to clinical areas* (March 2008), *interview recording form* C4a (July 2008). The audit results provided as assurance evidence demonstrate that good infection control practises were not implemented consistently throughout the trust during 2007/2008. It was not clear how the findings from audits have been used to achieve improvements in practice, or whether follow-up audits have been carried out to assess the levels of improvement.
c	The healthcare organisation assesses the risk of acquiring HCAI and takes action to reduce or	Evidence referred to in the evaluation against this line of enquiry was provided, on behalf of the healthcare organisation, by the following post holders:

	I: Lines of enquiry	II: Evaluation of evidence and findings
	control such risks. In doing so they must have:	Director of organisational development, nursing and therapies Deputy director of nursing: practice development
	made a suitable and sufficient assessment of the risks to patients in receipt of health care with respect to HCAI (Duty 3a)	Evaluation: The trust provided some examples to demonstrate where it has assessed risks to patients in receipt of health care with respect to HCAI, identified, recorded and implemented the steps to be taken. The trust has assessed its compliance with the Health Act 2006 and produced a robust action plan aimed at reducing healthcare associated infection levels (HCAI), highlighting gaps and describing the actions required. Whilst the action plan demonstrates that progress is being made in relation to the control of infection, a number of actions appeared to remain incomplete at the end of 2007/2008. Progress against this plan is reported to the trust board and is monitored by the strategic health authority *(reducing healthcare associated infections action plans* (November 2007 and February 2008*), board minutes 2007/2008, interview recording form* (July 2008).
	identified the steps that need to be taken to reduce or control those risks (Duty 3b)	The trust analysed the Healthcare Commission's report on *C. difficile* at the Maidstone and Tunbridge Wells NHS Trust. The results of this analysis were reported to the trust board in November 2007. Eight key areas were identified as needing consideration. These included monitoring bed occupancy rates/effective isolation, audit of proposed antibiotic policy and medical staff training in completion of death certificates. Other areas included IT systems for microbiology and infection control surveillance, review of reporting analysis and trends to the board and
	recorded its findings in relation to duties 3a and	

	I: Lines of enquiry	II: Evaluation of evidence and findings
	3b (Duty 3c) implemented the steps identified (Duty 3d)	guidance and standards for patient care. In order to reduce or control the risks identified, areas requiring consideration have been incorporated into the trust's action plan to reduce healthcare associated infections (*review of Healthcare Commission investigation into Maidstone & Tunbridge Wells gap analysis, reducing healthcare associated infections action plans* (November 2007, February 2008*), board minutes* (November 2007), . Further examples of steps taken to reduce identified risks were discussed and evidence of assurance provided. In response to an increase in cases of *C. difficile* in the spring of 2007, the medical director wrote to all consultants and doctors, advising them to restrict the use of *ceftriaxone*, and provided a general guide to the risks of prescribing other groups of antibiotics. Evidence showed some reductions in the number of cases between June and November 2007, however cases increased again in December 2007. The trust is taking further action by reviewing its antibiotics policy, restricting the use of those associated with *C. difficile,* bringing a consistent approach to policies and improving the engagement of clinicians. A new policy had not been introduced by 31st March 2008. Other examples of steps taken included the provision of an isolation facility for patients with diarrhoea for the autumn/winter 2007 period, development of an effective root cause analysis methodology, the introduction of 24-hour cleaning and completion of a deep cleaning programme across the trust *(letter to all consultants re C. difficile* (30 May 2007), *C. difficile and cetriaxone graph*, *Healthcare Commission intervention report* (April 2008), *reducing healthcare associated infections action plan* (February 2008), *isolation unit process for implementation, interview recording form C4a, nursing and therapies board minutes* (February 2008), *outbreak meetings* (December 2007 and January 2008), *root cause analysis example* (March 2008), *RCA meeting eldercare* (February 2008), *RCA review meeting renal* (December 2007), *trust board reports* (January 2008, *department of health visit* (December 2007), *governance committee minutes* (January 2008), *trust board minutes* (August 2007).

	I: Lines of enquiry	II: Evaluation of evidence and findings
	appropriate methods in place to monitor the risks	Arrangements in response to a reported outbreak of *norovirus* were provided as an example of where the risks of infection are being monitored, as well as completed MRSA root cause analyses. These included a plan to manage the findings. Trust representatives explained that the findings from these have been discussed at monthly clinical director meetings since November 2007. The Department of Health informed the trust in January 2008 that it would be taken off special reporting of MRSA and *C. difficile* rates. They commended the trust on its work in developing an effective root cause analysis methodology and held it up as an exemplar site in the region. However, the Healthcare Commission intervention report (April 2008) raised some concerns in relation to outbreak arrangements. When West Cornwall hospital site was visited, staff seemed to be unclear about the meaning of closure of a ward for infection control purposes. There were conflicting opinions as to whether this meant that the ward was closed to visitors or closed to admissions. A root cause analysis review meeting reported in December 2007, that root cause analysis was generally carried out by one individual on their own, with minimal support or input from the infection control team. A team approach was agreed for the future (*outbreak meetings* (December 2007 and January 2008), *root cause analysis example* (March 2008), *RCA meeting - eldercare* (February 2008), *RCA review meeting - renal* (December 2007), *trust board reports* (January 2008, *department of health visit* (December 2007), *Healthcare Commission intervention report* (April 2008), *interview recording form C4* (July 2008). The evidence of assurance provided by the trust did not demonstrate that appropriate methods are in place to monitor the risks of infection, in order to determine whether the steps taken to reduce or control risks have been effective. For example, staff are not using the incident reporting and risk management systems to record and monitor the risks to patients in receipt of health care with respect to HCAI. The incident reporting system does not appear to have a category for

	I: Lines of enquiry	II: Evaluation of evidence and findings
	of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAI (Duty 3e)	incidents that are linked to the prevention or control of infection. The corporate risk register is being used to record high level risks identified, but no evidence was provided to suggest this is happening at an operational level (*corporate risk register extracts, governance report to board – quarter 4 2007/2008*, *interview recording form* (July 2008). Another example of the absence of monitoring of risks is that clinical teams are not carrying out regular clinical reviews of *C. difficile* patients, including patient deaths, in order to determine what further steps need to be taken to reduce or control this particular infection *(Healthcare Commission intervention report* (April 2008), *Healthcare Commission report action plan)*.

Points of information

1. The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections *(The Hygiene Code)*

The Hygiene Code came into force on the 1st October 2006 and was reviewed and republished in January 2008. The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment, where the risk of HCAI is kept as low as possible.

Further information and a copy of the code can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081927

2. For each section of the basic Code there is an associated Annex. Each Annex identifies supporting guidance and other publications, which are intended to inform policy development. Annexes contain the key policy components and references to support compliance with the Code: they are **not** duties but Trusts must take them onto account. They must therefore have justification for not following the provisions of the contents of the relevant annexes in the Code. The following points of information are all derived from Annex 1.

3. Appropriate management systems **should be such as to demonstrate that responsibility for infection prevention and control is effectively devolved to all professional groups in the healthcare organisation and all clinical specialities and directorates and, where appropriate, support directorates or other similar units. (*The Hygiene Code Annex 1 Management, organisation and the environment)***

4. The role of the **Director of Infection Prevention and Control (DIPC)** is to:

be responsible for the Infection Control Team (ICT) within the organisation

oversee local control of infection policies and their implementation

report directly to the Board and from January 2008 directly to the Chief Executive (not through any other officer)

have the authority to challenge inappropriate clinical hygiene practice as well as inappropriate antibiotic prescribing decisions

assess the impact of all existing and new policies on HCAI and make recommendations for change

be an integral member of the organisation's Clinical Governance and patient safety teams and structures

produce an annual report on the state of HCAI in the organisation for which he or she is responsible and release it publicly

(*The Hygiene Code Annex 1 Director of Infection Prevention and Control (DIPC)*

5. The **infection control infrastructure** should encompass the following elements:

For acute Trusts, an ICT consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection control) and appropriate administrative and analytical support including adequate information technology

For other NHS bodies, an Infection Control Nurse or another designated person responsible for infection control matters

There should be 24-hour access to a nominated qualified Infection Control Doctor, or a consultant in communicable disease control.

(The Hygiene Code Annex 1 Infection Control Infrastructure)

6. Patient movements policy and planning. There should be evidence of joint planning between the ICT and the bed managers in planning

patient admissions, transfers, discharges and movements between departments and other healthcare facilities. Where necessary, ambulance trusts may need to be involved in such planning. *(The Hygiene Code Annex 1 Patient Movements)*

7. An assurance framework makes reference to activities that demonstrate that infection control is an integral part of Clinical and Corporate Governance.

These activities should include:

regular presentations from the DIPC and/or the ICT to the Board

review of statistics on incidence of alert organisms (e.g. MRSA, *Clostridium difficile*) and conditions, outbreaks and Serious Untoward Incidents

evidence of appropriate actions taken to deal with infection occurrences

an audit programme to ensure that policies have been implemented

(The Hygiene Code Annex 1 Assurance Framework)

8. The **infection control programme** should:

set objectives

identify priorities for action

provide evidence that relevant policies have been implemented to reduce HCAI

report progress against the objectives of the programme in the DIPC's annual report

(The Hygiene Code Annex 1 Infection control programme)

Table 1.3 Supporting evidence

Reference	**Document title**	**Date of document** **YYYY Month DD**
SBA03 REF 001	Annual report 2006/7	2008 June 27
SBA03 REF 002	Infection control policy	2007 December
SBA03 REF 003	Governance committee minutes	2008 March 13
SBA03 REF 004	Reducing healthcare associated infections action plan	2007 November 1
SBA03 REF 005	EMT paper re Health Act 2006 – revised gap analysis	2008 March
SBA03 REF 006	Report to EMT management of *C. difficile* at RCHT	2008 July 29
SBA03 REF 007	C. difficile audit acute trusts	No date
SBA03 REF 008	Hospital infection control committee (HICC) terms of reference	2007 May
SBA03 REF 009	HICC minutes	2007 June 5
SBA03 REF 010	Appendix 1 – HICC minutes re NED attendance	2007 June 5
SBA03 REF 011	Appendix 1 – HICC minutes re introduction of matron board reports	2008 February 11

Reference	Document title	Date of document YYYY Month DD
SBA03 REF 012	CNMCD report to trust board template	No date
SBA03 REF 013	Patient transfer form template revised 2007 December 12	2007 December 12
SBA03 REF 014	Source isolation policy	2008 December
SBA03 REF 015	*C. difficile* policy	2008 December
SBA03 REF 016	Side room matrix	2008 February 11
SBA03 REF 017	Microbiologist rota	2008 December
SBA03 REF 018	Healthcare Commission intervention report	2008 April
SBA03 REF 019	RCHT assurance framework	2008 February
SBA03 REF 020	HICC minutes	2007 May 1
SBA03 REF 021	E-mail to group general manager re Lowen ward infection control mandatory training	2007 October 31
SBA03 REF 022	Infection control policy	2006 July 25
SBA03 REF 023	Infection control figures for April 07 to March 08	2008 July 1
SBA03 REF 024	Final year-end 07-08 training activity profile	2008 April 28
SBA03 REF 025	Ward based training 2007	No date

Reference	Document title	Date of document YYYY Month DD
SBA03 REF 026	Ward based infection control training Aug/Sept 07	No date
SBA03 REF 027	CSCI report	2007 April 4
SBA03 REF 028	Nursing agency ltd	No date
SBA03 REF 029	Audit programme 2007-8	2007/2008
SBA03 REF 030	Infection control audit MAU	2007 July 16
SBA03 REF 031	Infection control audit Wheal Fortune	2007 October
SBA03 REF 032	Infection control audit Wheal Rose	2007 October 9
SBA03 REF 033	Line care month ward activities	No date
SBA03 REF 034	Activity form IV awareness month	No date
SBA03 REF 035	Interview recording form C4a	2008 July 8
SBA03 REF 036	Godolphin environment audit dirty utility	2008 January 9
SBA03 REF 037	Wellington environment audit dirty utility	2008 January 7
SBA03 REF 038	Saving lives HH results	2008 May
SBA03 REF 039	Ward weekly cleaning schedule – equipment (blank template)	No date

Reference	Document title	Date of document YYYY Month DD
SBA03 REF 040	Ward kitchen audit report May and June 2007	No date
SBA03 REF 041	Joint cleaning audit timetable 2007 acute medical wards	2007 July to December
SBA03 REF 042	Cleaning audit results	2007 January to June
SBA03 REF 043	Reducing healthcare acquired infection action plan 07 – draft 1	2007 November
SBA03 REF 044	Reducing healthcare acquired infection action plan	2008 February
SBA03 REF 045	Review of Healthcare Commission investigation into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS trust	No date
SBA03 REF 046	Executive visits re the Health Act	2007 August
SBA03 REF 047	Director visits to clinical areas	2008 March
SBA03 REF 048	Letter to all consultants re *C. difficile* May 2007	2007 May 30
SBA03 REF 049	*C. difficile* and *cetriaxone* (graph – September to November 2007)	No date
SBA03 REF 050	Isolation unit process for implementation	No date
SBA03 REF 051	Outbreak meeting	2007 December 4
SBA03 REF 052	Root cause analysis example	2008 March

Reference	Document title	Date of document YYYY Month DD
SBA03 REF 053	RCA meeting eldercare	2008 February 20
SBA03 REF 054	RCA review meeting renal	2007 December
SBA03 REF 055	Link nurse group minutes	2007 June 12
SBA03 REF 061*	Patient safety strategy – pocket guide for staff	No date
SBA03 REF 062	Notes – patient safety strategy meeting	2007 December 12
SBA03 REF 063	HICC meeting	2008 January 15
SBA03 REF 064	Department of Health visit	2007 December
SBA03 REF 065	RCHT PPIF ward survey report	2008 February 6
SBA03 REF 066	Numbers of staff attended infection control training April to September 2007	2008 July 9
SBA03 REF 067	Numbers of staff attended infection control training April 2007 to March 2008	2008 July 9
SBA03 REF 348	Interim operational policy for bed management and clinical site management – launched February 2008	2008 January
SBA03 REF 409	Corporate risk register extracts	2007 April and September/2008 January
SBA03 REF 105	Governance report to board – quarter 4 2007/2008	No date

Reference	Document title	Date of document YYYY Month DD
SBA03 REF 357	Trust story board on C4a	No date
SBA03 REF 443	Appendix 1 – HICC minutes	2007 May 7
SBA03 REF 444	E-mail re dates of IC training medical staff	2008 July 9
SBA03 REF 445	Evidence of medical staff IC training	2007/2008
SBA03 REF 446	Governance deep clean monies	No date
SBA03 REF 447	HCAI and deep clean template	2008 March
SBA03 REF 448	Health Act 2006 compliance and action plan	2007 June 27
SBA03 REF 449	Health Act 2006 summary of compliance	2007 July
SBA03 REF 450	Health Act 2006 summary	2007 June 27
SBA03 REF 451	Infection control policy document 2006 final version (revised)	2006 July 25
SBA03 REF 452	Minutes of governance committee meeting	2007 December 13
SBA03 REF 453	MRSA recovery action plan	2007 July
SBA03 REF 454	MRSA recovery action plan	2007 May
SBA03 REF 455	Rotas demonstrating implementation of 24-hour cleaning service	January/February 2008

Reference	Document title	Date of document YYYY Month DD
SBA03 REF 456	Senior medical staff mandatory half-days extra sessions – IC 20 minutes	2008 February 28
SBA03 REF 142	Trust board minutes	2007 May 31
SBA03 REF 144	Trust board minutes	2007 August 30
SBA03 REF 146	Trust board minutes	2008 January 10
SBA03 REF 147	Trust board minutes	2007 November 29
SBA03 REF 148	Trust board minutes	2008 February 21
SBA03 REF 153	Trust board report – healthy futures strategy	2007 July 26

Table 1.4 Evidence supplied but assessed as not relevant

Document title	Reason assessed as not relevant	Date of document YYYY Month DD
Programmes for mandatory training	Period covered by the evidence were outside the year of assurance.	2008 July

Appendix G Email dated 15 August 2008 to John Watkinson from HCC

15 August 2008

Dear John

Thank you for providing the Healthcare Commission with comments on the factual accuracy of our draft inspection reports in relation to the core standards inspection on 8 July 2008.

I have considered these carefully and where appropriate, have made amendments. Please find attached a copy of the outcome from the factual accuracy checking process.

Each inspection report will be subject to a robust quality assurance process – the final conclusions for each report will not be available to the trust until this activity has been completed.

Yours sincerely

Elizabeth Seale
Lead Assessor

SouthWest Region
Healthcare Commission
Dominions House
Lime Kiln Close
Stoke Gifford
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BS34 8SR

Attach. 5 response forms

Appendix H Response from HCC to RCHT on factual accuracy

Standards Based Assessment	
Response to factual accuracy of draft core standards inspection reports 3.0	

Trust name and trust code	**Royal Cornwall Hospitals NHS Trust/REF**
Name of lead assessor	**Elizabeth Seale**
Date of inspection	8 July 2008
Core standard	C04a

Page number	**Element and line of enquiry**	**Trust comments**	**Lead assessor's response**	**Agree with trust comments (Y/N)**	**Changes to evaluation of evidence and findings? (Y/N) State changes**	**Changes to conclusion/s of elements? (Y/N) State changes**	**Changes to conclusions of standard? (Y/N) State changes**
e.g. Pg 4	*e.g. Element 1, Line of enquiry a,*	*e.g. change last sentence from 10 staff to 15 staff*					

3	Element 1, line of enquiry a	Title of Deputy Director should state "Deputy Director of Nursing: education and practice development"	Upheld.	Y	Title amended.	N	N
3	Element 1, line of enquiry a	"There was a rise in the number of cases in March 2008" this is incorrect. There was a rise in Jan and Feb 08, not in March.	Upheld.	Y	Report changed to: *January and February 2008.*	N	N
4	Element 1, line of enquiry a [duty 2a]	Evidence " and action plan June 2008" Should state and action plan June 2007	Upheld.	Y	Date changed.	N	N

5	Element 1, line of enquiry a [duty 2c]	"A number of actions remained incomplete" At interview it was described how the action plan captures trust wide actions that emerge from completion of root cause analysis and periodic publications from the NHS and Department of Health, therefore it is a dynamic document. Inevitably, reprioritisation of actions has to take place and target dates clearly reflect any changes made. The numbering of actions in the plan reflects the original single action plan [October 07], once achieved, the action is recorded the following month, then removed from the action plan and located on an RCHT shared drive as evidence.	Not upheld, but report changed to add clarity.	N	Report changed to: *Although a number of actions remained incomplete at the end of 2007/2008, trust representatives explained that the action plan is a working document within which reprioritisation of actions is inevitable. Once achieved, actions are reported as such and then removed. Some of the delays in completion recorded are due to the need to increase resources to improve the infection control infrastructure.*	N	N

5	Element 1, line of enquiry a [duty 2c]	" ….the trust recorded that their competencies had not yet been identified" This relates to advanced level rather than basic and is misleading.	Not upheld.	N	No change to report.	N	N
5	Element 1, line of enquiry a [duty 2c]	"There was no evidence of analytical support" There is a dedicated audit and surveillance postholder. The story board refers to "Graphical data demonstrating the number of cases of both MRSA and Clostridium difficile is circulated each month by the infection control team to clinical nurse managers, clinical directors and general managers"	Upheld.	Y	Report changed to: *The trust explained that the infection control team includes a dedicated audit and surveillance coordinator. The trust stated that graphical data demonstrating the number of cases of both MRSA and C.difficile is circulated each month by the infection control team to clinical nurse managers. This was not however corroborated by documentary evidence.*	N	N

5	Element 1, line of enquiry a [duty 2c]	"The trust is trying hard to appoint to a substantive DIPC" is incorrect, it should state infection control doctor.	Upheld.	Y	Job title changed.	N	N
6	Element 1, line of enquiry a [duty 2f]	"There is no reference to screening of patients……" This is part of the IC policy [see MRSA Policy '08 section 16.1.3]	Not upheld (MRSA policy '08 not provided as evidence).	N	No change to report.	N	N
6	Element 1, line of enquiry a [duty 2f]	"orthopaedic patients are now screened" They have been screened for over 2 year.	Not upheld.	N	No change to report.	N	N

7	Element 1, line of enquiry a [duty 2f]	It was not clear from the evidence whether the form [transfer] was available across the trust…." This was part of the trust wide action plan and was a completed action.	Not upheld.	N	No change to report.	N	N
7	Element 1, line of enquiry a [duty 2f]	"There was no involvement of ambulance trusts" The infection control policy MRSA '08 section 11 and 12 refers to transport [ambulances] and discharge further the source isolation policy gives guidance on patients needing transfer by ambulance and advises contact with the South West Ambulance service.	Not upheld – see above.	N	No change to report.	N	N

7	Element 1, line of enquiry b	Title of Deputy Director should state "Deputy Director of Nursing: education and practice development"	Upheld.	Y	Title amended.	N	N
8	Element 1, line of enquiry b [duty 2c]	Report states review of the terms of reference [HICC] had not taken place since October 2005, this is incorrect. Minutes of HICC May 07, refer to the review taking place	Upheld.	Y	Report changed to: *The terms of reference dated May 2007 refer to the requirement to support and monitor the implementation of national policies, for example winning ways – matron's charter. No explicit reference is made the Health Act 2006 or the duties required under the act.*	N	N

8	Element 1, line of enquiry b [duty 2c]	Report states that meeting are not well attended particularly by medical staff. The use of the assurance framework is inappropriately applied to this duty. The assurance framework refers to 'a trust wide risk', the positive assurances support how we know we are doing OK in relation to the risk. In relation to HICC the evidence provided demonstrates there is engagement of medical staff. The HICC minutes provided as evidence indicate there is very good attendance including from medical staff. [over 20 attendees of which 2 are medical staff]	Not upheld, but report changed to add clarity.	N	Report changed to: *In practice, meetings during the year were not consistently well attended, particularly by staff from clinical areas although this was shown to improve towards the year end.*	N	N

8	Element 1, line of enquiry b [duty 2d]	" by which time 81% of staff had received some training……." The work some should be replaced with 'mandatory'	Upheld.	Y	Report changed to: *mandatory training*	N	N
8	Element 1, line of enquiry b [duty 2d]	"….does not demonstrate that the trust is giving prevention and control of infection sufficient priority" Dispute this fact, with 81% of all staff receiving mandatory training, that minutes of HICC demonstrate the monthly updates from matrons/clinical nurse managers about training in their areas. All staff receiving the Cornwall wide patient safety pocket guide.	Not upheld.	N	No change to report.	N	N

9	Element 1, line of enquiry b [duty 2d]	Second paragraph, second sentence joins two different matters together which is inaccurate. The statement that no evidence was provided regarding supervision of agency staff is correct. The outbreak meetings follow a set agenda, and invite the Health Protection Agency who provide support and advice to the RCHT..	Not upheld, but report changed to add clarity.	N	Report changed to: *No evidence of assurance was provided in relation to the supervision of staff. Trust representatives interviewed explained that outbreak meetings take place that follow a set agenda, and that supervision is included.*	N	N
9	Element 1, line of enquiry b [duty 2e]	Evidence used in relation the audit programme did not include any examples of West Cornwall, but report states otherwise?	Not upheld (reference: SBA03 REF 030 MAU audit 2007 July 16).	N	No change to report.	N	N

10	Element 1, line of enquiry b [duty 2e] para 2	"they declined to provide the notes" At interview we discussed the assurance mechanism and the involvement of the weekly executive team meeting. We explained that these were confidential meeting notes but if required we could make anonymous and provide as evidence. The discussion concluded with you that this would not be necessary.	Upheld.	Y	Report changed to: *Trust representatives interviewed explained that although action plans are monitored at executive team meetings, the minutes were not included in the evidence of assurance due to their confidential nature.*	N	N
10	Element 1, line of enquiry b [duty 2e] para 3	Follow up of audits and improvement of practice are recorded in the minutes of HICC.	Upheld.	Y	Reference to follow-up audits removed from this sentence.	N	N
10	Element 1, line of enquiry c	Title of Deputy Director should state "Deputy Director of Nursing: education and practice development"	Upheld	Y	Title amended.	N	N

13	Element 1, line of enquiry c	A number of pieces of evidence were provided from which a reasonable conclusion would be that appropriate methods are in place to monitor the risks of infection.	Not upheld, but report changed to add clarity.	N	Report changed to: *The evidence of assurance provided by the trust did not adequately demonstrate that appropriate methods are in place to monitor the risks of infection, in order to determine whether the steps taken to reduce or control risks have been effective. For example…….*	N	N

Appendix I HCC final infection control report

Healthcare Commission

Core standard: C4a infection control
Domain: Safety
Sector: All sectors

Region/area	South West/Cornwall, Devon, Dorset and Somerset
Trust code and name	REF Royal Cornwall Hospitals NHS Trust
Type of inspection:	Risk-based
Date of inspection	8 July 2008
Trust declaration	Compliant
Assessed assurance of compliance	Not adequate

This inspection guide is a resource for the Healthcare Commission's assessors to use when carrying out selective inspections for the assessment of core standards. The guide does not add any additional requirements to those published in: *www.healthcarecommission.org.uk/healthcareproviders/serviceproviderinformation/annualhealthcheck/nextyearsannualhealthcheck/criteriaforassessingcorestandards.cfm*

Core standard: C4a infection control
Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).

Summary of conclusion for level of overall assurance of compliance with the standard

Assessed level of assurance of compliance	Justification
Not adequate The healthcare organisation does not have adequate evidence to demonstrate reasonable assurance of compliance for this standard for the full year (1 April 2007 to 31 March 2008).	There is inadequate evidence to demonstrate reasonable assurance of compliance against this standard for the full year, for the following reasons: The trust was not able to demonstrate that it had effective systems and arrangements in place throughout the year to ensure that the risk of healthcare acquired infection is reduced. This includes policies, procedures, resources and leadership.

Summary of conclusions for the elements

Table 1.0

Element 1 conclusion	Justification
The healthcare organisation does not have adequate evidence for this element for the full year (1 April 2007 to 31 March 2008).	There is inadequate evidence to demonstrate reasonable assurance of compliance for the full year for this element, for the following reasons: It was clear from the assurance evidence seen during the inspection that the trust had worked hard during the year to ensure that it complied with the requirements of the Health Act 2006 as well as core standards for better health in relation to infection control. By the end of the year, plans were in place which should, if adequately resourced, enable them to fully implement the

	changes that have begun. However, the evidence submitted by the trust did not provide reasonable assurance that the trust had been able to achieve the required level of compliance by 31 March 2008. • The trust did not have a comprehensive infection control policy in place until January 2008. • The trust did not provide evidence that satisfactorily demonstrated infection control policies and procedures launched towards the end of the year had been embedded. For example, an audit of the usage of the patient transfer/discharge form was planned to be completed by February 2008 but evidence provided did not clarify if this was achieved. The introduction of a uniform policy and a policy for the effective use of antibiotics in both minimising the risk of *C. difficile* and treating it effectively were outstanding at 31 March 2008. • The trust did not have a director of infection prevention and control (DIPC) in place for three months of the year. The trust does not have consultant medical expertise with specialist training in infection control. Although the trust has taken action to ensure that technical advice is available from microbiologists, these gaps demonstrate that the infection control infrastructure is not adequately resourced. • Other resources available to secure an effective infection control infrastructure were not considered adequate. In particular, the size of the infection control team, the absence of a planned preventive maintenance schedule, the provision of sinks for hand washing and improvements required to the pathology and other IT systems. • There is poor uptake of infection control training by certain groups of medical staff. • Improvements in cleaning schedules had not been fully embedded at the end of the year. • Trend analyses of HCAIs are not being reported to the trust board. • Audit results have shown some poor levels of compliance with the hygiene code, including hand washing. Medical staff are not adequately reviewing cases of patient deaths to identify future risks and incidence of *C. difficile*.

Guidance for assessors for inspection against this standard

- **Use of findings of others**

Where the Commission has information from other organisations that demonstrates that a trust has positive assurance for relevant lines of enquiry for a standard we will rely upon this information rather than requesting additional information from the trust at the core standards inspection visit. **Assessors will be directly sent the necessary information for the trusts they need to assess.**

The table below outlines the core standards for which there may be information from either:

- The Audit Commission ALE (Auditor's Local Evaluation)
- The NHS Litigation Authority risk management standards
- PEAT (For C21, please check for Hygiene Code visits)

Sector	NHSLA	ALE	PEAT
Acute	C4a, C4b, C4d, C5a, C6, C13b, C14b, C16	C7ac, C7b, C21, C6, C8a, C14a (element 2), C17	C21 (element 2), C15a (element 1)
PCT	C4a, C4b, C4d, C5a, C13b, C14b, C16	C7ac, C7b, C21, C6, C8a, C14a (element 2), C17	C15a (element 1)
MH&LD	C4a, C4d, C5a, C6, C14b, C16	C7ac, C7b, C21, C6, C8a, C14a (element 2), C17	C21 (element 2), C15a (element 1)
Ambulance	C4a, C4b, C4d, C5a, C14b	C7ac, C7b, C21, C6, C8a, C14a (element 2), C17	NA

- Further notes for completion of this inspection guide are now found at the back of the document, including explanations of each section, and guidance provided to trusts explaining the terms "significant lapse" and "reasonable assurance". If you are not familiar with this process you may find these helpful to refer to.

Core standard C4a infection control

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).

All organisations

Element 1:
The healthcare organisation has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006).

Table 1.0 Element 1 conclusion – see page 2

Table 1.1 Element 1 summary of findings

	I: Lines of enquiry	II: Evaluation of evidence and findings
a	The Hygiene Code requires healthcare organisations to have in place appropriate management systems for infection prevention and control which must include the following:	Evidence referred to in the evaluation against this line of enquiry was provided, on behalf of the healthcare organisation, by the following post holders: • Director of organisational development, nursing and therapies • Deputy director of nursing: education and practice development Evaluation: Trust representatives explained that although they did not meet their target of 24 (50%) reductions in MRSA for 2007/2008, the number overall had reduced by 25%. There was a rise in the number of cases in January and February 2008. The trust's local target for the reduction in cases of *C difficile* by 25% was not achieved. There was an actual increase in the number of cases of in 2007/2008. Although there were reductions in the second half of the year, the trend increased towards the year end. The trust reported a number of examples of actions taken during the year to ensure compliance with the Health Act and to reduce the occurrence of HCAI, such as the introduction of bedpan macerators, purchase of 85 commodes, root cause analyses carried out on

	I: Lines of enquiry	II: Evaluation of evidence and findings
	• the mechanisms by which the board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI. These should include implementing an infection control programme and infection control infrastructure (Duty 2c)	Trust representatives explained that compliance with the Health Act 2006 had been assessed and priorities identified have been incorporated into an action plan. Although a number of actions remained incomplete at the end of 2007/2008, trust representatives explained that the action plan is a working document within which reprioritisation of actions is inevitable. Once achieved, actions are reported as such and then removed. Some of the delays in completion recorded are due to the need to increase resources to improve the infection control infrastructure. For example, the trust has identified the need to agree and implement an infection control education strategy. During February 2008, it was reported that the strategy was to be adopted by June 2008, following agreement to increase resources. The DIPC's annual report had not been completed at the time of the inspection *(interview recording form C4a, reducing healthcare associated infections action plan* (November 2007 and February 2008), *governance report to board quarter 4* (April 2008). The trust is aware that the capacity of the infection control team to maintain and implement up to date policies, and change practice, is an issue. This was commented on in the Healthcare Commission intervention report April 2008, which the trust confirmed they had considered as part of their assurance process. The trust is reviewing its arrangements in relation to the hygiene code, including the availability of resources. The trust has not had strong leadership of the infection control team for some time, compounded by several years without an infection control doctor. The team is small and has extensive responsibilities, including community hospitals and the three Royal Cornwall hospital sites. These are situated over a wide geographical area. It is understood that a business case has now been prepared to expand the team during 2008/2009. In the absence of an infection control doctor, the trust has access to just two medical microbiologists, whose ability to visit wards is restricted. They are however accessible by telephone. The trust is trying hard to appoint a substantive infection control doctor, but reported that they have experienced some difficulty in attracting applicants. The trust has link nurses, located at each of the hospital sites, who were described as key in taking the infection control agenda forward. Trust representatives explained that they meet quarterly to update and develop their skills. It was not entirely clear from the evidence reviewed what their role was in practice and the trust recorded that their competencies had not been identified during the year. The trust explained that the infection control team includes a dedicated audit and surveillance coordinator. The trust stated that graphical data demonstrating the number of cases of both MRSA and *C. difficile* is circulated each month by the infection control team to clinical nurse managers, clinical directors and general managers. This was not however corroborated by documentary evidence. The trust plans to replace the pathology IT reporting system and introduce an infection control

	I: Lines of enquiry	II: Evaluation of evidence and findings
		surveillance system in 2008/2009 (*Healthcare Commission intervention report* (April 2008), *reducing healthcare associated infections* (February 2008), *line care month ward activities, activity form IV awareness month, interview recording form C4a* (July 2008), *link nurse group minutes* (June 2007). As part of its infection control programme, the trust carried out a number of audits during 2007/2008 which included *saving lives* audits. In addition to this programme, audits of patient areas were carried out by the trust's patient and public involvement forum (PPIF) as well as cleaning audits and audits of ward kitchen areas *(RCHT PPIF ward survey report* (February 2008), *saving lives hand hygiene results November to May 2008* (May 2008), *ward kitchen audit report* (May and June 2007), *ward weekly cleaning schedule template, hospital infection control committee minutes* (January 2008), *medical group joint cleaning audit July–December* 2007, *cleaning audit results January–June 2008*). The trust is aware that improving the physical environment is an ongoing challenge. The Healthcare Commission report confirmed that the trust has identified the risks associated with a backlog of maintenance work, including repairs to flooring in order to reduce the risk of infection. Good progress was being made towards completing this work by the end of the year. The trust did not provide evidence that it has a planned preventive maintenance schedule in place. Evidence provided showed that the second highest number of reported incidents relate to environmental matters. A high proportion of these involved clinical waste and an unsafe/inappropriate clinical environment, including damaged flooring and fixtures and fittings falling to the floor *(reducing healthcare associated infections action plan* (April 2008*), Healthcare Commission intervention report* (April 2008*), interview recording form C4a* (April 2008), *governance report quarter 4* 2007/2008, *RCA review meeting – renal* (December 2007).
	• a policy addressing, where relevant, admission, transfer, discharge and movement of patients between departments, and within and between healthcare facilities (Note: for ambulance trusts, this should reflect the transfer of potentially infectious patients between facilities) (Duty 2f) (See Points of Information 1-6)	The infection control policy in place until the launch of a new policy in February 2008 did not contain up-to-date advice on the admission, transfer, discharge and movement of patients. Although the new policy does not address the points set out in this line of enquiry, it is supported by other procedures and guidance, which were launched at the same time. These documents include advice on how the transfer and discharge of patients should be managed. There is no reference to admissions or screening of patients but trust representatives explained that all elective orthopaedic patients are now screened for MRSA prior to admission. The trust did not provide evidence that satisfactorily demonstrated how the infection control policy and supporting procedures had been shared with staff but explained that they are available on the trust's intranet

	I: Lines of enquiry	II: Evaluation of evidence and findings
		document library. Evidence of assurance reviewed demonstrated that the trust is aware that inconsistencies in the application of relevant policies occurred in some areas during the year, for example ward closure procedures *(infection control policy* (July 2006), *infection control policy* (December 2007), *source isolation policy and procedure* (December 2007), *C. difficile guidance* (December 2007), *Healthcare Commission intervention report* (April 2008), *interview recording form C4a* (July 2008), *governance report quarter 4 2007/2008)* . The trust introduced a patient transfer/discharge form that includes a section on healthcare associated infection (HCAI) during the year. It was not clear from the evidence provided whether the form was available across the trust by the end of March 2008, or how consistently it was being used for inter-hospital and ward transfers. An audit of the usage of the form was to be completed by February 2008, but the evidence provided did not clarify if this was achieved *(patient transfer form template* (December 2007), *reducing healthcare acquired infection action plan* (February 2008), *interview recording form C4a* (July 2008). The trust is utilising single rooms to isolate infected patients and microbiologists are available to give further advice on a 24-hour rota basis. The trust introduced a bed management policy in February 2008, setting out the arrangements for joint planning and liaison between the infection control team and bed managers. There was no evidence of the involvement of ambulance trusts *(side room matrix, microbiologist 24-hour rota, interim operational policy for bed management and clinical site management* (January 2008). **Conclusion:** The healthcare organisation **has not provided** evidence of reasonable assurance for all aspects of this line of enquiry.
b	The healthcare organisation should have in place appropriate management systems for infection prevention and control, including the following:	Evidence referred to in the evaluation against this line of enquiry was provided, on behalf of the healthcare organisation, by the following post holders: • Director of organisational development, nursing and therapies • Deputy director of nursing: education and practice development Evaluation:

	I: Lines of enquiry	II: Evaluation of evidence and findings
	• An appropriate assurance framework (Duty 2c);	The trust described the process for monitoring and reporting on progress towards achievement of infection control action plans. A document produced to report on progress towards reducing healthcare associated infection and the trust's assurance framework are used to report progress to the board. The board receives a performance report that includes the number of MRSA and *C. difficile* cases, but does not include a trend analysis or comparative data for benchmarking purposes. The governance report for the final quarter of 2007/2008 which includes an analysis of complaints and incident data showed that the second highest number of reported incidents related to infrastructure or resource issues. It was noted from a review of the evidence of assurance that the presentation of information in board reports was not always consistent and lacked clarity on some occasions. The Healthcare Commission intervention report, provided as evidence of assurance, gave examples of inconsistency and lack of clarity in board reporting in relation to infection control. The trust accepted the need to agree a revised format to improve board reporting. It was not clear from the evidence whether the necessary agreement had been reached by 31 March 2008. Matters relating to infection control are discussed at the hospital infection control committee, which reports to the board via the governance committee. Infection control became a standing item on the governance committee agenda in December 2007. The terms of reference dated May 2007 refer to the requirement to support and monitor the implementation of national policies, for example *winning ways – matron's* charter. No explicit reference is made to the Health Act 2006 or the duties required under the act. The committee is chaired by the DIPC and has an appropriate complement of members, including a non-executive director. In practice, meetings during the year were not consistently well attended, particularly by staff from clinical areas although this was shown to improve towards the year end with 65% of members attending in February 2008 *(RCHT assurance framework* (February 2008), *reducing healthcare associated infections action plan* (November 2007 and February 2008), *reducing healthcare associated infections – evidence and achievements* (November 2007), *governance committee minutes* (March 2008), *governance report to board quarter 4* (April 2008), *interview recording form C4a* (July 2008), *hospital infection control committee minutes* (May and June 2007, and January and February 2008), *Healthcare Commission intervention report* (April 2008).
	• Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the	Evidence provided by the trust showed that attendance at mandatory infection control training was poor in the first six months of the year. It was reported that some pre-arranged sessions were not being attended and that doctors were a particular problem. An analysis of the attendance of medical staff to September 2007 provided by the trust, showed attendance for some groups of doctors to be very low. For example, only 5% of consultants and 2% of registrars had attended infection control training, although the average percentage overall for doctors was

	I: Lines of enquiry	II: Evaluation of evidence and findings
	measures required to prevent and control risks of infection (Duty 2d);	39%. At this point, the figure for nurses' attendance was 26% and 11% for healthcare assistants. Overall attendance improved by 31 March 2008, by which time 81% of staff had received mandatory training in prevention and control of infection. The trust provided an analysis of the mandatory training figures at the end of the year which showed the gaps in attendance still related mainly to doctors and healthcare assistants. The overall figure for doctors had risen from 39 to 52% but the numbers of SHOs for example was recorded as 17% and HCAs 33%. Evidence showed that half-day mandatory training sessions took place in March 2008 for senior medical staff that included a 20-minute session on infection control. Although attendance figures overall improved in the second half of the year, the poor attendance by some staff groups and the approach to training for medical staff does not demonstrate that the trust is giving the prevention and control of infection sufficient priority *(e-mail to group general manager re Lowen ward infection control mandatory training* (October 2007), *e-mail re infection control figures April 2007 to March 2008* (July 2008),*numbers of staff attended infection control training April to September 2007, numbers of staff attended infection control training April 2007 to March 2008, evidence of medical staff IC training 2007/2008, final year-end 2007/2008 mandatory training activity profile* (April 2008), *ward based infection control training August and September 2007, patient safety strategy – pocket guide for staff, interview recording form* (July 2008). Board and governance committee papers recorded a massive reduction in central line infections due to targeted training delivered during September 2007 by the infection control team. There were concerns raised however in March 2008 in root cause analysis (RCA) reports that peripheral lines and IV sites continued to be a concern (*governance committee minutes* (January 2008), *trust board minutes* (August 2007), *root cause analysis example* (March 2008), *RCA meetings – eldercare* (February 2008), *RCA review meeting – renal* (December 2007). Two satisfactory examples of agency staff having received infection control training from their employers were provided *(CSCI report* (April 2007), *nursing agency report, interview recording form* (July 2008).
	• A programme of audit to ensure that key policies and practices are being implemented appropriately (Duty 2e).	No evidence of assurance was provided relation to the supervision of staff. Trust representatives interviewed explained that outbreak meetings take place that follow a set agenda, and that supervision is included *(interview recording form* (July 2008). Monthly training sessions for contractors working in clinical areas were to be developed with the infection control team by 31 March 2008. It was not clear from the evidence provided if this was

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	I: Lines of enquiry	II: Evaluation of evidence and findings
	Trusts who are able to demonstrate NHSLA Level 2 should not be assessed for this LoE. (See points of information 1, 2, 7 & 8)	achieved *(reducing healthcare acquired infections action plan* (February 2008). The trust had an audit programme during 2007/2008 which included *saving lives* audits. Audit results highlighted a number of areas for improvement and did not demonstrate that key policies and practices were being implemented appropriately. One example was an ongoing waste issue at West Cornwall hospital, one of the trust's three sites. This resulted in clinical and domestic waste and dirty linen being piled high in one room, awaiting collection. This was considered to present a risk of cross-contamination of waste and contamination of the storage area. Other examples included a dirty infusion pump, breast milk stored in a dirty fridge, condemned items and surplus equipment taking up storage space and the absence of sinks for hand washing *(audit programme 2007/2008, infection control audit MAU* (July 2007), *infection control audit Wheal Fortune* (October 2007), *infection control audit Wheal Rose* (October 2007), *Godolphin environment audit dirty utility* (January 2008), *Wellington environment dirty utility* (January 2008). A number of other audit results were provided as evidence of assurance. For examples, audits carried out by the trust's patient and public involvement forum (PPIF) in June and October 2007 and hand hygiene audits from November to March 2008 carried out by trust staff. Concerns raised related to inadequate storage space and clutter, with bathrooms used as equipment stores and repositories for out of date equipment, poor maintenance of the environment, low use of alcohol gels at trust entrances and some low levels of hand washing *(RCHT PPIF ward survey report* (February 2008), *saving lives hand hygiene results November to May 2008* (May 2008). Audits of ward kitchens were carried out during the year and regular cleaning audits across the trust were introduced in January 2008, based on national cleaning standards. Common issues raised were in relation to cleanliness of kitchens, food expiry dates and fridge temperature records not being kept. The trust continues to implement actions and dedicate resources to improve its cleaning regime *(ward kitchen audit report* (May and June 2007), *ward weekly cleaning schedule template, hospital infection control committee minutes* (January 2008), *medical group joint cleaning audit July–December* 2007, *cleaning audit results January–June 2008*). In addition to the audit programme, the trust provided evidence that members of the executive team had visited wards from time to time to assess the environment and discuss the Health Act 2006 with staff. Following these visits, issues were recorded, together with action planned to address them, which is considered to be a very positive approach. Trust representatives interviewed explained that although action plans are monitored at executive team meetings, the

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	I: Lines of enquiry	II: Evaluation of evidence and findings
		minutes were not included in the evidence of assurance due to their confidential nature (*executive visits re the Health Act* (August 2007), *director visits to clinical areas* (March 2008), *interview recording form* C4a (July 2008). The audit results provided as assurance evidence demonstrate that good infection control practises were not implemented consistently throughout the trust during 2007/2008. It was not clear how the findings from audits have been used to achieve improvements in practice. **Conclusion:** The healthcare organisation **has not provided** evidence of reasonable assurance for all aspects of this line of enquiry.
c	The healthcare organisation assesses the risk of acquiring HCAI and takes action to reduce or control such risks. In doing so they must have: • made a suitable and sufficient assessment of the risks to patients in receipt of health care with respect to HCAI (Duty 3a) • identified the steps that need to be taken to reduce or control those risks (Duty 3b) • recorded its findings in relation to duties 3a and 3b (Duty 3c)	Evidence referred to in the evaluation against this line of enquiry was provided, on behalf of the healthcare organisation, by the following post holders: • Director of organisational development, nursing and therapies • Deputy director of nursing: education and practice development Evaluation: The trust provided some examples to demonstrate where it has assessed risks to patients in receipt of health care with respect to HCAI, identified, recorded and implemented the steps to be taken. The trust has assessed its compliance with the Health Act 2006 and produced a robust action plan aimed at reducing healthcare associated infection levels (HCAI), highlighting gaps and describing the actions required. Whilst the action plan demonstrates that progress is being made in relation to the control of infection, a number of actions appeared to remain incomplete at the end of 2007/2008 for example, the introduction of a uniform policy and development of a policy for the effective use of antibiotics in both minimising the risk of *C. difficile* and treating it effectively. Progress against this plan is reported to the trust board and is monitored by the strategic health authority *(reducing healthcare associated infections action plans* (November 2007 and February 2008*), board minutes 2007/2008, EMT paper Health Act 2006 revised 2008 gap analysis March 2008, interview recording form* (July 2008).

	I: Lines of enquiry	II: Evaluation of evidence and findings
	• implemented the steps identified (Duty 3d) • appropriate methods in place to monitor the risks of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAI (Duty 3e)	The trust analysed the Healthcare Commission's report on *C. difficile* at the Maidstone and Tunbridge Wells NHS Trust. The results of this analysis were reported to the trust board in November 2007. Eight key areas were identified as needing consideration. These included monitoring bed occupancy rates/effective isolation, audit of proposed antibiotic policy and medical staff training in completion of death certificates. Other areas included IT systems for microbiology and infection control surveillance, review of reporting analysis and trends to the board and guidance and standards for patient care. In order to reduce or control the risks identified, areas requiring consideration have been incorporated into the trust's action plan to reduce healthcare associated infections (*review of Healthcare Commission investigation into Maidstone & Tunbridge Wells gap analysis, reducing healthcare associated infections action plans* (November 2007, February 2008*), board minutes* (November 2007), . Further examples of steps taken to reduce identified risks were discussed and evidence of assurance provided. In response to an increase in cases of *C. difficile* in the spring of 2007, the medical director wrote to all consultants and doctors, advising them to restrict the use of *ceftriaxone*, and provided a general guide to the risks of prescribing other groups of antibiotics. Evidence showed some reductions in the number of cases between June and November 2007, however cases increased again in December 2007. The trust is taking further action by reviewing its antibiotics policy, restricting the use of those associated with *C. difficile*, bringing a consistent approach to policies and improving the engagement of clinicians. A new policy had not been introduced by 31st March 2008. Other examples of steps taken included the provision of an isolation facility for patients with diarrhoea for the autumn/winter 2007 period, development of an effective root cause analysis methodology, the introduction of 24-hour cleaning and completion of a deep cleaning programme across the trust *(letter to all consultants re C. difficile* (30 May 2007), *C. difficile and cetriaxone graph, Healthcare Commission intervention report* (April 2008), *reducing healthcare associated infections action plan* (February 2008), *isolation unit process for implementation, interview recording form C4a, nursing and therapies board minutes* (February 2008), *outbreak meetings* (December 2007 and January 2008), *root cause analysis example* (March 2008), *RCA meeting eldercare* (February 2008), *RCA review meeting renal* (December 2007), *trust board reports* (January 2008, *department of health visit* (December 2007), *governance committee minutes* (January 2008), *trust board minutes* (August 2007). Arrangements in response to a reported outbreak of *norovirus* were provided as an example of where the risks of infection are being monitored, as well as completed MRSA root cause analyses. These included a plan to manage the findings. Trust representatives explained that the findings from these have been discussed at monthly clinical director meetings since November

	I: Lines of enquiry	II: Evaluation of evidence and findings
		2007. The Department of Health informed the trust in January 2008 that it would be taken off special reporting of MRSA and *C. difficile* rates. They commended the trust on its work in developing an effective root cause analysis methodology and held it up as an exemplar site in the region. However, the Healthcare Commission intervention report (April 2008) raised some concerns in relation to outbreak arrangements. When West Cornwall hospital site was visited, staff seemed to be unclear about the meaning of closure of a ward for infection control purposes. There were conflicting opinions as to whether this meant that the ward was closed to visitors or closed to admissions. A root cause analysis review meeting reported in December 2007, that root cause analysis was generally carried out by one individual on their own, with minimal support or input from the infection control team. A team approach was agreed for the future (*outbreak meetings* (December 2007 and January 2008), *root cause analysis example* (March 2008), *RCA meeting - eldercare* (February 2008), *RCA review meeting - renal* (December 2007), *trust board reports* (January 2008, *department of health visit* (December 2007), *Healthcare Commission intervention report* (April 2008), *interview recording form C4* (July 2008). The evidence of assurance provided by the trust did not adequately demonstrate that appropriate methods are in place to monitor the risks of infection, in order to determine whether the steps taken to reduce or control risks have been effective. For example, staff are not using the incident reporting and risk management systems to record and monitor the risks to patients in receipt of health care with respect to HCAI. The incident reporting system does not appear to have a category for incidents that are linked to the prevention or control of infection. The corporate risk register is being used to record high level risks identified, but no evidence was provided to suggest this is happening at an operational level (*corporate risk register extracts, governance report to board – quarter 4 2007/2008, interview recording form* (July 2008). Another example of the absence of monitoring of risks is that clinical teams are not carrying out regular clinical reviews of *C. difficile* patients, including patient deaths, in order to determine what further steps need to be taken to reduce or control this particular infection *(Healthcare Commission intervention report* (April 2008), *Healthcare Commission report action plan).* **Conclusion:** The healthcare organisation **has not provided** evidence of reasonable assurance for all aspects of this line of enquiry.
This is all the evidence that the trust board used as evidence of reasonable assurance of compliance with this element (see evidence tables for list of supporting/non-supporting documentation).		

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Points of information

1. The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections *(The Hygiene Code)*

The Hygiene Code came into force on the 1st October 2006 and was reviewed and republished in January 2008. The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment, where the risk of HCAI is kept as low as possible.

Further information and a copy of the code can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081927

2. For each section of the basic Code there is an associated Annex. Each Annex identifies supporting guidance and other publications, which are intended to inform policy development. Annexes contain the key policy components and references to support compliance with the Code: they are **not** duties but Trusts must take them onto account. They must therefore have justification for not following the provisions of the contents of the relevant annexes in the Code. The following points of information are all derived from Annex 1.

3. Appropriate management systems should be such as to demonstrate that responsibility for infection prevention and control is effectively devolved to all professional groups in the healthcare organisation and all clinical specialities and directorates and, where appropriate, support directorates or other similar units. (*The Hygiene Code Annex 1 Management, organisation and the environment)*

4. The role of the **Director of Infection Prevention and Control (DIPC)** is to:

- be responsible for the Infection Control Team (ICT) within the organisation
- oversee local control of infection policies and their implementation
- report directly to the Board and from January 2008 directly to the Chief Executive (not through any other officer)
- have the authority to challenge inappropriate clinical hygiene practice as well as inappropriate antibiotic prescribing decisions
- assess the impact of all existing and new policies on HCAI and make recommendations for change
- be an integral member of the organisation's Clinical Governance and patient safety teams and structures
- produce an annual report on the state of HCAI in the organisation for which he or she is responsible and release it publicly (*The Hygiene Code Annex 1 Director of Infection Prevention and Control (DIPC)*

5. The **infection control infrastructure** should encompass the following elements:

- For acute Trusts, an ICT consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection control) and appropriate administrative and analytical support including adequate information technology
- For other NHS bodies, an Infection Control Nurse or another designated person responsible for infection control matters
- There should be 24-hour access to a nominated qualified Infection Control Doctor, or a consultant in communicable disease control.

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(The Hygiene Code Annex 1 Infection Control Infrastructure)

6. Patient movements policy and planning. There should be evidence of joint planning between the ICT and the bed managers in planning patient admissions, transfers, discharges and movements between departments and other healthcare facilities. Where necessary, ambulance trusts may need to be involved in such planning. *(The Hygiene Code Annex 1 Patient Movements)*

7. An assurance framework makes reference to activities that demonstrate that infection control is an integral part of Clinical and Corporate Governance.

These activities should include:

- regular presentations from the DIPC and/or the ICT to the Board
- review of statistics on incidence of alert organisms (e.g. MRSA, *Clostridium difficile*) and conditions, outbreaks and Serious Untoward Incidents
- evidence of appropriate actions taken to deal with infection occurrences
- an audit programme to ensure that policies have been implemented

(The Hygiene Code Annex 1 Assurance Framework)

8. The **infection control programme** should:

- set objectives
- identify priorities for action
- provide evidence that relevant policies have been implemented to reduce HCAI
- report progress against the objectives of the programme in the DIPC's annual report

(The Hygiene Code Annex 1 Infection control programme)

Table 1.3 Supporting evidence

Reference	Document title	Date of document YYYY Month DD
SBA03 REF 001	Annual report 2006/7	2008 June 27
SBA03 REF 002	Infection control policy	2007 December
SBA03 REF 003	Governance committee minutes	2008 March 13
SBA03 REF 004	Reducing healthcare associated infections action plan	2007 November 1
SBA03 REF 005	EMT paper re Health Act 2006 – revised gap analysis March 2008	2008 March
SBA03 REF 006	Report to EMT management of *C. difficile* at RCHT	2008 July 29
SBA03 REF 007	C. difficile audit acute trusts	No date
SBA03 REF 008	Hospital infection control committee (HICC) terms of reference	2007 May

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Reference	Document title	Date of document YYYY Month DD
SBA03 REF 009	HICC minutes	2007 June 5
SBA03 REF 010	Appendix 1 – HICC minutes re NED attendance	2007 June 5
SBA03 REF 011	Appendix 1 – HICC minutes re introduction of matron board reports	2008 February 11
SBA03 REF 012	CNMCD report to trust board template	No date
SBA03 REF 013	Patient transfer form template revised 2007 December 12	2007 December 12
SBA03 REF 014	Source isolation policy	2008 December
SBA03 REF 015	*C. difficile* policy	2008 December
SBA03 REF 016	Side room matrix	2008 February 11
SBA03 REF 017	Microbiologist rota	2008 December
SBA03 REF 018	Healthcare Commission intervention report	2008 April
SBA03 REF 019	RCHT assurance framework	2008 February
SBA03 REF 020	HICC minutes	2007 May 1
SBA03 REF 021	E-mail to group general manager re Lowen ward infection control mandatory training	2007 October 31
SBA03 REF 022	Infection control policy	2006 July 25
SBA03 REF 023	Infection control figures for April 07 to March 08	2008 July 1
SBA03 REF 024	Final year-end 07-08 training activity profile	2008 April 28
SBA03 REF 025	Ward based training 2007	No date
SBA03 REF 026	Ward based infection control training Aug/Sept 07	No date
SBA03 REF 027	CSCI report	2007 April 4
SBA03 REF 028	Nursing agency ltd	No date
SBA03 REF 029	Audit programme 2007-8	2007/2008
SBA03 REF 030	Infection control audit MAU	2007 July 16
SBA03 REF 031	Infection control audit Wheal Fortune	2007 October
SBA03 REF 032	Infection control audit Wheal Rose	2007 October 9
SBA03 REF 033	Line care month ward activities	No date
SBA03 REF 034	Activity form IV awareness month	No date
SBA03 REF 035	Interview recording form C4a	2008 July 8
SBA03 REF 036	Godolphin environment audit dirty utility	2008 January 9
SBA03 REF 037	Wellington environment audit dirty utility	2008 January 7
SBA03 REF 038	Saving lives HH results	2008 May
SBA03 REF 039	Ward weekly cleaning schedule – equipment (blank template)	No date
SBA03 REF 040	Ward kitchen audit report May and June 2007	No date
SBA03 REF 041	Joint cleaning audit timetable 2007 acute medical wards	2007 July to December
SBA03 REF 042	Cleaning audit results	2007 January to

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Reference	Document title	Date of document YYYY Month DD
		June
SBA03 REF 043	Reducing healthcare acquired infection action plan 07 – draft 1	2007 November
SBA03 REF 044	Reducing healthcare acquired infection action plan	2008 February
SBA03 REF 045	Review of Healthcare Commission investigation into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS trust	No date
SBA03 REF 046	Executive visits re the Health Act	2007 August
SBA03 REF 047	Director visits to clinical areas	2008 March
SBA03 REF 048	Letter to all consultants re *C. difficile* May 2007	2007 May 30
SBA03 REF 049	*C. difficile* and *cetriaxone* (graph – September to November 2007)	No date
SBA03 REF 050	Isolation unit process for implementation	No date
SBA03 REF 051	Outbreak meeting	2007 December 4
SBA03 REF 052	Root cause analysis example	2008 March
SBA03 REF 053	RCA meeting eldercare	2008 February 20
SBA03 REF 054	RCA review meeting renal	2007 December
SBA03 REF 055	Link nurse group minutes	2007 June 12
SBA03 REF 061*	Patient safety strategy – pocket guide for staff	No date
SBA03 REF 062	Notes – patient safety strategy meeting	2007 December 12
SBA03 REF 063	HICC meeting	2008 January 15
SBA03 REF 064	Department of Health visit	2007 December
SBA03 REF 065	RCHT PPIF ward survey report	2008 February 6
SBA03 REF 066	Numbers of staff attended infection control training April to September 2007	2008 July 9
SBA03 REF 067	Numbers of staff attended infection control training April 2007 to March 2008	2008 July 9
SBA03 REF 348	Interim operational policy for bed management and clinical site management – launched February 2008	2008 January
SBA03 REF 409	Corporate risk register extracts	2007 April and September/2008 January
SBA03 REF 105	Governance report to board – quarter 4 2007/2008	No date
SBA03 REF 357	Trust story board on C4a	No date
SBA03 REF 443	Appendix 1 – HICC minutes	2007 May 7
SBA03 REF 444	E-mail re dates of IC training medical staff	2008 July 9
SBA03 REF 445	Evidence of medical staff IC training	2007/2008
SBA03 REF 446	Governance deep clean monies	No date
SBA03 REF 447	HCAI and deep clean template	2008 March
SBA03 REF 448	Health Act 2006 compliance and action plan	2007 June 27

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Reference	Document title	Date of document YYYY Month DD
SBA03 REF 449	Health Act 2006 summary of compliance	2007 July
SBA03 REF 450	Health Act 2006 summary	2007 June 27
SBA03 REF 451	Infection control policy document 2006 final version (revised)	2006 July 25
SBA03 REF 452	Minutes of governance committee meeting	2007 December 13
SBA03 REF 453	MRSA recovery action plan	2007 July
SBA03 REF 454	MRSA recovery action plan	2007 May
SBA03 REF 455	Rotas demonstrating implementation of 24-hour cleaning service	January/February 2008
SBA03 REF 456	Senior medical staff mandatory half-days extra sessions – IC 20 minutes	2008 February 28
SBA03 REF 142	Trust board minutes	2007 May 31
SBA03 REF 144	Trust board minutes	2007 August 30
SBA03 REF 146	Trust board minutes	2008 January 10
SBA03 REF 147	Trust board minutes	2007 November 29
SBA03 REF 148	Trust board minutes	2008 February 21
SBA03 REF 153	Trust board report – healthy futures strategy	2007 July 26

Table 1.4 Evidence supplied but assessed as not relevant

Document title	Reason assessed as not relevant	Date of document YYYY Month DD
Programmes for mandatory training	Period covered by the evidence were outside the year of assurance.	2008 July

Instructions for completion of the inspection guide

Inspection guides will be tailored where possible to the specific core standard and sector being assessed. Above each element the guide sets out the types of organisation to which the element is applicable (e.g. all sectors, ambulance services, acute services, etc).

- **Level of overall assurance of compliance** (Page 1)
  The overall conclusion for the standard should be recorded on page 1 of the inspection guide beside the section level of assurance of compliance once you have completed the rest of the inspection guide. Overall assurance of compliance is determined by the category selected in the "Summary of conclusion for overall assurance of compliance" table on the page 2 of the inspection guide. Select the relevant category and delete the remaining two categories.

- **Summary of conclusion for level of overall assurance of compliance table** (Page 2)
  There are three categories of assurance of compliance listed down the left hand column, and a range of possible justifications for each in the right hand column. Indicate the conclusion for the trust's level of overall assurance of compliance with the standard by deleting the two inappropriate categories. Then delete the inappropriate justifications within the right hand side column for that category. Please provide references to the appropriate tables (element conclusions) where requested. If there is considered to be a significant lapse as a result of a combination of issues at element level, please give reasons.

- **Element conclusions** (starting on Page 3)
  The conclusion for the elements should be recorded here. There are three categories of conclusion down the left hand column. Select the appropriate conclusion by deleting the two inappropriate categories. The corresponding 'justification' field must be identified by deleting the inappropriate choices.

  Where a significant lapse has been identified at the element level, please give reasons. (See also information point below on "What is a significant lapse?").

  Please note: A significant lapse could also arise as a result of the healthcare organisation's failure to ensure that the services provided by independent contractors are meeting the relevant aspects of an element.

- **Summary of findings**
  These are tables for the individual elements and their corresponding lines of enquiry.
  Column I: the lines of enquiry are set out in this column for each element. Each line of enquiry should be considered during the inspection, including all of the aspects of the line of enquiry.
  Column II: an evaluation of evidence and findings should be recorded in this column. This should be a summary of findings for each line of enquiry with references to the evidence (i.e. the document title) that has informed these findings.

  Conclusion: Please note whether you think the trust has or has not provided evidence of reasonable assurance for all aspects of each line of enquiry.

- **Points of information**
  Additional information for each element, where available or necessary, is set out under the **point/s of information** sections after each summary of findings table. This section has been included to provide contextual information on aspects related to the elements or background information for particular lines of enquiry.

- **Supporting evidence**
  For each piece of evidence that has informed the findings for the element the reference, document title and date of document should be recorded. The referencing convention for evidence is SBA 03, Trust Code, 000…n, full title, date issued (P*).
  SBA 03 is Standards Based Assessment, 3rd year

000…n is a sequential reference assigned to the individual document/piece of evidence
The date format should be YYYY Month DD
*P indicates when a document is only available in hard copy

For example: SBA 03, AB3, 013, Data of PCT services, 2007 January 14.

If you are referencing a document within your evaluation and findings, please use the following format: *Title* (Publisher, Date)

- **Irrelevant evidence**
  Please record details of any evidence supplied by the trust but which you assessed as not relevant. Please give a brief reason for your assessment.

- **If a Primary Care Trust (PCT) is the subject of the inspection** two additional sections of the inspection guide should be completed:

  - **Independent contractors**
    An evaluation of evidence and findings should be provided in relation to a PCT's arrangements for independent contractors. This table is provided for each element that applies to a PCT, and sets out which independent contractor groups should be considered during the inspection.

  - **Commissioned services**
    An evaluation of evidence and findings should be provided and the **supporting evidence table** should be completed in relation to a PCT's arrangements for commissioned services. Commissioned services relate to the overall standard.

- **What is a significant lapse?**
  The 2007/2008 criteria for assessing core standards provides the following guidance to trusts:
  Trust boards should decide whether a given lapse is significant or not by considering the extent of risk to patients, staff and the public, and the duration and impact of any lapse. There is no simple formula to determine whether a lapse is significant. A simple quantification of risk, such as the death of a patient or the loss of more than £1million, cannot provide a complete answer.

  Determining whether a lapse is significant depends on the standard under consideration, the circumstances in which a trust operates (such as the services they provide, their functions or the population they serve), and the extent of the lapse (e.g. the level of risk to patients, the duration of the lapse and the range of services affected). Note that where a number of issues have been identified, these issues should be considered together as to whether they constitute a significant lapse.

- **What is reasonable assurance?**
  The 2007/2008 criteria for assessing core standards provides the following guidance to trusts:
  Reasonable assurance, by definition, is not absolute assurance. Reasonable assurance must be based on documentary evidence that can stand up to internal and external challenge.

The core standards are not optional and describe a level of service which is acceptable and which must be universal. We expect each trust's objectives to include compliance with the core standards, and that the organisation will use its routine processes for establishing assurance.

Trusts' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the elements.

Where healthcare organisations provide services directly, they have the main responsibility for ensuring that they meet the core standards. However, their responsibility also extends to those services that they provide via partnerships or other forms of contractual arrangement (e.g. where human resource functions are provided through a shared service). When such arrangements are in place, each organisation should have reasonable assurance that those services meet the standards.

Appendix J HCC briefing to SHA

Introduction

This year's results of the Healthcare Commission's Annual Health Check (AHC) will see the Royal Cornwall Hospitals NHS Trust rated as weak on quality of services for the third year running. For use of resources this year, the trust will receive a rating of fair. For the two previous years the trust was rated weak on both quality of services and use of resources. The trust is one of the poorest performers in the country for its quality of services. One aspect of the Healthcare Commission's AHC quality of services rating is performance against Department of Health's core standards. Every NHS trust in the country assesses its performance against these standards. It then makes a public self-declaration on how it is meeting these core standards for the year of assessment. This self declaration also includes a statement on the measures that the trust has in place to meet the requirements of the hygiene code.

For the year April 1st 2007 to March 31st 2008 the board of the Royal Cornwall Hospitals NHS Trust declared that it was reasonably assured of compliance for the full year with thirty five of the forty three standards. In relation to eight standards for which the trust board declared non-compliant, it stated that it had taken actions which would ensure the standards had been met by the end of the year.

Background

- **May 2006 – Royal Cornwall Hospitals NHS Trust declaration for the period 1st April 2005 – 31st March 2006**

In May 2006 the trust declared full year compliance with all forty three of the core standards for the declaration period 1st April 2005 – 31st March 2006. In July the Healthcare Commission was notified by the trust that some irregularities had been identified in the reporting of the core standards and that the declaration did not reflect the trust's true position. Following an internal review, the trust revised its declaration to not met against nine standards and insufficient assurance against a further eleven standards. This along with their poor financial assessment of use of resources gave the trust a rating in the AHC as weak/weak. Within that year the Healthcare Commission also undertook a service reviews in medicines management and children's services. The trust was rated weak for medicines management, and fair for children's services.

- **October 2006 –concerns raised about the management of waiting lists**

In October 2006 the Healthcare Commission was informed by the trust and the strategic health authority that there were concerns about the management of the waiting lists. An external review of the management of waiting lists took place. There was however a considerable delay in agreeing and concluding the final report and subsequent action plan to respond to the concerns and issues raised. A paper went to the trust board in March 2007 detailing the outcomes of the review and actions that were to be taken. The Healthcare Commission was kept informed by the strategic health authority of the progress the trust was making in implementing the recommendations from the review and of any impact on patient safety. Evidence from the recent core standards assessment

identified that there were concerns about how many patients had been medically disadvantaged; 6000 patients were identified who needed to be reviewed and treated by mid October 2007. Although it appeared that plans were in place to provide the board with regular reports on progress, no further evidence was found at the core standards assessment to demonstrate that the board or its sub-committees had received these reports throughout 07/08.

- **May 2007 – Royal Cornwall Hospitals NHS Trust declaration for the period 1st April 2006 – 31st March 2007**

In May 2007 the trust declared that it had only met thirteen of the core standards for 2006/2007. The remaining thirty were declared not met for which action plans were in place to ensure that seven would be met by the March 31 2007 and the remaining twenty three met by 31 March 2008.

The results of the heart failure improvement review were also released around this time. Cornwall health community was rated as weak. This review identified a number of issues for both the acute and the primary care trust. This result also demonstrated how far behind the trust was in meeting the NICE clinical guidance and the national service framework for heart failure. Although this was clearly acknowledged by the trust's medical director, it was very difficult to get senior clinical and management engagement from the acute trust. It took many months to achieve an action plan that was fit for purpose. Progress on implementation of the action plan is slow. Both the PCT and the acute trust have responsibility for ensuring progress continues but a lack of engagement at a senior management level from the acute trust to drive this forward has been observed. This is believed to have been exacerbated by the departure of a consultant cardiologist with special interest in heart failure last year.

- **October 2007 – January 2008 – Healthcare Commission intervention**

In October 2007 once again results of the AHC rated the trust as a weak for both quality of services and use of resources. The trust was identified as the poorest performer in the country. The trust recognised that it had serious shortcomings and was keen to work with the Healthcare Commission in order to help assure the safety of patients as quickly as possible. In light of serious concerns about the trust's declared poor adherence to the core standards, the investigations team undertook an intervention at the trust to:

- Establish whether the trust, in recognising the extent of the previous problems, was now taking the necessary action to deal with them;
- Examine the trust's governance systems to check they were appropriate and that there was a satisfactory arrangement in place for the management of risk.

The intervention took place between November 2007 and January 2008.

As part of this process, the Healthcare Commission reviewed documents requested from the trust; visited clinical areas in November 2007 and again in January 2008; attended a meeting of the trust's board and a meeting of the local authority overview and scrutiny committee. Interviews were held with forty three staff from the trust, Cornwall and Isles

of Scilly Primary Care Trust and South West Strategic Health Authority. The team included external advisers who provided advice and guidance throughout. In addition, statistical analyses were carried out of information, largely derived from the trust itself but also from other relevant organisations.

The Healthcare Commission published a report in April 2008 that recognised the beginnings of improvement were in place. Progress would need to be sustained across the whole trust to ensure that the change was embedded. The report made eleven recommendations. In making these recommendations the Healthcare Commission recognised that were a number of significant challenges for the trust and that some of the more complex changes would take longer to complete. Three of these recommendations related to infection control and the requirements of the hygiene code. There were also three recommendations that related to governance systems, particularly that the trust board should review the information presented to them to ensure that it is clear and accurate and enables the board to discharge its functions effectively. This recommendation was quite specific as the effectiveness of the reporting arrangements was still being refined at the time of our visit. There were some concerns about the way the board was reported to and the quality of the information that was provided. For example, in the report, it was noted that a table in the infection control annual report presented to the board in March 2007 contained information about C.difficile up to March 2007, but the graph only went up to December 2006. This meant that the trust's board did not have clear up to date information about the increase in the number of cases of C. difficile that occurred in the spring of 2007. The board was formally updated on the trust's progress against the recommendations from the Healthcare Commission's intervention report at its board meeting on 5th August 2008. The Healthcare Commission has agreed with the trust that it will formally review progress on implementation of the report's recommendations at its review which is due to take place in early December 2008. This review will be lead by the Healthcare Commissions investigations team.

- **May 2008 Royal Cornwall Hospitals NHS Trust declaration for the period 1st April 2007 – 31st March 2008**

As mentioned above in May 2008 the trust declared that for the year ending March 2008 it had been fully compliant with thirty five standards out of forty three standards. There had been a high level of non-compliance with standards in the previous years, with previously published planned dates for compliance by 31 March 2008. Taking this into account together with the recommendations from the intervention report, this declaration by the trust on its level of full year compliance with the core standards appeared to be overly optimistic.

As part of the Healthcare Commission's annual assessment of performance of the NHS, trusts are assessed on their level of compliance against the Governments core standards. The Healthcare Commission uses a risk based system, where those trusts deemed most likely to have incorrectly declared that they comply with standards are inspected. To assess which trusts are most at risk of undeclared significant lapses, each trust's declaration is cross checked against thousands of items of data. This cross checking applies to all the standards where a trust has declared the board is reasonably assured of compliance. This year we also tested standards that would be met by the end of the year (31 March 2008). Once this cross checking has taken place we identify approximately 20% of trusts to follow up and test the accuracy of the evidence they used when making their declarations. The 20% comprises of those trusts we consider are most at risk of having

undeclared significant lapses against the core standards and some trusts are selected at random.

For the Royal Cornwall NHS Trust there were thirteen standards which the trust board had declared it was compliant on, but that our cross checking systems identified at high risk of non-compliance. This was in addition to the eight standards which the trust had declared it had significant lapses in compliance within the year, but had put plans in place to resolve by the end of the year. A full list of the high risk standards is in appendix 1. For each trust that is identified to receive an inspection visit, five standards are then selected as part of this review. The summary of selected standards report (appendix 2) provides the rationale for why Royal Cornwall Hospitals NHS Trust was selected for a follow-up assessment and provides more detailed cross-checking information.

The trust was therefore selected for a risk based core standards inspection visit, to take place on a date between June and July 2008. Because of the level of concern the Healthcare Commission had in the accuracy of the trust declaration, the Head of Region South West, contacted the trust to provide an opportunity for the trust board to reconsider its declaration. This was declined; the chief executive stated the trust board was confident in the position it had declared. The assessment visit took place on July 8. The five standards identified for assessment were: C7a/c corporate and clinical governance and risk management, C4a infection control, C4b safe use of medical devices, C13a dignity and respect and C20b privacy and confidentiality.

The findings and judgements from the follow-up assessment determined that the trust board was not assured of compliance with all five of these standards for the assessment year April 07 to March 08. These judgements were made on the evidence that the trust had used to assure itself that it was compliant. Core standards are not optional and describe a basic level of service which is acceptable and must be universal. When making their declaration on core standards trust boards should consider all aspects of their services, staff groups and whether they have reasonable assurance that the trust has complied with each standard across all its services, for the full year without any significant lapses. The five reports attached in appendix 3 give the full detail of the findings and judgements from the assessments. However, below is a summary of the key findings for the standards that were assessed.

- **Key findings from the risk based core standard inspection**

<u>*Core standard*</u>

- *C7a&c: corporate and clinical governance. Healthcare organisations: a) apply the principles of sound clinical and corporate governance*
  b) undertake systematic risk assessment and risk management

<u>Conclusion</u>

A number of issues were identified for this standard which, when considered together constituted a significant lapse. The evidence provided by the trust did not demonstrate that there were effective arrangements in place for clinical governance throughout the year. Some of examples of this included lack of a clinical governance strategy; slippage on delivery of the clinical audit plan; lack of medical staff involvement in key activities,

including clinical audit, root cause analysis training, incident reporting, and implementation of NSF's. Although there were a number of changes made throughout the year to the structure and framework for clinical governance much of this took place towards the end of the year and had not been embedded. The evidence did not demonstrate that clinical governance systems were operating effectively.

The composition of the trust's remuneration committee conflicts with the NHS trust's model standing orders 2006. For example the chief executive and director of human resources are part of this committee's membership and the terms of reference state that the chief executive needs to be in attendance for the committee to be quorate. This prevents the committee from functioning correctly and being independent of management, as set out in the model standing orders.

The trust was not able to demonstrate that there were clear lines of accountability and ownership extending from the front line through to the board for identifying, acting upon risks and reviewing progress at a clinical level. Examples of this were that risk management training was not deemed to be mandatory, no risk manager in post throughout the year, lack of understanding of the difference between risk management and health and safety. An internal audit of the trust's risk management systems during the year found a number of weaknesses. There was not satisfactory evidence that the recommendations from that report had been acknowledged and satisfactorily acted upon. The risk management system, which is one of the trust's key internal control mechanisms, was identified as high risk in the annual report from the head of internal audit's opinion, and acknowledged in the chief executive's annual statement on internal control, which forms part of the trust's annual report.

Core standard

- *C4b: safe use of medical devices. Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised*

Conclusion

The trust was not able to provide adequate assurance that all permanent and professional staff who medical devices had been trained in the use of medical devices. It was unable to demonstrate that it monitored performance on the management of medical devices through an annual report to the board, which is an MHRA requirement. Evidence did not provide assurance that users' experience was represented within the advisory group. There was a lack of evidence to demonstrate that adequate training was in place for maintenance/repair staff, including the recognition of differences between single use, single patient use and reusable medical devices. These issues considered together constituted a significant lapse.

Core standard

- *C4a infection control. Healthcare organisations keep patients safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduce, with particular emphasis on high standards of hygiene and cleanliness.*

Conclusion

A number of issues were identified in relation to this standard which, when considered together constituted a significant lapse. The trust was not able to demonstrate it had effective leadership, systems and arrangements in place throughout the year to ensure that the risk of healthcare acquired infection was reduced. Although there was evidence to demonstrate that the trust had worked hard during the year to ensure it complied with the requirements of the hygiene code and core standards in relation to infection control, these arrangements need to be adequately resourced and policies and procedures need to be fully embedded. Some examples of this were: the infection control policy was not in place until January 2008; there was no director of infection prevention and control in place for three months of the year; poorly resourced infection control team including the absence of an infection control doctor; absence of a planned preventive maintenance schedule; poor uptake of training in certain groups of medical staff; trend analysis of HCAI's not reported to the board; poor audit results relating to hand washing and ward kitchen hygiene.

Core standard

- *C13a dignity and respect. Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect*

Conclusion

A significant lapse was identified for this standard. The trust was not able to provide evidence to demonstrate that staff received training in support of the race, gender and disability schemes, had access to training in equality and diversity or customer care, or were trained in undertaking equality impact assessments. There was no evidence of how staff were supported to meet the needs of the black and minority ethnic groups. The evidence provided showed that the race equality scheme had not been updated since 2005, and the accompanying action plan was out of date as it related to 2004/5. There was no evidence that the implementation of the action plan was monitored. Similarly although there was a disability scheme and action plan there was no evidence of how staff were trained to support its implementation or how actions were monitored.

Core standard

- *C20b privacy and confidentiality. Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.*

Conclusion

A significant lapse was identified for standard C20b as there was evidence from the trust that demonstrated a significant number of lapses occurred in relation to mixed sex accommodation throughout the year. There was one example of forty occasions where

mixed sex accommodation breaches occurred and took up to a week to resolve. Measures were identified to reduce the risk of mixed sex accommodation and the trust judged these measures were successful, there was however, no evidence presented to demonstrate that the actions were effective and had reduced the number of mixed sex breaches.

- **Key themes from the assessment visit**

The assessment team had concerns about the trust's assurance process. This related to how judgements were made about the level of compliance with core standards based on the evidence the trust used to assure itself. There appeared to be a failure to recognise that significant lapses had occurred during the year of assessment for a number of standards, or to recognise the cumulative effect of the issues identified and the impact of those on the declaration of full year compliance. It appears that in January 2008 the trust introduced a new approach to assessing levels of compliance. They introduced a quantitative approach that was based on a risk assessment scoring system. However, this system does not appear or may not take full account of the qualitative aspects of compliance. Prior to the introduction of the new system the evidence seen as part of the assessment was that the trust had assessed itself as non-compliant on a number of standards but these would be resolved by 31 March 2008. However, in the case of some standards, the trust had assessed that there were risks of on going non compliance at the end of the assessment year. In September 2007 for example, seven standards were assessed as high risk of not being compliant by the end 2007/2008 and a further twenty two standards considered at medium risk. A report to the executive management team highlighted the issues preventing compliance at that time. It is difficult to see how the gaps identified in September 2007 could have been addressed retrospectively and therefore full year assurance of compliance declared for a number of these standards.

Prior to approving the 2007/2008 declaration, an extra-ordinary governance committee meeting took place where non-executive directors received reports from executive standard leads for six standards. They were given the opportunity to challenge the evidence presented to them in support of this sample. All present at this meeting agreed the process used by the organisation to reach its self-assessment against compliance with all 43 standards and approved five of the six presented to them as being compliant for the full year. These judgements were extrapolated across the other standards which had been reviewed by the trust's executive team only and not subject to challenge by the full board.

The Healthcare Commission's intervention took place within the assessment year (2007/2008) and clearly identified areas where improvement was required. There was a direct link from the intervention report to a number of the standards such as C7ac, C7e, C4a, C13a and C20b, but the trust did not appear to consider the impact of these findings on their declaration of compliance.

The lack of training and quality of training to help staff understand their responsibilities has been a theme throughout the assessment. For example staff have not been provided with training to support the implementation of policies and procedures such as the race, gender and disability equality schemes. There was evidence that some mandatory training was delivered via information leaflets and composite training sessions for example 20 minute slots for doctors on infection control. There was a lack of evidence of training for some groups such as medical staff. The NHSLA in their recent assessment also picked up similar concerns about training.

No members of medical staff were involved in the assessment visit. This is particularly worrying considering that C7ac is focussed on clinical governance. Evidence presented on standards showed a lack of medical involvement or leadership in some key activities such as audit, root cause analysis, incident reporting and risk management.

It appears that the focus of the trust's executive team tended towards processes and systems with a distinct absence of outcome evidence. For example there is little evidence of shared learning from incidents across the trust. This raises doubts that the senior team and therefore the board can be confident that risks are identified appropriately, managed and followed up and learning shared.

As part of this assessment, links to other standards and evidence seen has raised concerns about the validity of a number of other standards the trust declared compliant on. These are listed in appendix 4. But a couple of examples are:

- C2a child protection - the head of internal audit opinion and annual report made reference to child protection being high risk, with concerns about employment checks for staff, particularly criminal records bureau checks.
- C7e race equality - evidence from 13a and the intervention showed that the policy was out of date, implementation of action plan not completed or monitored, poor quality impact assessments.
- C14 complaints – response times, investigations and shared learning.

- **September 24th 2008 Meeting with the trust to confirm outcome to the assessment**

A meeting took place with the chief executive and director of marketing on 24 September to advise them of the results of the assessment. The trust chair was also invited to attend this meeting. The Healthcare Commission was advised he was unable to attend and although the offer was extended to include any non-executive director, this invitation was not taken up.

Understandably the chief executive expressed surprise and some irritation at the judgements. Although the final reports were not made available to the trust until the end of the meeting, they had received copies of the reports as part of the factual accuracy checking process. Therefore the conclusions being given at the meeting should not have been surprising. As part of the discussion in the meeting it became apparent that both trust representatives appeared to have failed to understand the principle of declaring a standard to be compliant. Their view was that by showing in-year improvement, or that action had been taken in one service, this was sufficient for a declaration of compliance. They did not seem to have fully understood that for the board to declare reasonable assurance of compliance they should be confident that all services were complying with the standard for the full year without any significant lapses. Communications with the trust the previous year also demonstrated a lack of understanding at senior level of the three categories that standards can be declared, compliant, not met, or insufficient assurance.

The chief executive indicated that the trust would appeal against the outcome.

- **Summary**

The outcome of the core standards assessment was that in respect of all five standards the Healthcare Commission judged the trust board not to have had reasonable assurance of compliance. The trust board at Royal Cornwall Hospitals NHS Trust had overstated its level of compliance with the Department of Health core standards. There is also a concern about the level of compliance achieved beyond the five standards that were inspected. In making the declaration and as a result of the inspection, there is evidence to suggest the trust's systems of assurance are not satisfactory and the Healthcare Commission is concerned about the lack of engagement of medical staff. Although there was evidence that a lot of work had taken place through the year to improve systems and processes, these have not yet become fully embedded and substantial improvement in outcomes has not been observed. Compliance with core standards should not be seen as an end in its own right but the foundations on which the trust builds services that provide good quality care to patients.

Appendix K Mr Biggs' record of his conversation with John Watkinson on 3 July

Dear All,

I have spoken to John Watkinson this morning. I said we were surprised and concerned about the degree of improvement that the trust had declared in light of the findings and recommendations in the intervention report. I reminded him that declaring compliance was a declaration of full year compliance with standards. I gave some specific examples from the intervention report including infection control concerns about leadership, capacity of the infection control team and the environmental concerns relating to cleaning rates and fabric of the maternity unit.

John said that they had used a systematic approach to quantify the lapses that were identified, they had had detailed discussions with the board including non execs and he was confident that the declaration was correct. He emphasised that he had no motivation to declare a false position as declaring compliance with 21 standards would be a significant improvement from 13 last year. He said that he was looking forward to the inspection next week (Tuesday 18 July) and hoped that the external validation of the declaration would be an important step for staff and the public.

John said that he would look again at the declaration. I said that if on reflection he had concerns about the position they had declared that he should call me in advance of the inspection. If I did not hear from him then the inspection go ahead as planned.

From the tone of the conversation, I don't expect to hear from him and that the inspection will go ahead as planned. I am concerned that we may end up qualifying the trust on several standards and that may call into question other standards which they have declared compliance but we will not be following up. The follow up in September will be a good opportunity to check across a broader range of issues prior to AHC publication.

Appendix L RCHT action plan following Hawker review

1. INDEPENDENT REVIEW OF MANAGEMENT & GOVERNANCE

1.1 In February 2009 the final report on the Independent Review of Management and Governance at the Trust was published. The conclusions and recommendations were accepted by the Trust Board.

1.2 To provide the Chairman's Committee with full assurance that these recommendations are being implemented the attached assurance document has been prepared which specifically provides both an update of current progress, risk assessment and source of assurance.

1.3 At the time the report was published the 27 recommendations were classified as red, high risk. Since this time it is the view of the Trust that all 27 recommendations have now been implemented.

1.4 The risk assessment considered the extent to which the desired outcome will be achieved and the following broad principles have been adopted.

Red – Not yet started or high risk issues currently threatening delivery.

Amber – In progress, some assurance issues still outstanding or completed but further assurances still needed to embed delivery.

Green – In progress, all actions on track, no risk to delivery or completed and no further material assurances needed to embed delivery.

1.5 There are six areas which have been assessed as complete but further assurances are still needed to embed delivery. These are: -

Staff Rostering – further work to embed practice (target May 2010)

Theatres – clear plans now in place but delivery phase commencing. (Aim to have more assurance on completion by May 2010)

Service Line Reporting – Assurance report to Board due April 2010.

Review of Divisional Arrangements – Finalise HR structure, benchmark arrangements. (July 2010)

Organisation Development Programme formalised and approved by Trust Board. (Aim to complete by June 2010)

HR Function – final HR structure. (July 2010)

INDEPENDENT REVIEW PROGRESS SUMMARY

Internal Risk Assessment

Report Reference	Summary Recommendation	Exec Lead	23-3-10 Rec. Complete Yes/No	Feb-09	Sep-09	Nov-09	Jan-10	Mar-10	Trend Jan to March	Target green date
99.1	Standards for Better Health	DNMT	YES	R	A	G	G	G	SAME	Achieved
99.2	Financial Plans	DF	YES	R	A	A	A	G	UP	Achieved
99.3	Staff Rostering	DHR/COO	YES	R	A	A	A	A	SAME	May-10
99.4	Productive Ward	DNMT	YES	R	A	G	G	G	SAME	Achieved
99.5	HRG4	DF	YES	R	A	A	G	G	SAME	Achieved
99.6	Theatres	COO	YES	R	A	A	A	A	SAME	May-10
99.7	Prompt Payment Code	DF	YES	R	A	A	G	G	SAME	Achieved
99.8	Revisit KPMG Report	DF	YES	R	G	G	G	G	SAME	Achieved
99.9	Payroll weaknesses	DHR	YES	R	A	G	G	G	SAME	Achieved
99.10	Service Line Reporting	DF	YES	R	A	A	A	A	SAME	Apr-10
99.11	Board reporting	CEO	YES	R	G	G	G	G	SAME	Achieved
100.1	PCT relationships	CEO / Chair	YES	R	A	G	G	G	SAME	Achieved
100.2	PCT joint programme of work	CEO / Chair	YES	R	A	G	G	G	SAME	Achieved
100.3	External Development Support	CEO / Chair	YES	R	A	A	G	G	SAME	Achieved
100.4	Estates Strategy	DEF	YES	R	A	A	A	G	UP	Achieved
101.1	Review of Divisional Arrangements	CEO	YES	R	A	A	A	A	SAME	Jul-10
101.2	Divisional Accountability	CEO	YES	R	G	G	G	G	SAME	Achieved
101.3	Professional Leadership	DNMT / MD	YES	R	A	A	G	G	SAME	Achieved
101.4	External clinical relationships	DNMT / MD	YES	R	A	G	G	G	SAME	Achieved
101.5	Non-Executive capability	Chair	YES	R	G	G	G	G	SAME	Achieved
101.6	Board development	CEO / Chair	YES	R	A	A	G	G	SAME	Achieved
101.7	Executive team development	CEO	YES	R	A	A	G	G	SAME	Achieved
101.8	Orgnanisational development	DHR	YES	R	A	A	A	A	SAME	Jun-10
101.9	HR Function	DHR	YES	R	A	A	A	A	SAME	Jul-10
101.10	Media management policy	CEO	YES	R	G	G	G	G	SAME	Achieved
102.1	Stakeholder confidence	CEO / Chair	YES	R	G	G	G	G	SAME	Achieved
102.2	Performance monitoring of this plan	CEO / Chair	YES	R	G	G	G	G	SAME	Achieved

Totals:						
	RED	27	0	0	0	0
	AMBER	0	20	14	8	6
	GREEN	0	7	13	19	21

INDEPENDENT REVIEW OF MANAGEMENT & GOVERNANCE

ASSURANCE REPORT

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
99.1	The Trust should establish clear, director led, project management arrangements for improving its Healthcare Commission ratings and the self certification process.	Clear Director led project management arrangements in place.	**YES**	DNMT	A comprehensive change to the Trust's approach has been implemented. Each standard has a self assessment which outlines exactly what is needed in the way of evidence to be able to demonstrate compliance. Where there are gaps in evidence action plans are being monitored continuously. Minimum 37 out of 44 standards are expected to be compliant in 2009-10. Sources of Board Assurance: - Integrated performance report		S4BH declaration made ahead of deadline – 37 compliant standards 5 not met but will be compliant at year end – All on target for compliance by end of year. Monthly reporting to EMB if any significant breaches which would change declaration. CQC Registration – pre-application submission made pre 18 Dec deadline. Currently:	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
					Independent Consultant reviews Audit Committee Governance Committee Internal Audit Reviews Action Plans Self Assessments SHA and PCT reviews Executive Reviews		• Creating a trust-wide database. • Mapping all assurance evidence stored centrally to the new registration regulations (S4BH, NHSLA, other assessments). Head of Quality & Patient Safety and Trust Board Secretary co-ordinating CQC the registration process. Submission to CQC needs to be by 29 Jan – draft to EMB 12 Jan; final to Board 28 Jan – registration submitted within timeframe, confirmation of registration without conditions awaited.	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
							Need to identify leads for each of the essential standards. Training for Q&PS teams 25 Jan. Training for the Divisions early Feb. CQC registration achieved and maintenance activity continuing	
99.2	Three financial plans should be produced immediately: a short term plan to reduce expenditure in the current year; a plan for coping with the year-end variance, including the ability of the Trust to make the necessary loan	2008-09 financial targets achieved. 2009-10 plan signed off by Board, PCT and Strategic Health Authority by April 2009.	**YES**	DF	Financial Plans for 2009-10 signed off by the PCT and SHA. Zero based budget setting process. Current predictions are that £8.255m surplus for the year will be achieved. Expected I&E benefits have been realised following MEA exercise. Sources of Board Assurance: -		Delivery of month on month position. (Ongoing)	LTFM developed and work on future (11/12 and beyond) SIP commenced

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	repayments this year; and a financial plan for 2009-10 which should include fully identified cash releasing efficiency schemes to be implemented before April 2009 and also some provision for contingencies. In each case it would be prudent for the Trust to discuss and agree proposals with the PCT and SHA given the ongoing support the Trust will require in achieving sustainable financial stability.				Integrated performance report Board recovery trajectory – Sept 09/Oct 09 Divisional performance reviews Service improvement programme office. Audit committee. Board meeting with Divisional Teams and approval of finance trajectories until year end. MEA report to Trust Board January 2010.			
99.3	The Trust should implement an electronic staff rostering system to	Electronic staff rostering system implemented	**YES**	DHR	Review of Sources of Board Assurance: - E-Rostering Board		Whilst ward areas are live, work is needed to embed practice, change	A revised nursing and midwifery skill mix will be

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	derive service and financial benefits.	as 'live'.			(Commencing February 2010) Rostering Weekly Task & Finish Group Meeting (Recommencing February 2010) Notes; Action Plan; Integrated Rostering Performance Scorecard.		culture and realise benefits. Auto-Roster element of system incorrectly configured and further reduction in staff personal preferences required. Contracts agreed with staff in July 2009 (effective for 12 month period) cannot be altered until July 2010, however review will commence in May 2010. Auto-Roster temporarily suspended, allowing for Ward Managers to provide improved standard of off duty. Insufficient	finalised no later than July 2010. A full project review will be carried out by the new project manager no later than August 2010.

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
							improvement noted, therefore Wards now unable to utilise Kernoflex until appropriate sign off achieved as per roster calendar by both Ward Manager and Matron. Creation of 'Additional Duties' facility removed, owing to anecdotal evidence of inappropriate use. This should result in significant savings for Trust. Monthly tracking of savings to be evidenced and reported to Trust Board. E-Rostering administrators now directed to	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
							undertake face to face with ward managers and Matrons on a monthly basis to assist accurate completion and usage of system. 'Employee On Line' module to be planned for May 2010, allowing for staff to self roster, increasing engagement and accuracy with rostering system may incur slight delay whilst potential IT issues are resolved.. 'Payroll' module to be introduced by May 2010, increasing accountability of Ward Managers to	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
							ensure effective off duty. Inaccurate rostering would cause individual staff pay and budgets to be affected. Programme lead and E-rostering facilitators meeting early implementing Trust 24/03/10 to ensure rapid roll out across RCHT.	
99.4	The Trust should implement the national productive ward initiative	Commencement of implementation of product ward initiative including project plan and project management arrangements in place. Detailed roll out plan in place.	**YES**	DNMT	This project has been established and launched, resources recruited and implementation is under way. This project will take some months to completely implement but all processes are now established to confirm implementation and green status. Source of Board Assurance: -		Good progress has been achieved on the flagship ward – patient status at a glance; storage location = 50% reduction in time looking for items; ward engagement and staff motivation /satisfaction increased. Delays will be apparent following	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
					Integrated performance report		Norovirus and Severe Weather impact. 6 further wards have commenced – Trauma 1&2, WCH Med 1&2, Roskear and WCH OPD. Areas for organisational roll out:- Colour coding of stores cupboard – 3 wards per 3 months. Patient status at a glance – boards bought, embossing currently being completed – minimum of 5 wards per month on return. Nursing/ward	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
							metrics – waiting for meeting on 22.01.10 with PCT – nursing quality metrics being evaluated. Nursing metrics in place. RCHT are achieving far above the progress rate of many other trusts nationally.	
99.5	Review the fitness for purpose of the clinical coding resource, to confirm what changes to capacity, training and coding processes need to be implemented to successfully manage HRG4 and ensure that all income due is billed	HRG 4 data captured and signed off by every specialty in the hospital and agreed with the PCT.	**YES**	DF	The Trust HRG4 project has been concluded and the tariff for 2010-11 activity has been calculated. The Trust coding audits show an acceptable level of performance. Sources of Board Assurance: - HRG4 Programme Board Audit Commission audit			Data quality (including clinical coding) strategy scheduled for Aug TB

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	appropriately				reports on PbR Audit Committee PbR benchmarking reports to Audit Committee			
99.6	On publication of the PriceWaterhouseCoopers review of operating theatre utilisation, the Trust should produce a clear project management implementation plan supported by clear leadership and accountability. Similarly, the Trust should develop action plans to improve and performance manage clinical performance in other areas	Project plan in place for the theatres review and action plan for improving clinical productivity in place for all areas.	**YES**	COO	The robustness of the Division of Anaesthetics and Theatres' SIP (£3.35m) is currently the subject of Executive challenge to establish the levels of savings, both recurring and non-recurring, that can be achieved from the current programme in 2010/11 and in future years. This will result in a lower than expected delivery this year. The role and function of the Anaesthetics/Theatre Programme Board requires a re-focus on the outcome measures including the SIP targets for the 14 individual projects. The Divisional		Plans are place, now there is a need to embed delivery and drive the benefits as part of the 2010-11 £19.7m service improvement programme.	A revised SIP Plan with agreed deliverables for 2010/11 needs Executive review and sign-off.

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
					Manager for Patient Support and SIP will now chair this group. At Trust level delivery of the projects is managed by the Clinical Productivity Board, chaired by the COO, and reporting directly to the Executive Management Team. Progress to date includes: A revised anaesthetic and theatre workforce plan is now the subject of Executive consideration. The objective is to establish a base staffing level which will meet current demand and reduce significantly the high variable pay costs. Productive theatre initiative lead now in post			

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
					and has developed project milestones. 'Visioning' workshops are currently being held at RCH and WCH to ensure theatre staff are fully engaged in the programme. The pre-operative assessment facility situated in the Tower Block needs further work to ensure the Trust can maximise theatre capacity and reduce 'on the day' cancellations. This work is being led by the Senior Matron for Division of Anaesthetics and Theatres. The List Broker role has been the subject of a recent review to maximise theatre utilisation. This work is being overseen by the Deputy COO.			

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
					Theatre Direct, located in Trelawny Wing, became operational in May and flow into theatres has improved significantly, as has the patient experience. It has highlighted the need to develop a similar facility in the Tower Block to support gynaecology and the general surgical specialties. Sources of Board Assurance: - Integrated performance report. Executive Team meetings. Divisional Performance Reviews. Service improvement programme office. Clinical Productivity Board. Theatres KPIs			

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
					Ad hoc meetings as required.			
99.7	A focussed plan should be produced to improve the Trust's performance under the prompt payment code.	Action plan in place, performance improving.	**YES**	DF	Detailed plan to improve performance was agreed. Month on month improvement being achieved. In month performance has consistently improved throughout 2009-10. For the month of February 2010 the position achieved for Non-NHS invoices was 93% and cumulatively for the year 87%. The Trust applied to become a signatory to the prompt payment code on 12 November 2009. Sources of Board Assurance: - Integrated Performance Report			Current performance in excess of 90%. Action plan to deliver 95% agreed

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
					Divisional reports and performance reviews. PSPP Action Plan Better practice code sign up November 2009.			
99.8	Review the KPMG findings of August 2007, with a view to determine how far the Trust has made progress in addressing the issues highlighted in that report	Formal audit committee review of the KPMG findings to determine progress made. Ensure action plans in place for any outstanding items.	**YES**	DF	The Trust's Audit Committee revisited progress in July 2009 and concluded that there was now assurance that financial reporting processes are fit for purpose, embedded and subject to ongoing improvement. Sources of Board Assurance: - Audit Committee report July 2009 Internal audit External audit ALE score Integrated performance report		2 elements remain issues and these are covered elsewhere in this plan: - Patient Level Costing Strategy development	
99.9	A plan to resolve control weaknesses	Action plan in place too	**YES**	DHR	Significant progress has been made. Improved			There are continuing

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	within the payroll system needs to be formulated and implemented as soon as possible.	resolve control weaknesses within the payroll system.			controls have been implemented and a self-assessment against these payroll controls has been completed. This self-assessment was discussed with the audit committee at January 2010 meeting. The annual payroll internal audit has also provided positive assurance. Sources of Board Assurance: - Payroll Strategy; Controls Processes; KPIs for all customers; Payroll SLA Review meetings; External Audit reports; Internal Audit reports; Audit Committee Notes; Payroll User Guide Monthly controls reports			concerns about business continuity. The department lacks "experience in depth" having recently lost key members of staff.
99.10	The Trust must	Patient level	**YES**	DF	Launch events were held		Now to roll out	Good progress

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	make speedy progress in implementing service line reporting, if it is to have a stronger cost control at divisional and clinical service levels. The SHA should provide sufficient support to the Trust to implement this key initiative as soon as possible	costing/service line reporting implemented and income and cost data available at patient level, HRG, consultant, specialty and service line.			with the DoH, Project Board in place, software acquired, organisational engagement events have taken place and the first cut of Patient Level information has now been produced and presented to the Project Board. A full report will go to the Trust Board in April 2010. An independent review has been commissioned to assure the Board of our approach. Sources of Board Assurance: - Patient Level Costing Project Board Patient Level Costing Project Team.		Patient Level Costing across the Trust. Board report April 2010.	has been made in a very complex and detailed costing system. The Trust is now in a position to roll out to clinical champions and full Trust roll out scheduled from September. The Trust is also developing Divisional I&E reporting

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					April 2010 Board paper.			
99.11	To enhance board understanding and accountability, executive directors should augment their comprehensive quantitative monthly performance report to the Board with trend analysis and a qualitative commentary providing the reasons for all adverse variance and the action being taken to address them, by whom and in what timescale.	Revised Board reporting arrangements implemented including integration of finance and performance data with workforce and quality and safety data.	**YES**	CE	Integrated performance report completed since June 2009. Sources of Board Assurance: - Integrated performance report Audit Committee Executive Management Board		None identified	
100.1	The leaders of the Cornwall health system need to establish effective, trusting and sustainable inter-	Strategies of the Trust and PCT developed jointly. Significant	**YES**	CE / Trust Chairman	The Trust and PCT have adopted the 'Getting Patients Treated' (GPT) approach to ensure close joint working in service delivery and planning.		None identified other than maintaining existing progress.	Further examples of assurance: Strong clinical input to Getting Patients

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	organisational relationships, as the basis for jointly leading the strategic planning and development of services. These relationships need to be established first and foremost by Chairs and chief executives of the Trust and PCT, supported by respective boards and clinical leaders of both organisations.	evidence of collaborative working.			The GPT group is the vehicle for monitoring the progress of various work streams. PCT Board colleagues joined the RCHT Board for a strategy development day in July 2009 and this will be ongoing. A PCT event took place on the 27th November 2009. The Chief Executive and Chairs meet frequently. The RCHT strategy has been produced with the engagement of PCT colleagues. Relationships at all levels are significantly improved. Sources of Board Assurance: - Strategy development process			Treated with more recent speed dating event providing a set of clinically led priorities for improvement. Clinical leadership to all QIPP groups Board to Board meeting in May 2010 to further develop and strengthen relationships. Establishment of NHS Leadership Forum to ensure aligned NHS leadership – at both clinical and managerial levels. Appointment of Medical Director at PCT

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					Getting Patients Treated Group Performance Management Group Strategy launch in November 2009.			which is enabling the strengthening of clinical relationships across the two organisations. The Trust's strategy responds to the PCT's broader commissioning strategy.
100.2	The Trust and PCT should establish a clear programme of joint work to address short and longer term issues of mutual operational and strategic concerns to themselves, the patients they serve and the SHA. The work programme should have clear project management	Strategies of the Trust and PCT developed jointly. Significant evidence of collaborative working.	**YES**	CE / Trust Chairman	As 100.1 above		As 100.1 above	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	arrangements, leadership, accountabilities, resource implications and timescales for action							
100.3	Development of the inter organisational working arrangements may require external development support; and the strengths and benefits arising from the implementation of these arrangements should be externally assessed after six and twelve months	Strategies of the Trust and PCT developed jointly. Significant evidence of collaborative working. External assessment after 6 to 12 months confirms progress.	**YES**	CE / Trust Chairman	As 100.1 above. SHA external oversight through performance review processes monitors progress.		At some point it may be appropriate to commission an external review of the progress being made however this is not considered appropriate at the present time with actions in place through the joint GPT work plan to be given time to deliver.	SHA (Neil Goodwin) to provide external assurance of progress at an appropriate time. Date to be determined by Chief Executive and Chairman.
100.4	The estates strategic framework discussed by the Board in June 2008 needs to be	The current estates strategy is revised to take account	**YES**	DEF	This relates closely to the delivery of the Trust's Service Strategy. Much preparatory work is included in the current		Conclusion of updated estates strategy following agreement of clinical strategy.	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	developed into a full estates strategy, incorporating technical, financial and risk data for discussion and agreement by the Board.	of the clinical strategy and includes detailed technical, financial and risk data for discussion and agreement by the Board.			estates strategy and site development control plans. A detailed Clinical Site Development Programme Board now leads on the management of the whole Trust capital programme and specifically is managing all projects within the remit of the Clinical Site Development Board. Sources of Board Assurance: - Estates strategy ALE Score Strategy development process CSDP Board		(March 2010)	
101.1	The Trust board should decide, for example by benchmarking, whether its management resource is	Management arrangements are reviewed and revised arrangements are signed off by the Board	**YES**	CE	Finance, HR and Governance structures have been reviewed to enhance Divisional support. A development programme for divisional teams including personal		HR structure implementation to be on hold until new HR Director in place. However interim changes are being implemented	

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	sufficient and if so, correct the position especially at divisional level. Additional resources to support the development of the divisions should be sourced internally by reviewing corporate management functions; for example, given the overlap between marketing and delivery functions, the marketing department should be disbanded and its resources redistributed across the divisions to meet the need and develop their management infrastructure.	and benchmarking has taken place to confirm adequacy of resources.			coaching support for individual team members is being put in place. The marketing function has been disbanded. Benchmarking has been undertaken and is being taken forward at the Non-Clinical pay Board and via the Executive Management Board. The Divisional development programme has commenced. A review of the HR function has taken place and an Interim HR Director in place to take these actions forward. Sources of Board Assurance: - Divisional weekly meetings Divisional monthly		by the Interim Director. (July 2010)	

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					performance reviews. Support services business plans and customer satisfaction surveys where available. Integrated performance report. External HR Review			
101.2	The divisions should be established as self-standing business units as soon as possible, with divisional directors fully accountable for all staff and resources within their divisions. This means, among other things, a clear structure being established within divisions, with divisional managers, supported by nurse managers, named management	Revised Divisional structures implemented and established as self standing units with named resource from support functions. Divisional Directors accountability shifted from Medical Director to COO.	**YES**	CE	A single line of accountability from Divisional Directors, Managers and Nurses to the COO was introduced in May 2009. A system of earned autonomy has been agreed and is in place in relation to financial controls. The Business Intelligence and Assurance Unit is in place from September 09; this will support the Divisions ability to focus upon appropriate improvement opportunities. Divisions have started to consider the "Road to semi-autonomous business			

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	accountants and information analysts. Multiple managerial responsibilities should be eliminated. The divisional directors should be accountable to the Director of Delivery who would also appraise their performance with input from the Medical Director. Similarly the divisional nurse managers should be accountable to the divisional managers who would appraise them, with input from the DoN.	Nurse Managers accountable to Divisional Managers.			unit status". This will be fully defined by July 2010. Sources of Board Assurance: - Revised Divisional management arrangements. Revised Divisional control arrangements. Divisional weekly meetings Divisional monthly performance reviews. Integrated performance report			
101.3	The proposed changes in divisional management	Divisional Management Structures established	**YES**	MD / DNMT	The Divisional Management structure has been established and continues to		Action plan for development of Divisions as business units	Divisional structures revised 1st June 2010 to

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	structures and accountabilities would free the medical and nursing directors to spend more time on strengthening their professional leadership, internally and externally, rather than on the day to day direct management of clinical and other staff; and to professionally lead challenging policy and strategy issues requiring significant clinical leadership, eg clinical strategy, healthcare associated infections, other concerns to the public and the Care Quality Commission.	Medical and Nursing Directors active engagement in developing the RCHT Strategy and Clinical Services Development Plan Director of Nursing exec lead for S4BH Directors of Medicine and Nursing lead re-structuring of the Governance team, appointment of a Head of Quality and			strengthen. The Directors of Medicine and Nursing are in regular communication with external organisations and attending meetings to enhance external relations. They have lead roles in developing the Strategy, in infection control and in CQC reporting. The DNMT is the lead exec for S4BH. MD and DNMT involved in the engagement process following the launch of the draft strategy. Presentations given to PCT Board and PCT Community Health Services Board. The senior nursing structure has been revised. Appointment of 2 Deputy MDs in Mar 10 to complete the revision of the medical directors		remains to be developed. (July 2010) Draft Strategy and site development plan launched – 02.11. 09	align with improvements in patient flow and the Clinical Site Development Plan (CSDP). CSDP implemented with initial projects completed. Dependency on further Financially Challenged Trust capital risk assessed. 1st July 2010, Deputy Medical Directors take up their portfolios. One will be maintaining professional standards and

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	Stronger professional leadership should also enhance the development of clinical governance as the basis for strengthening the quality and safety of services and professional development of clinical staff	Patient Safety. Trust will be actively engaged in the SW SHA patient safety initiative			office Sources of Board Assurance: - Integrated performance report Divisional management structure. South West Nursing and Medical Directors meetings. Medical and Nursing directors direct involvement in the SW SHA patient safety initiative. Draft RCHT Strategy and Clinical Site Development Plan launched 02.11.09			the other focusing on academic and education. Divisional Quality Group now established and stabilised under the joint chairmanship of the Medical Director and Director of Nursing, Midwifery & AHPs.
101.4	The medical and nursing directors should develop their external profiles in order to, among other things, support the	Directors of Medicine and Nursing regularly attend "Getting Patients	**YES**	MD / DNMT	Sources of Board Assurance:- PCT Performance Review meetings PCT quality monitoring Meetings with CQC staff		Longer term evidence of the development of successful external relationships. Activities continue	Medical Director and Director of Nursing, Midwifery & AHPs engaged with Executives

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	Chief Executive in the development of external relationships, for example with clinical colleagues in primary and community care; with other hospitals providing services for the Trust's patients; and with other NHS and non-NHS organisations such as social care and the SHA. This will be particularly important as part of the Trust's process for securing support and confidence from a wide range of NHS and non-NHS organisations and stakeholders for a vibrant, sustainable future of the	Treated". Establish working relationships with key individuals of partner organisations Director of Medicine and/or Director of Nursing will attend PCT Quality Monitor and Performance reviews. Establish links with colleagues in other acute trusts, the SHA and CQC			Attending meetings of SW SHA Medical and Nursing Directors, and other SHA meetings. MD and DNMT are enrolled in the "top leader" programme giving development and networking opportunities. Appointment of substantive MD and DNMT Dec 09 Getting Patients Treated PCT quality monitoring and performance review Meetings with CQC staff Attending meetings of SW SHA Medical and Nursing Directors Medical Director working with the MD of the PCT in developing QIPP groups with appropriate RCHT representation		to develop and maintain external relationships. PCT quality monitoring achieving a higher delivery rate than ever before.	of partner organisations, facilitating strengthened relationships.

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	organisation within the network of the regional NHS.							
101.5	The Appointments Commission and South West SHA, in collaboration with the new Trust Board Chair, should review the capability of non-executive director membership of the Board to ensure it is fit for purpose in terms of skills, experience and the ability to constructively challenge and support the executive directors as part of the Board's role to manage the future of the Trust.	The Trust Chairman has reviewed the capability and make up of the Non Executive Directors of the Board.	**YES**	Trust Chairman	Revised Board structures have been agreed by the Trust Board, the Trust Chairman has reviewed the non-executive composition of the Board. Sources of Board Assurance: - Revised Board structures Board Assurance Committees – Governance and Audit Chairman's appraisals		None identified Interviews for a new Non Executive Director took place w/c 8 March 2010. The review of the skills and capability of the Non Executive Directors of the Trust Board is undertaken continuously by the Chairman..	
101.6	Given the troubled history of the Trust, coupled with	Board development programme	**YES**	Trust Chairman / CE	Revised Board structures have been agreed by the Trust Board, the Trust		Strategic Board Away Day has been planned for 5	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	frequent changes of board membership and the challenge of establishing effective inter-organisational relationships and strategic development, the Trust Board should establish a programme of Board development to strengthen its intra-board working, including the development of effective non-executive challenge; the development of executive directors as corporate board directors; and development of the board's role as the principal leadership group for managing	established and commenced. Executive composition of the Board reviewed. Executive Director development established.			Chairman has reviewed the non-executive composition of the Board. The Chief Executive has reviewed the executive composition of the Board. The 3 key Executive Director posts have now been recruited. A new Head of Training and Development has been put in place to lead the whole OD programme. A Board development programme will commence in March 2010 Sources of Board Assurance: - Revised Board structures Board Assurance Committees –		May 2010 . A Board development programme will be established starting from this date.	

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	the future of the organisation on behalf of the Trust's staff and external stakeholders.				Governance and Audit Chairman's appraisals Revised Executive Structures Executive Directors appraisals Remuneration Committee 30th march board away day, substantive appointments made			
101.7	Establish a programme of development of the Chief Executive's executive team to help it develop operational and strategic priorities, effective inter-organisational relationships and understanding of the role, contribution, support and challenge of the non-executive	Executive Director development established.	**YES**	CE	The executive team held its first away day on Sept 18th. A full programme of team development cannot begin in earnest until the full team is substantively in place. However three Executives and four divisional directors are taking part in the top NHS South West leader programme. All Executives have been allocated a coach. A Head of Learning Development has been		Board Away day on 30 March 2010. Revised to 5 May 2010 due to absence of key Executive Directors and the new posts DoHR and DoF being recruited. Integrated performance report is under review as will the assurance framework be developed further and linked to the	

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	director and Board.				appointed to lead on Organisation Development part of which is Board and Executive Development. Sources of Board Assurance: - Integrated performance report Board Assurance Committees – Governance and Audit Revised Executive Structures Executive Directors appraisals Remuneration Committee NHS top leaders programme		strategy.	
101.8	The Trust should commission an extensive and ongoing programme of organisational development for	Organisational Development plan in place with agreed actions.	**YES**	DHR	The implementation of these recommendations has formed a significant part of the OD plan. Diagnostic work on the Trust's whole strategic		All of the strands of the Organisational development programme to be formalised in a paper to the Board in May.	The Independent Review contains all the main elements of an OD Plan. A discussion is

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	the organisation as a whole to enhance its managerial capacity and capability, particularly at divisional level and in other departments responsible for delivery of the Trust's services				HR approach has been undertaken. A service improvement programme has been formally established including programmes reviewing clinical productivity, medical pay, non-medical pay, non-pay and back office. A new Head of Learning and Development has been appointed and diagnostic work completed. The resultant programme includes Board Development, Executive Development & Coaching, formal Coaching for all Divisional leadership teams, leadership programmes for management. The Director of HR to take forward Trust wide		Interim Director of HR to lead.	proposed as to whether a separate OD Plan is required.

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
					OD programme. Sources of Board Assurance: - HR Director's report to Board and EMB Diagnostic report on Leadership Development; Diagnostic report on HR function EMB Meeting Notes/agendas; Exec Development events. Chairs Progress Committee Coaching contracts Head of Training/Learning and Development role. Service improvement programme.			
101.9	The Trust should support the HR director in reviewing the current capabilities	HR function reviewed, revised structure agreed and	**YES**	DHR	Interim changes established pending a major review and scope of HR Directorate to be led by Interim HR		Recruitment and implementation of revised HR structures. However interim	Interim HR structure in place. Recruitment process for the

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	and operational effectiveness of the HR function as part of the progress currently being made to professionalise it.	implemented.			Director. External review of HR commissioned and reported. Experienced Interim HR Director in place. Sources of Board Assurance: - HR revised organisational Structure; Local Negotiating Committee (Senior Doctors) EMB Notes; Strategic Resources Committee Minutes. HR Review by Steve Griffen.		changes are being implemented by the Interim HR Director.	permanent HRD to begin in July with a planned start date of October/November 2010.
101.10	The Trust should review its media management policy and ensure that all staff are aware of how liaison with the media is to be	Media management policy reviewed, approved by Trust Board and	**YES**	CE	Policy reviewed, approved by Board and disseminated. Sources of Board Assurance: -		Communications Strategy is to be developed during the early part of 2010. Draft	

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	conducted and managed, particularly over potential changes to services that are likely to be seen as sensitive and/or contentious by the public and other stakeholders.	distributed to all staff.			Media management policy Media interest reports		Communications Policy has been developed and is in the process of being reviewed and updated. New Head of Communications appointment will be advertised shortly.	
102.1	Work with the SHA to extend its current efforts to establish positive relationships with Cornwall NHS and non-NHS stakeholders to: explain it's role as the regional headquarters of the NHS; to listen to views about local health services; and to reassure Cornwall stakeholders that the SHA has a		**YES**	Trust Chairman / CE	Much work is ongoing to strengthen relationships throughout Cornwall. Joint strategy meetings with PCT colleagues are in place, GPT group established, regular chair and chief executive liaison. Strategy development being undertaken in full consultation with community partners. RCHT draft strategy published. Engagement plan in place.		Publish RCHT final strategy with full agreement and sign off from PCT and NHS South West. (March 2010) Meetings will be held between RCHT and Local Involvement Network (LINk) in Cornwall. We also have a clinical representative attending the Health & Well	Final strategy published. Frances Kean is our clinical representative for the Health & Well Being Board .

Report Ref	Recommendation	Success Criteria	Completed	Lead Director	Trust Assurance / Evidence	Risk Score at March 2010	Actions requiring further Assurance	Follow up June 2010
	positive interest in supporting the development of the local health and social care system for the benefit of the people of Cornwall.				Sources of Board Assurance: - Strategy development process Getting Patients Treated Group Performance Management Group Chair / CEO meetings NHS South West		Being Board from March 2010 onwards.	
102.2	The SHA should agree with the Trust Board and also with the PCT, where relevant, performance monitoring arrangements for overseeing implementation of the recommendations of this Review.	Performance monitoring arrangements for this review agreed.	**YES**	Trust Chairman / CE	The Chairman has set up a progress monitoring committee, which will meet prior to every Board meeting to review progress against this action plan. The Trust's Audit Committee will also review progress as will the Board. Sources of Board Assurance: - Chairman's Progress Committee Trust Board report September 2009		None identified	

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					Audit Committee NHS South West			

Appendix M John Watkinson's response to Hawker report and note of the trust and confidence hearing

Response on behalf of John Watkinson to Draft Independent Review of Management and Governance at the Royal Cornwall Hospitals Trust ("the Trust")

Reservations

1. You will or should be aware that our client reserves his rights and remedies as to the reasons given by the Trust and SHA for commissioning the Independent Review and due process of your client's Review.

2. Without prejudice to those reservations, our client has agreed to provide his comments on the draft Report provided.

Overview

3. The reason given by the Trust and SHA for commissioning this Report was to "consider whether issues of competence and behaviour highlighted in Bromley Hospitals have in any way occurred in Royal Cornwall Hospitals Trust" and to "also clarify whether the Royal Cornwall Hospitals' financial, management and government arrangements have been, and remain appropriate". It would follow that your client's Report would be limited to those issues. It also follows that as the Bromley Report purportedly centred on Mr Watkinson's tenure as its CEO, the focus of the Panel's independent review is equally focussed on him.

4. The Trust and SHA were both well aware as to the likely contents of the Bromley Report when a draft was circulated in April 2008 and as to the final outcome of the Bromley Review in July 2008, when the Report was finalised by Mr Taylor. They were, therefore, both well aware that Mr Watkinson disputed much of the contents of the Bromley Report and had provided detailed comments on the inaccuracies of assumptions and facts made in the Report which were challenged by him.

5. Until August 2008, the stance taken by the Trust and SHA was they accepted the Bromley Report was not accurate and, therefore, not of concern and that Mr Watkinson was not to blame and so was to be supported.

6. Due to intervening events, that attitude changed, and it is Mr Watkinson's position that the Review was commissioned as a fishing expedition, to try to find matters that could be used to justify his ultimate dismissal.

7. With that concern in mind, and because the stated reason for the Review is focussed on determining issues as to his governance, Mr Watkinson's comments will naturally address some of the matters set out in the draft Report, taking that concern into account.

General Concerns

8. Now that the draft Report has been seen, it is of concern that:-

8.1 In the first paragraph, your client repeats the statement from the joint SHA/Trust Press Release on 25 September 2008 about the deficit figures in respect of Bromley Hospitals. This is a matter that has been of much concern to Mr Watkinson and, as he has pointed out most vigorously, those figures, if accurate, do not relate to his period of tenure with Bromley Hospital.

8.2 The reality is that Mr Watkinson pursued a financial strategy for Bromley Hospitals that was extensively consulted upon and received significant internal and external support as validated by PWC working in partnership with Bromley Hospitals. They prepared a Turnaround Report which was finalised in December 2006, just before Mr Watkinson left Bromley Hospital to join the Trust. This is an accurate and contemporaneous report of Mr Watkinson's tenure. It found Bromley Hospitals were in a financially sustainable position in the medium-term, supported by clearly defined structures and processes for continuing to engage stakeholders. This is a matter of public record. Of such concern is the continuing repetition of Bromley Hospitals' deficit figures and the juxtaposition to our client that potential defamation proceedings are being considered and is the subject of current correspondence between our client and the concerned parties. In summary, your client's repetition of this statement alleges falsely that while Mr Watkinson was CEO of Bromley Hospitals, he presided over an unacceptable £23M in-year deficit and an accumulated debt of £87M. In addition, that he took part in a cover-up to under report this in year deficit figure by £10M. Your client's Report should consider and provide for Mr Watkinson's concerns.

8.3 Despite the Trust and SHA limiting the Review to concerns of the Board's leadership, governance and conduct as its stated aim, your client has sought to broaden out the terms of reference to a full due diligence review of the performance of the Trust and then, again, to go beyond even its own terms of reference as set out in paragraphs 66 and 67 of the draft Report. Our client maintains this is consistent with it being a fishing expedition in respect of his position.

8.4 It is our client's position that in the Report, the Review Panel has been selective in its findings, resulting in a lack of balance and inconsistencies in approach which materially disadvantages our client.

Comments on contents of Draft Report

We shall give Mr Watkinson's comments on the Report, indicate inconsistencies in approach and lack of balance as appropriate. Given time constraints and the restrictive conditions prescribed in respect of providing us with copies of the draft report, not every paragraph is addressed. This should not be taken as Mr Watkinson's agreement as to the accuracy of the same, and he reserves the right to comment further, if required.

Finance

9. Your clients refer to the District Auditor's Report of 2006 recording the financial challenges facing the Trust prior to Mr Watkinson taking up his position. The Auditor's Annual Audit Letter for 2006/7 clearly indicated the depth of the financial crisis facing Mr Watkinson on his arrival.

The financial position for Mr Watkinson's year of tenure is set out in the District Auditor's Annual Letter of September 2008. We believe that it is not in contention that the District Auditor's Annual Letter is thorough and independent. We further contend that this report should be the basis for any analysis of the financial standing of the Trust at the time of Mr Watkinson's suspension. It is its thoroughness and independence that reflects the position as at the date of Mr Watkinson's suspension and can be relied upon.

10. The opening statement District Auditor's Annual Letter for 2008 has the key message:

"The Trust's financial statements for the year ended 31 March 2008 and the supporting working papers were of a very high standard, and I issued an unqualified opinion on the financial statements on 20 June 2008".

The third key message also validates that the Trust had a surplus of £1.2M for 2007/8, which was a significant improvement on the performance in the previous year, prior to Mr

Watkinson's tenure, when it incurred a deficit of over £36M.

12. Your client's Report questions that surplus figure. It states that the surplus was only achieved through external financial support of some £7M. To the best of his recollection, this is not Mr Watkinson's understanding. He believes the District Auditor expressly stated that the £7M was correctly characterised as additional non-recurrent income and not external financial support. We would ask that your client obtains a letter written by Mr Bill Shields, Director of Finance and Performance at the SHA, to Mr Budge the then District Auditor, confirming the same and adjust their report accordingly.

13. We would also point out that even on your client's own interpretation, converting a £36M deficit to a £5.8M deficit would have been no small achievement in itself, and worthy of positive comment.

Paragraph 12

14. The difficulties referred to in paragraph 12 related to a period of time when the organisation was in severe conflict with the community, the PCTs and the SHA, local councils, for example, such as Hayle Town Council and patient groups, such as Healthwatch. Additionally, the specific difficulties with the three primary care trusts predated Mr Watkinson's arrival by three months. This should be made clear.

Paragraph 13

15. The impression given here is that the Trust was already beginning to improve before Mr Watkinson's appointment in January 2007. This is disputed. Matters were so bleak that Sir Ian Carruthers, the Chief Executive of the SHA, made several approaches in late 2006 to the then Chairman of Bromley Hospitals Trust, Mr Anthony Levy, to secure Mr Watkinson's urgent release to the Trust. In addition, it is understood the Finance Director who had been appointed in April 2006 was found not to have the requisite experience to handle the role effectively, and was subsequently moved to a finance director role in a smaller Trust. PWCA, the Management Consultants working with the Trust, had withdrawn from the project prior to Mr Watkinson's arrival, because we understand the Trust had been uncooperative. No doubt this can be validated by the Panel.

16. At the same time, there had been regular media focused calls for the Trust's Board to resign. The proposition to close St Michael's Hospital had generated public concern, causing a demonstration of thousands of people, petitions etc., all just prior to Mr Watkinson's arrival. Internally, relationships with staff were in crisis. The then management's review of medical and clinical support staff had seriously damaged relationships; Staff organisations protested and medical staff were angered. The Turnaround Plan designed and imposed by the previous Board had not been owned by middle managers nor clinicians. An early independent review initiated by Mr Watkinson set out the full severity of the personal and organisational issues facing the Trust. The Panel is referred to this document.

Trust Board

Paragraph 19

17. It is not clear whether this paragraph intends to contain a criticism of Mr Watkinson. If so, this should be rectified. It is clear that the Trust had the worst performance in the country on Standards for Better Health and a £36M deficit, when Mr Watkinson arrived in January 2007. It was accordingly both desirable and inevitable that the Board would change.

ANALYSIS AND FINDINGS

Financial management and performance

Paragraph 24

18. It is not clear from the draft Report whether this paragraph is intended to be a criticism of Mr Watkinson. The matters selected from the KPMG Report as matters that needed to be addressed significantly ignore the positive aspects found in the KPMG Report. The Panel also fails to acknowledge that the matters identified as in need of being addressed were going to be addressed by the new Trust Management Team. Please see in the Projections Overview of KPMG's statement:

"The Trust Management Team is in a state of transition with a new Chief Executive (joined January 2007), a Chairman (joined June 2007) an Interim DoF seconded from the SHA (mid June 2007). It is noted that the new team has already started to take steps to address some of the issues raised in this Report, through acknowledgement of the areas of weakness and restructuring of senior management and non-executive directors, to ensure a top team that is fit for the purpose. During the preparation of the mTFm, this team engaged well with the process and demonstrated an appetite and determination to tackle the issues that it faces."

19. Following the recruitment of Joe Teape as a capable Finance Director, Mr Teape immediately started work on the matters identified. We contend, therefore, that if any adverse comment is placed in this paragraph in respect of Mr Watkinson, then this paragraph should be reworded to reflect a balanced review of the KPMG Report and record the matters identified as needing to be addressed were those on which Mr Watkinson and the management team were actively engaged in addressing.

Paragraph 25

20. The agreed scope of your client's review is limited to the date of our client's suspension. On the day he was suspended, Mr Watkinson attended a meeting of the Trust's Finance Committee. At that meeting, Mr Teape tabled a paper which indicated the financial position as at month 5 and demonstrated how, with cooperation and focus, the target surplus of £4M could be achieved for 2007/8. The Panel is asked to consider the paper. If the financial position has worsened since that date, then that should not be reflected in this report in respect of a review of Mr Watkinson's management and performance.

Paragraph 26

21. As set out above, the Finance Committee report indicated, the key issue to identifying the level of the CRES target for 09/10 was the determination of the recurrent level of income. At the time Mr Watkinson was suspended, this was certainly not clear, with discussions ongoing with the PCT about a potential contract overshoot of £2.9M. This excluded any extra work required to meet the 13 week referral to treatment target. The draft Report is silent on this matter.

Paragraph 28

22. At the time of Mr Watkinson's suspension, the "three problem" areas referred to, namely Service Line Reporting, Electronic Staff Rostering and the Productive Ward Initiative were all performing well. The suspension of Mr Watkinson, the Interim Director of Nursing and Therapy and other top management may inevitably have removed direction and undermined the momentum in

those areas. This was anticipated by Mr Watkinson, and why we specifically requested that his suspension be lifted so that he and his management team could continue to turn around the Trust. These matters should be reflected in the Report.

Income, payments and payroll

Paragraph 30

23. The Report should reflect that the responsibility for cash flow is joint with the PCT and SHA, and does not solely lie at the Trust's door.

Paragraph 31

24. With regard to the External Auditor's identification of control weakness within the pay roll system, this was being addressed by the Director of Human Resources, who had developed a specification to deal with the audit criticisms. The current status of internal audit lies outside the scope of the draft Report, as it falls after Mr Watkinson's suspension. Please ask the Panel to review this matter with the Director of Human Resources.

Financial reporting and staffing

Paragraph 32

25. As noted by the Panel the Audit commission and External Audit both acknowledge the tremendous achievement and improvement in ALE scores. It is acknowledged that continuing momentum and focus was required to maintain the Trust's turnaround. The Panel's comment "However there is still much more to do" appears to us like a poor reflection on Mr Watkinson. If this is merely a reflection of the fact that the Trust continues to face challenges then it can pass without comment. However, if there is any weight to be attached to the comment to Mr Watkinson's disadvantage, then it should be removed.

Risk Management

Paragraph 34

26. We contend this does not reflect the full position. The Annual Audit Letter of 07/08 identifies many improvements in organisational performance and governance, including, at paragraph 26:

"The Trust has developed its risk management arrangements and strengthened its assurance framework".

Paragraph 35

27. The requirement to meet the 13 week referral to treatment target is a priority set by the SHA and was something on which Mr Watkinson and Mr Teape were actively working prior to Mr Watkinson's suspension.

Operational efficiency

Paragraph 36

28. The Theatre Project was identified by the Divisional Team and enabled by Mr Teape. Bed numbers had been reduced by over 100 in the earlier two years, largely as a result of commissioning and utilising reviews by Secta Consulting. These review reports contained significant bench-marking sections.

In relation to the targeting of areas for further efficiency:

- The Trust has recently adopted a Value for Money Strategy which sets out the relevant framework.

- The Trust networked good ideas from elsewhere, such as the introduction of Clinical Site Management Team, which was instrumental in delivering the Trust's Accident and Emergency access performance.

- The Trust utilised the value for money work of the External and Internal Auditors as well as any external reviews it itself commissioned.

- There was a weekly Value for Money meeting directly following the Executive Management Team meeting, where the Directors and Mr Watkinson met to both review key, existing schemes and generate new ideas. For example, the development of the Cornwall Food Programme opportunity was progressed through this meeting.

The Panel is asked to reflect this in their report.

Healthcare Commission Ratings

Paragraph 37

29. Again, the Report does not fairly balance the performance under Mr Watkinson. On his arrival at the Trust, it was acknowledged that it was the worst performing Trust in England in 06/07 in relation to Standards for Better Health, and was a poor performer in other areas of the Health Check.

30. The core standards performance improved from 13 out of 44 in 06/07 to 31 out of 43 in 07/08.

31. The performance in the overall Quality of Service element of the Health Check also improved, with the "Existing Targets" section achieving a "Partly Met" performance and "New Targets" section receiving an "Excellent" rating. Within the existing targets section lay the Trust's much improved performance on the Accident and Emergency service 4-hour access target; the Trust has regularly been within the top ten performers in England. The Panel is requested to review this paragraph to provide for a more balanced report.

Paragraphs 38 and 39

32. The reporting in paragraphs 38 and 39 appears to reflect poorly on Mr Watkinson. The Panel's terms of reference (paragraph 7) relate to reviewing the processes engaged, rather than considering whether actual decisions reached were correct. It was the Trust's Board's Governance Committee's and Senior Management Team's considered judgments that resulted in the self-certification decisions. We refer the Panel to the Internal Audit Reports which show that the risk rating had been reduced from "Very High" in September 2006 to "Medium" in January 2008. Accordingly, we ask the Panel to comment on the adequacy of process, rather than the decision itself in line with its own terms of reference for the sake of

consistency.

Performance monitoring and management

Paragraph 40

33. Please ask the Panel to note that the review referred to was produced without Mr Watkinson's supervision, and it contains various omissions. The red indicators dealing with Finance were being addressed by Mr Teape. In relation to the red indicators concerning Healthcare Acquired Infection, up to the time of Mr Watkinson's suspension infection levels from clostridium difficile had significantly reduced from the levels of the previous year, and the performance was within the target set. This can be verified by the Panel and should be reflected in the report for balance.

Strategy and business planning

Paragraph 41

34. It is acknowledged that there was an insufficient estate strategy for the Trust, but this was picked up from the June 2008 Audit, and was being addressed. We see no reason for the need to state "partly" addressed. The criticism had been acknowledged, and process put in place to start to address the issue.

Paragraph 43

35. With regard to the reference to the comment that the PCT had been waiting for a capacity plan for Orthopaedics since early 07, the draft report does not reflect that many versions of the Orthopaedics Capacity Plan were provided to and rejected by the PCT. Despite this, the speciality increased substantially its performance regarding the 18-week referral-to-treatment target. The Panel's reporting is, therefore, seen as unbalanced.

36. An external review, completed just after John Watkinson's arrival in January 2007, found many serious problems and issues with waiting list management, including the placing of thousands of patients onto suspension lists. The consequent programme of work to deal successfully with each and every patient, implement and reform systems and then use the new infrastructure to meet the waiting time reduction targets was a major organisational/health community achievement. This is not reflected.

Paragraph 44

37. On his arrival, Mr Watkinson found that it was the culture of various stakeholders to look to the SHA and PCT rather than the Chief Executive and Board for strategy. Turning this around and working on developing Trust Strategy had only just begun to gain some momentum when the Acting Director of Strategy was removed from the organisation by the Acting Chairman, Mr Mills. This should be reflected in the Report.

Upper GI cancer service

Paragraph 46

38. We would like to make it clear that Mr Watkinson took no partisan stance in the consideration of centralising the three upper GI cancer service centres across Cornwall and Devon. He

understood the proposal was that cancer services in Exeter, Plymouth and Cornwall would be centred in Plymouth. The merging of the three centres would result in costs savings and operating efficiencies. The concept of a single centre, however, was subsequently undermined by the rejection of the Royal Devon and Exeter Foundation Trust at its public Board meeting on 31 October 2007. The Panel will no doubt validate this. It was, therefore, seriously in doubt that a single centre based in Plymouth without the participation of Royal Devon and Exeter, could result in any benefit to Cornwall, or costs savings and operating efficiencies.

39. With regard to public consultation not being required, legal Counsel advised Mr Watkinson and the Trust that the HOSC did not have the authority to determine public consultation. A decision on consultation requirements rested with each individual organisation. Mr Watkinson maintains a two stage implementation was not proposed or discussed in the HOSC meeting and the accuracy of this statement should be revisited by the Panel.

40. With regard to media agencies, Mr Watkinson's recollection is that aside from the Chairman of the Medical Staff Committee, the only media appearance from the Trust's doctors on this issue was by the Medical Director, who judged it appropriate to reassure patients and the public, following fear-generating comments by the Medical Director of the Cancer Network Board. We should be clear that Mr Watkinson took no side on this issue, save to safeguard the Trust's interests. This was to advise the Trust that it had a legal duty to consult as advised by lawyers to the Trust and that while the issue was to be resolved, the current service in Cornwall was not unsafe.

Our strategic development examples

Paragraph 47

41. The Panel is requested to review the minutes of the Business Care Case Review Group which it is understood will demonstrate an appropriate process of internal scrutiny and review prior to any decision being taken to introduce a new service in line with good governance practice.

Trust management and leadership

Paragraph 51

42. The accuracy of this statement is not disputed but Mr Watkinson wants his explanation to be recorded. The opportunity for review was by way of a telephone call and was not a formal part of the Standards for Better Health process. At the time, Mr Watkinson took the approach as a friendly informal call just to give him the opportunity to see if the Trust wanted to check its position. Given the confidence of the Board in its decisions on self-certification, Mr Watkinson was satisfied that it was not necessary to take up the offer. It did not occur to him given the informality of the approach and the context he had put on it, that this was a matter that needed to be referred to the Board. If he had so judged, he would have done so. Again, you will recall the Panel's review is limited to process rather than considering decisions made. For the sake both of balance and consistency the Panel is requested to reword this paragraph.

Paragraph 53

43. We are concerned in respect of the reporting in this paragraph. It will be appreciated that the make-up of the Board at the time presided over the worst performing trust. Market testing and contracting out has been part of the policy framework of the NITS for many years. The plan to sell the car park was, therefore, entirely consistent with this and consistent with addressing the Trust's poor financial performance. The then Director of Finance gave the Board the

advice that the whole consideration could be set against the current year's accounts. The District Auditor did resolve the issue of financial accounting and the Director of Finance was wrong in her advice. Nevertheless, a positive Value for Money report was received and shared with the Board. The deal generated over £8M in cash which reduced the Trust's cumulative deficit. An arrangement was then agreed with the Department of Health. SHA and PCT concerning the establishment of a formal loan agreement with a repayment profile that included contributions from the Trust and the PCT. The implementation of this proposal was, therefore, beneficial to the Trust and it is not clear why the non-executive directors took issue with it or resigned over the management of the car parking issue. It should be noted a full vote was taken at the Board and the proposal was carried. This should be reflected in the draft report.

Trust management outline and style

Paragraph 54

44. The Panel are not clear why the proposed audit investigation was stopped. It is Mr Watkinson's recollection that the new Chairman, Mr Peter Davies, stopped the audit activity. In Mr Davies' judgement, the auditors of a financially challenged organisation had more pressing tasks to be dealt with at that time.

Paragraph 55

45. It is not clear whether a light management structure is a criticism. In any event, benchmarking was an integral element of the organisation development programme as to review and should be noted.

Paragraph 57

46. It is rejected that there was any hubris. The financial performance was based on sound financial achievement.

Paragraph 58

47. For the record, this was not Mr Watkinson's decision. The commitment to this investment was made by the PCT in their Healthy Futures document. The implementation plan was simply a response to declared Commissioning intentions. Mr Watkinson rejects the contention that he did not weigh up proposals effectively and should be noted.

Paragraph 59

48. The contention that there was a team within a team is rejected. The Executive management team substantively appointed after Mr Watkinson's appointment includes four directors from within the Trust, two from within the South West region, one from Leeds Teaching Hospital and one from Bromley Hospitals' Trust. No one from Bromley Hospitals was appointed to a post that had Board voting rights. The two temporary appointments from Bromley Hospitals were (1) the Interim Director of Nursing and Therapies, Julia Dutchman-Bailey, who is identified in paragraph 62 of the draft report as someone of high calibre, and (2) Strategic development work which was undertaken by the Acting Director of Strategy, Ian Gibson, is also given a positive review in paragraph 41 of the draft report. Please ask the Panel to review their reporting in this paragraph.

Paragraph 60

49. The generalised comments made in this paragraph as to Mr Watkinson's humour and a suggestion that there was a culture of fear are serious accusations. No such issues were ever raised with Mr Watkinson. The draft report does not disclose who was interviewed. Unless the allegations are particularised to enable Mr Watkinson to address the same, then these comments should be removed under the principles of natural justice.

50. Mr Watkinson would also refer the Panel to two independent reviews of the Trust dated 26 February 2007 and 6 July 2008 which provide a frank critique of the functioning of the Trust but also provides evidence of how the organisation's culture had developed positively under Mr Watkinson's leadership.

Engagement of professional staff

Paragraph 61

51. With regard to the allegation of a poor history of engaging professional staff, Mr Watkinson points out that the Divisional Directors' Board was joined on a monthly basis by the Director of Service Delivery and the Interim Director of Nursing & Therapies specifically so that they could discuss performance and delivery issues, and this should be reflected in this paragraph.

Paragraph 63

52. The Panel is asked to review its finding and validate the fact that the level of investment and support increased under Mr Watkinson's leadership.

Paragraph 65

53, The Panel should make further enquiries of the Medical Director and Interim Director of

Nursing & Therapies as Mr Watkinson's recollection is that they both put an appropriate level of effort and time into networking.

Paragraphs 66 & 67

54. These paragraphs are outside the terms of reference.

Paragraph 68

55. This does not accurately reflect the fact that the PCT and Trust relationship has produced many positive results including effective implementation of the PCT's Healthy Futures strategy.

Paragraph 69

56. The Panel's conclusion in this paragraph may well be correct, but it should be considered whether this belief has been fuelled by the level and frequency of interventions in Cornwall made by the SHA and the creation of a £250M 'Risk/Strategic Development Reserve' at SHA level which does give it financial power over the Trust.

Edwin Coe LLP

Dated 29 January 2009

Capsticks
DX:
59461
Putney

FAO: Gerard Hanratty 17 February 2009

BY DX AND FAX:

Your Ref: GCH/052082 **020 8780 4728**
Our Ref: RJH/WAT.58.2

Dear Sirs

Our client: John Watkinson

Your clients: Independent Panel - Independent Review of Management and Governance at the Royal Cornwall Hospitals NHS Trust

We acknowledge receipt of your letter and your clients' further draft Report on 10 February 2009.

As we were unable to keep a copy of the first draft Report provided without conclusions, please advise us of the paragraphs which reflect our client's comments and on what basis the Panel have not included or addressed his other comments.

Meanwhile, we enclose short further note commenting on the latest draft Report for inclusion, to enable the Panel to rebalance certain findings and factual inaccuracies.

The Panel will appreciate, to the extent that inaccuracies and inconsistencies in the Report pertain, the findings cannot be other than flawed. Please advise by return the date on which the Panel intend to publish the Report.

Yours faithfully

Edwin Coe

LLP Enc.

Response on behalf of John Watkinson to Draft Independent Review of Management and Governance at the Royal Cornwall Hospital Trust ("the Trust") received 10 February 2009

Reservations

1. You are aware that our client reserves his rights and remedies as to the reasons given by the Trust and SHA in commissioning the Independent Review and due process of your clients' review.

   Without prejudice to those reservations, our client provides his comments on the further draft Report provided. As you are aware, we do not have a copy of your clients' previous draft Report, which excluded recommendations and conclusions. We are, therefore, not able to cross reference. However, we are aware that many of the concerns and matters of inaccuracy were drawn to your attention and have not been adopted and, therefore, those comments are submitted for further consideration and will be relied upon in the absence of correction, balancing comment or the noting of Mr Watkinson's representations where they affect him directly. To that end, we attach copy of the response submitted on 29 January 2009 as Appendix 1, and would ask that your clients ensures these are brought to the Trust Board's attention.

3. Our client remains concerned that the findings are selective and exclude positive comment of the Trust Board and corporate team and, therefore, wishes to bring these additional matters to the Panel's attention.

4. We have sought to highlight matters of most concern for the assistance of the Panel. Where criticisms are raised in the Report but not commented upon, this should not be taken as an acceptance of such criticisms, but simply that it falls outside the scope of this response.

5. Similarly, our client does not comment on the recommendations made. The findings are challenged in so many instances that there can be no integrity for the basis of the recommendations.

REPORT

Background

1 . *Paragraph 1*

   We note amendments have been made in an attempt to lessen the defamatory impact on our client. However, our client is still of the view that the content is defamatory by implication.

2 . *Paragraph 5*

   We refer you to paragraph 5 of Mr Watkinson's response. This concern has not been addressed.

3. *Paragraph 7*

   As previously pointed out, your client's claim to review process and not actual decisions has not been consistently adhered to by them. Please look at paragraph 59 by way of what appears to be a gratuitous example.

4. *Paragraph 8*

   The factual inaccuracies brought to your attention by Mr Watkinson have largely been ignored and certainly not reflected as requested.

5. *Paragraph 9*

   Your client's Report omits to reflect upon the financial improvements made under our client's leadership identified in the Auditors Annual Letters for the periods 2006/07 and 2007/08. This is, again, a reflection on the imbalance of the report.

6. *Paragraph 10*

   Again, the Report should give credit for the Trust's performance in relation to compliance with the Core Standards and the Quality of Service dimension of the Annual Health Check, which improved significantly between 2006/07 and 2007/08.

   The HCC' s recent report on compliance with the Code of Hygiene Practice, together with an associated press release from the Trust, indicate the Trust has been reducing levels of infection in 2008/09.

   The sale of the management of the car parks was conducted with the inherited, poorly performing Board. The sale significantly benefited the Trust.

   There had been many independent, external verifications of the significant improvements at the Trust; for example, the views of the NHS Performance Support Team, whose report in January 2008, states "In just 12 months, we have seen unrecognisable change in many aspects of the Trust's business".

   The reporting in this paragraph as it stands gives a misleading and one sided picture.

7. *Paragraphs 9 and 10*

   The contents of paragraphs 9 and 10, whilst obviously not solely relating to Mr Watkinson, are nevertheless seen as selective and could be viewed as disadvantageous to Mr Watkinson without the full picture being reported upon.

8. *Paragraph 11*

   Central Financial Management Controls. The summary in this paragraph is rejected by Mr

Watkinson. The Report fails to acknowledge the corporate team produced a comprehensive array of central financial management controls, including Business Planning, effective Budgeting and a monthly Performance Management process with each Division.

The Review presents no evidence to support its allegation that the Trust has tended to externalise its strategic challenges. Its reference to the Trust failing to exercise leadership on the Upper GI Cancer Service Strategy points to a biased approach in this Review. The recently announced proposals for Upper GI Cancer Services are consistent with the Trust Board's consistently held position, subject to the need for formal consultation being recognised. The treatment of this issue by the SHA is the very matter giving rise to Mr Watkinson's detrimental treatment by the SHA and Trust Board since the resignation of Peter Davis.

Mr Watkinson can point to relationships with stakeholders within Cornwall having improved massively from the crisis-torn situation that existed when he was appointed in January 2007.

It is contended, therefore, that your clients' sweeping comment that the Trust Board and Chief Executive have failed to follow sufficiently the spirit of the codes of conduct for NHS boards and managers and/or have failed to achieve the overall standards of management and governance expected of a public service such as the Trust is evidence of your clients' negative stance to the performance of the Board and Mr Watkinson's team. We would ask the Panel to remove these references unless such comments can be empirically proven which we suggest, again, cannot be the case. On the contrary, the Panel's objection to reconsider their views by considering the Auditors' Annual Letters and improvements indicated in the year 2007/08 Letter and after the Independent Management Reviews is difficult to balance without the conclusion that the Review is not independent.

9. *Paragraph 58*

This paragraph, we believe, has been amended, but still alleges that the 2007/08 surplus was built on additional financial support. This is now inconsistent with the Panel's revised paragraph 24 of the Report which refers to "non-payment by results" income of £7M from the PCT.

It is our client's contention that a significant amount of this income was made permanent in the 2008/09 Service Level Agreement with the PCT. Please ask the Panel to check and make appropriate amendment.

10. *Paragraph 59*

For the record, the commitment referred to was in the PCT's Healthy Fixtures' Strategy. Please ask the Panel to review and amend accordingly.

11. *Paragraph 71*

Please can you clarify on behalf of your clients whether there is an unfavourable inference being drawn as to the actual improvement achieved by the Trust? If so, it is our understanding that the HCC shows a significant improvement by the Trust, which included the Trust moving from the worst performer in England to a top 10 performer on the Accident and Emergency 4 hour wait target. Again, we ask the Panel to reflect the same for consistency and fairness.

12. *Paragraph 76*

The Report does not state in what way the process was flawed. Please ask the Panel to take into account the HCC's reported comments in the 'Summary of Intervention at RCHT' in April 2008, that "Regular progress reports were being submitted to the Trust's Board. When we observed a trust board meeting, we noticed that non-executive members of the board were appropriately questioning executive members on the detail of the Report". We do not believe it is in dispute that the Panel was not present at any Board meeting to assess objectively performance. Again, the Panel has not positively reported the improved compliance from 13 out of 44 standards in 2006/07 to 31 out of 43 in 2007/08, which is a further example of unbalanced reporting.

13. *Paragraph 79*

You refer to the comments made on behalf of our client on the draft Report. It is not a fair representation to say that differences of view were played out in the media. The Panel has ignored the fact that the Health Minister's interview on Radio Cornwall on 14 October 2008, in which, we understand, he stated that a Report by the HCC indicated the Trust's service was unsafe, a statement that was directly contrary to the outcome of the recently performed Independent Clinical Review. 'To that extent, it can be said the Minister was responsible for undermining public confidence. We would also point out that from recently announced plans for taking this service forward, the Trust's position and approach to the issue appears to have been largely vindicated. The Trust has always supported a single centre, provided all three current centres were involved. The recent support for the plan indicated by Royal Devon and Exeter is, therefore, a welcome change to their previous position. It is and has been Mr Watkinson's belief that the issue outstanding is the need for formal consultation, which is a legal requirement on individual NI-IS organisations in relation to changes of this nature. This should be reflected in the Report.

14. *Paragraph 83*

Again, we query the balance and objectivity of this paragraph. We refer to the HCC report entitled 'Summary of the Intervention at RCHT' dated April 2008, which stated "We were told during interviews that the impact of the new leadership team is being felt positively within the Trust, and

most of the comments from staff at different levels within the organisation reflected a sense of new, open and listening leadership". Please ask the Panel to rebalance this paragraph.

15. *Paragraph 84*

The Report does not reflect that any finding of poor quality board working and leadership between Board members refers to the previous Board which presided over the worst performing NHS Trust; that this Board was subsequently replaced and with which our client had good working relations at least until the resignation of the Chair, Peter Davis.

16. *Paragraph 86*

We draw your attention to the letter dated 27 June 2008 from Matthew Taylor, MP for Truro and Falmouth, to Mr Watkinson:

"As I think you know, the Cornish MPs met with ministers and officials to discuss funding issues ... It was clear from the discussions that there is a real appreciation of the progress that has been made at RCHT, and I thought that you would want to know this".

Again, there is a reference to the Trust receiving financial support in 2007/08, but despite this being drawn to your clients' attention, the reference to external financial support being given persists.

17. *Paragraph 98*

The Panel's opinion in respect of Mr Watkinson's failure to achieve overall standards of management and governance is rejected, specifically in terms of the provision of information to the Board, development of basic management systems and processes and partnership working of sufficiently sustainable trust and depth.

Information to the Board was significantly improved, particularly with regard to financial management. The Trust was a "system free zone" when Mr Watkinson arrived in January 2007, and both the 2006/07 and 2007/08 Annual Audit Letters and the two Independent Management Reviews give clear evidence of significant improvement in systems and processes. Finally, Mr Watkinson and the Board (prior to Mr Davis' resignation) have moved the Trust from a position of being in conflict with all its major stakeholders, to a position where it now enjoys general support with the exception, it appears, of the CEO of the SHA.

Conclusion

18. *Paragraph 103*

We refer to the Panel's conclusion and comment:-

Prior to Mr Watkinson's suspension, for reasons which he vigorously maintains are nothing to do with performance or governance issues, the new Board had:

i. improved its annual health check performance;

ii. delivered a financial surplus for the first time in years (with independent auditor confirmation);

iii. improved services to patients so that both its maternity and accident and emergency services are top 10 performers;

iv. reduced infection levels which have been recently reported;

v. as evidenced, two independent Management Reviews, one performed at the start of Mr Watkinson's tenure and one effected slightly over a year later, delivered major improvements in organisational culture and functioning.

This, we maintain, does not sit fairly with a conclusion of a failing organisation.

Edwin Coe LLP

17 February 2009

JOINT INDEPENDENT REVIEW OF MANAGEMENT & GOVERNANCE AT THE ROYAL CORNWALL HOSPITALS NHS TRUST (RCHT)

NOTES OF THE HEARING PANEL MEETING *WEDNESDAY* 15 APRIL 2009 ALVERTON MANOR HOTEL, TREGOLLS ROAD, TRURO, CORNWALL

Purpose of Meeting: to consider whether there has been a breach of trust and confidence between Mr John Watkinson, Chief Executive, RCHT and the Trust as employer and, if so, whether the position of John Watkinson as Chief Executive remains tenable at the Royal Cornwall Hospitals NHS Trust.

Present: **Panel Members:**

Roger Gazzard — Non-Executive Director (Hearing Meeting Panel Chairman)
Patrick Wilson — Non-Executive Director

John Watkinson — Chief Executive, RCHT

The Hearing Panel Chairman welcomed Mr John Watkinson, Chief Executive, of RCHT, who was accompanied by his personal representative, Mr Graham Webster. Mr Webster said that he was an ex NHS manager who had operated at all levels including Board and was an active health campaigner but advised that he was attending the meeting purely as Mr Watkinson's personal representative.

Mr Webster asked that Mr Watkinson be se copy of the notes being taken, in order that he and Mr Watkinson could check them for accuracy. The Director of Human Resource said that draft minutes of the hearing would be given and any comments raised by them on the notes would be considered.

The Panel Chairman explained that the Panel was in place to consider if there was a breakdown of Trust and Confidence in John Watkinson, as the current, Chief Executive, at RCHT and would be asking questions relating to the externally commissioned report from the Joint Independent Review Team, commissioned jointly by the RCHT Trust Board and NHS South West Strategic Health Authority, a copy of which was provided to Mr. Watkinson on 10th March, 2009. The Panel Chairman reminded all those present that the meeting was confidential and any matters discussed must absolutely remain confidential to those present, other than professional/legal advisors.

The Panel Chairman said that the Hearing Meeting was not a misconduct Hearing Meeting under the RCHT disciplinary procedure, but was a Trust and Confidence Hearing Meeting to consider Mr Watkinson's conduct, leadership and working relationships, in the context of considering if Trust and Confidence between the RCHT Board and Mr Watkinson had broken

down.

The Panel Chairman explained that the process of the Hearing Meeting would allow the Panel to put forward some questions which would, where possible, be in chronological order of the review report. Mr Watkinson would also be given the opportunity of inviting Mr Peter Davies [ex-Chair, RCHT] to present evidence in his support and to provide a witness statement. At the end of the meeting Mr Watkinson would be given the opportunity to finally communicate to the panel anything else in support of his position.

He advised that, following the Hearing Meeting Meeting the Panel would report to the RCHT Trust Board which would make a decision in relation to the outcome. This decision would be communicated to Mr Watkinson at the earliest opportunity, which was likely to be Friday 17 April 2009 at the earliest.

The Panel Chairman advised that Mr Davies had asked that the Panel asked all its questions regarding the report prior to inviting Mr. Davies into the Hearing Meeting. Mr Watkinson said that he understood the allegation regarding him was about trust and confidence relating to the RCHT Board and Mr Davies was the key witness in rebutting that allegation. He advised that he wished to refer to his performance early in the proceedings and would therefore like to invite Mr Davies in when raising this matter. He said that the Panel should be in receipt of his lawyer's rebuttal of the points in the Independent Review Report, dated 17 February 2009 (appendix A — letter from Edwin Coe LLP attached and forming part of the Hearing Meeting Panel papers].

The Panel Chairman referred to paragraph 2 of appendix A which stated that Edwin Coe did not have a copy of the previous draft Report, which had excluded recommendations and conclusions. Mr Watkinson explained that when the first draft came out he was not allowed to have a copy. He was advised that he could attend an office to review the report and would be supervised but could not take formal notes. It was later agreed he could have a copy which was with the lawyers and he could only see it under supervision of the lawyer. He had therefore been unable to cross-reference his comments to the first report.

Mr Watkinson asked the Panel Chairman on what date the panel had received a copy of appendix Ai containing his rebuttals (“the rebuttal letter”) The Director of HR advised that the Panel had been given copies far the Hearing Meeting but the organisation had received the comments from Edwin Coe Solicitors on behalf of Mr. Watkinson prior to the Hearing Meeting. Mr Watkinson advised that there had been a formal request for appendix A to be made available to the Board before the Board considered the report and asked whether Board members had seen it. He suggested that, when the Board had adopted and accepted the Joint Independent Review Report, it had done so without having full information available if they had not also been given copies of Appendix A containing his rebuttal. He said that was therefore challenging the whole decision making of the Board. The Chairman accepted the Non-Executive Directors had not seen the rebuttal letter until the day before and that the Board members had not seen it prior to them discussing and accepting the Governance and Management Review on or before they decided to allege a breach of trust and confidence.

The Panel RESOLVED to note his comment.

Mr Webster advised that, in a letter from RCHT's solicitors, Capsticks, dated 10 March, they had indicated that Appendix A had been made available to the RCHT Board. He said that Mr Watkinson was attending the Hearing Meeting on the understanding that the Panel was fully conversant with that document.

The Director of HR said that the Panel was in place to consider the process of the review report. The Panel noted the comments made by Mr Webster and Mr Watkinson. Mr Webster said that it was fundemental that Mr Watkinson's rebuttal was considered by the Board before the Hearing Meeting could proceed and suggested there be an adjournment to allow the panel members an opportunity to read and consider the rebuttal letter. This was dismissed by the Panel Chairman.

The Panel Chairman advised that the Panel was there to make a recommendation following the Hearing Meeting Meeting today but confirmed that ~~no decisions had been taken by~~ the RCHT Trust Board, had made a decision to accept the Independent Review Report. ~~, and that the Trust Board would only consider making a decision based on the outcome todays meeting.~~

Mr Watkinson reiterated that his comments on the Report had been submitted and the lawyers had asked for them to be made available to Board members. He said that Capsticks had thought this had happened as they had advised in

their letter that, "where you have asked for responses provided to be forwarded to commissioners of the report this has been done". He said that the fact the Panel had only received the response the previous day indicated that the Board had accepted the Independent Review report without having seen his response and had therefore decided to run a Hearing Meeting with incomplete information. Again, the Panel members noted the comments made by Mr. Watkinson and his representative. He was advised that this was a separate matter relating to the commissioning and publication of the external Joint Independent Review Report, and was a separate matter to the issues being discussed today. The Panel advised that they were in full receipt of the relevant rebuttal from Mr. Watkinson via his solicitors.

The Panel members proceeded to ask questions (shown in bold with the name of the Panel member asking the question shown in italics). Mr Watkinson's responses are shown below each question.

1. **From November 2007, it has been found that there was a substantial erosion of trust between RCHT and the C&IOS PCT, do you believe this erosion of relationship could have been avoided? [ref. para 22 of the JIRR] -** *Patrick Wilson*

Mr Watkinson said that the Independent Review process, based on the Bromely Report, was a sham. Following Peter Davies' resignation he had been concerned about the political change and had taken a formal report to the RCHT Board advising the Trust that it should effect formal public consultation before making any changes in Upper GI Surgery. Following that, Mr Watkinson said there had *been* further pressure by the SHA and said he had been victimised first by them and then the RCHT Board. He said that the Trust had breached its legal obligations to him in relation to the formal suspension and that the Press Release, which was issued following his suspension, was inaccurate and critical of him. He reiterated that there had previously been an understanding between Mr Peter Davies and the SHA that the Bromley Report was nothing and would, be handfed and would not be an issue for Mr. Watkinson. Mr Watkinson advised that he had clear communication from the SHA to back this up. After Mr Davies' resignation it had changed.

Mr Watkinson said that, "Specifically, in relation to the question my response is as contained in the rebuttal letter from the lawyer. " [ref. Section 41 of the Hearing Meeting Panel Pack of documentation - letter from Edwin Coe Solicitors to Capsticks Solicitors dated 17 February 2009]. He said that this letter had never been acknowledge nor had it received any feedback as to why things were included or excluded. ~~Because it had never been specifically dealt with in his view he said that was his reply and he was not going to add anything to that because it had not been treated with any respect.~~ Mr Watkinson referred that Panel to the existence of email correspondence between Peter Davies and the SHA which would support his position.

He said that in relation to point 88 he had not replied! but wished to comment. He said, "There *has* been no breach of confidence between myself and the Board. That is my position. Within that context I am saying the answers to the questions are in the paper".

Mr Patrick Wilson advised Mr Watkinson that the paper would be taken account of in any conclusions by the Panel. He reiterated question 1, **asking whether Mr Watkinson felt there was an *erosion* of trust between RCHT and PCT.**

Mr Watkinson said that there was a response to that: in the paper *[ref. Section 4 of the Hearing Meeting Panel Pack of documentation -.letter from Edwin* Coe *Solicitors to Capsticks Solicitors dated 17 February 2009]* and that the issue was about making subjective disclosures.

Mr Wilson advised Mr Watkinson that the Hearing Meeting meeting was an opportunity for him to give a reply to the questions being asked by the Hearing Meeting Panel.

Mr Watkinson responded by saying that he was replying the medium of the Paper.

Mr Wilson asked what page in that document answered the question.

Mr Watkinson responded by saying, "I was told you had this paper six weeks ago and had had it when you took the decision."

Mr Webster asked whether the Panel felt it appropriate to take Mr Watkinson's written response back to the Board and reconsider the matter in the light of that.

The Director of HR advised that the Panel Board members should not be responding. The two members of the Board could not answer the question on behalf of the whole Board and said that the Hearing Meeting must return to the process of the Hearing Meeting, which was to consider if there is a breakdown of Trust & Confidence in the Chief Executive. The matter being raised by Mr. Watkinson was entirely different, and related to the process managed by the external Joint Independent Review Team, and their solicitors.

Mr Webster said that the Board had not had the opportunity to see the paper. He therefore asked whether it would be appropriate to take it back to the Board before proceeding any further with the Hearing Meeting process. He suggested that this should be considered very carefully and it was agreed there should be an adjournment to give the Panel the opportunity to decide whether the Hearing Meeting should proceed.

THE HEARING MEETING WAS ADJOURNED.

Mr Watkinson and Mr Webster returned to the Hearing Meeting at the request of the Panel. They were advised that the Hearing Meeting Meeting would continue and that the Panel was constituted as a Hearing. Meeting Panel to consider if there was a breakdown of Trust and Confidence in Mr. Watkinson, as Chief Executive of the RCHT, and not to discuss the process arrangements of an entirely separate body, is the external Joint Independent Review team. The Hearing Panel Chairman reiterated that this meeting was established to ask Mr Watkinson questions regarding Trust and Confidence matters, and that Mr. Watkinson would be asked a series of questions to which he would be given the opportunity to respond. Mr Watkinson was advised that if he chose not to respond to a question and the Panel had to interpret his response from that contained within Appendix A it may not cover what was specifically asked and that it would be noted that Mr Watkinson chose not to answer specific questions. Again it was reiterated that it would be in Mr. Watkinsons best interests to respond to specific questions for his own benefit.

The Panel Chairman said that the Panel had noted Mr Watkinson's previous comments relating to Appendix A but said that the comments were outside the process of the Hearing Meeting and the Hearing Meeting was therefore to proceed. Mr Watkinson was advised that it would be helpful, if he felt there were questions answered by Appendix A, to point the Panel to the specific answer in that document.

Mr Webster asked for it to be formally recorded that the issue relating to Appendix A had been raised by Mr Watkinson and that, having taken these comments into consideration, the Panel had decided* to *go ahead with the Hearing Meeting.

The Panel proceeded to ask the questions:

1. **From November 2007, it has been found that there was a substantial erosion of trust between RCHT and PCT, do you believe this erosion of relationship could have been avoided? [ref. pare 22 of the JIRR] —** *Patrick Wilson*
   This question was reiterated and it was noted that Mr Watkinson's response was that the answer was as contained in the letter (appendix A).

2. **If so, how could you as CEO and leader of the organisation, have avoided the significant relationship deterioration as noted by the Review team?** – Patrick Wilson

Mr Watkinson advised that the Panel had the answer to the question in the rebuttal letter ~~lawyer's reply~~. He advised that he did not accept the Independent Review Panel report. He said the Bromley Report was inaccurate and

incomplete and that he was at the Hearing Meeting because he was a whistleblower and blew the whistle on Upper GI. He reiterated that he had made the paper available weeks ago and that the Trust's solicitors had said they had made it available to the Board. He said that the Panel had therefore had weeks to assimilate it.

The Panel Chairman asked Mr Watkinson if he wished to add anything to that contained in the paper to which Mr Watkinson replied, "Both questions are answered in the paper".

3. **How do you respond to the comment that relationships within the organisation of RCHT need improvement? [para 12, page 4 of the JIRR] — What as Chief Executive, and in your opinion, did you do to improve inter-organisational relationships? —** *Patrick Wilson* Mr Watkinson said he was confident that there was a substantive report on that in the paper and that in that document they had cross-referenced and gave an example of the two management reviews which had shown improvements in the organisation.

Mr Wilson asked Mr Watkinson if he could be specific about where this response was in the paper. Mr Watkinson suggested that the Panel should find the answer themselves and that the reply indicated that both reviews had been taken to the Board.

Mr Wilson asked Mr Watkinson if he was clear that for the first three questions he did not wish to make any further comment, nor refer to the specific section of his paper (Appendix A) relating to the question and wished to leave it to the panel to interpret his answers accordingly. Mr Watkinson said that the comments were clear in the paper (Appendix A) and it was not up to him to assimilate it.

4. **How would you respond as a leader, Chief Executive Officer, to the statement that there was an 'over optimistic presentation of the Trust's achievements' during 2007-08? —** *Roger Gazzard*
Mr Watkinson replied that his answer was in the paper.

5. **Since January 2007, can you explain why the Review Report found that overall standards of management and governance expected of a public service organisation have not been achieved?**
- Roger Gazzard

Mr Watkinson said that he did not accept the statement and said that there were many rebuttals in his paper. He said that the whole report was a sham *and* the whole issue was about whistleblowing on Upper GI and said that his comments in the paper adequately covered his response.

6. **The Review Report outlines at least 3 non-Executive Directors resigned over concerns about governance of the Trust. As Chief Executive what actions did you take to address these concerns?**
Mr Watkinson said when the Non-executive directors (NEDs) resigned they had a meeting with
the SHA where their issues were addressed. He said that he had not been involved in post resignation discussions. He said that he had not included it in his paper because it was not an issue chief executives were inhereantly involved in. He said he had not been made aware of why the first two NEDs resigned. He said that he was aware of why Peter Davies had resigned and that was because of Upper GI. The other three were a closed process and he had not seen the reasons why they had resigned.

He was asked whether the SHA had made him or the Chairman aware of the reasons for the resignations. Mr Watkinson said that they may have made the Chairman aware but they had not advised him.

7. **Given the enormity of the financial position and the significance of the transformation required for the organisation, as Chief Executive, do you consider the extensive use of Interim managers appropriate? —** *Patrick Wilson*
Did you take into account the longer-term effects of interim managers on the organisation? — *Patrick Wilson*
Mr Watkinson said that he had been given notice of the Hearing Meeting and had been advised of specific areas about which the Panel wished to talk to him but he had been given no advance notice of this question.

Mr Watkinson was advised that each of the questions related to the trust and confidence issue, and as outlined in his letter inviting him to the Trust and Confidence Hearing Meeting, issues would be discussed around the external Joint Independent Review Report [JIRR]..

Mr Webster said that they should have been given notice of the areas and issues the Panel were going to raise if the areas were not already covered in Mr Watkinson's response.

The Panel Chairman said that the Review Panel was beng held to discuss the findings of the JIRR and asked Mr Watkinson whether he was saying he was not willing to respond to the Hearing Meeting.

The Director of HR said that the letter had stated that there would be a number of questions and gave some examples and it stated that questions would relate to the full Joint Independent Review report of which had been made available to Mr. Watkinson.

Mr Watkinson said that the examples were meaningless. The Panel Chairman said that the examples were purely en indication of some of the Trust and Confidence issues. The whole reawson for the Hearing Meeting today was to explore those issues contained within the Joint Independent Review Report.

Mr Watkinson said that this was an example of the victimisation and asked for this point to be noted.

Mr Wilson requested that the Panel return to the trust and confidence questions around the use of interim managers and asked how Mr Watkinson would respond.

Mr Watkinson advised that he had nothing to add as he had specifically dealt with matters in his paper.

8. **How, given the transient nature of these managers, did you as CEO compensate for the consequent negative impact on stakeholder relationships? -** *Patrick Wilson* Mr Watkinson advised the Panel that he had dealt specifically with matters in the paper and had nothing further to~~would not~~ add to it. He said, "I believe we are talking about whistleblowing and persecution".

Mr Wilson asked whether Mr Watkinson wished to leave it to the Panel to interpret his answer from the letter and Mr Watkinson said, “Yes".

9. **As Chief Executive, how do you respond to the over-optimistic view about the annual health check self-assessment, following the Health Care Commissions' [HCC] inspection of five specific standards? —** *Roger Gazzard*

Mr Watkinson said that the Trust had not declared five — it had declared four. He had no

other comment to add as it was covered in his written response.

10. **Having been contacted by the HCC with the opportunity for the Board to reconsider HCC standards and self-assessment position, you declined this opportunity. Can you confirm why you declined the opportunity? —** *Roger Gazzard*
Mr Watkinson said that his written rebuttal covered this very comprehensively and that governance was led by Mr John Mills. He was again asked why he had not gone back to the Board as that was not covered in his rebuttal. Mr Watkinson said that it *was* covered adequately. He said, "You have created a situation of your own making. I am not trying to be difficult. We had an adjournment to review your position and whether we should carry on — you have decided to carry on, I think it is inappropriate. If you can't put your hands specifically on the paragraph, that is your creation. There is at least one paragraph and possibly two dealing effectively with this – ~~which I consider to be a trivial point which was a phone call~~ which I had not considered significant at the time and which had never been followed up in writing",

11. **Given that when you joined the organisation you were aware that relationships with key stakeholders would immensely contribute to the overall performance and support required of the organisation, and as CEO, and the leader of the organisation, what action did you take to reduce the damage within the public arena from Trust medical staff, who participated in external media interviews in relation to upper GI? —** *Patrick Wilson*
Mr Watkinson advised the Panel that, in his letter, there was a clear response denying that it happened and he said that he would like to draw the Panel's attention to that. When asked to indicate the page in his letter he advised that it was not his job to assimilate it and had nothing else to add.

12. **As Accountable Officer with responsibility for managing and improving relationship issues, given the negativity quoted in the media, how, given the opportunity would you now manage the situation? —** *Patrick Wilson*
Mr Watkinson said that the Trust had handled the media very well. There were several issues regarding PR in the report which were all effectively handled in his written response. He said that the key point was that there was no substance to the allegations and underlined his view that this was a phoney process.

Mr Wilson asked where his response was covered in his letter, Mr Watkinson said that it was the same reply as previously stated and that it was all in his rebuttal. He said that the process adopted by the Panel was quite wrong. He reiterated his concerns about the fact that Capsticks had told him that the Board had had his rebuttal letter. He said he wanted to make sure the Board had the full information before taking the decision to support the Report. He said that that the Report was inaccurate and unfair and added; "You have come to this meeting without being able to assimilate my responses".

Mr Wilson said that Capsticks were the legal representatives of the external Joint Independent Review Panel and the nothing to do with the RCHT Trust.

Mr Watkinson said that Capsticks were ~~not~~ the Review Panel lawyers and they had said that his papers had been given to the commissioners that is the Board of the RCHT Trust.

Mr Wilson confirmed that the papers had been received by the commissioners of the Report

on the date stated in their letter and confirmed that the Panel had this information as part of their Hearing Panel documentation pack.

THE MEETING WAS ADJOURNED.

Following the adjournment, the Hearing Panel Chairman advised Mr. Watkinson that:-

- **This Hearing Meeting was constituted to consider whether there had been a breakdown of Trust and Confidence between John Watkinson, as Chief Executive and the RCHT Trust Board as the employer;**

- **The Hearing Meeting Panel had heard and noted Mr. Watkinson's' comments regarding the process regarding the externally commissioned Joint Independent Review however, this meeting was purely to consider the issue of whether there had been a breakdown of Trust & Confidence between the employee and the employer;**

- **The Panel Chairman reiterated that this Hearing Meeting was an opportunity for Mr. Watkinson to respond to and consider questions raised by the Hearing Panel, and afforded Mr. Watkinson the opportunity to reply and comment upon the content and comments raised from the external Joint independent Review;**

- **The meeting would not consider issues or matters in relation to the processf of the Joint Independent Review, which was a process matter outside of the remit of this Hearing Meeting, which Mr. Watkinson would need to deal with separately with the Joint Independent Review Team or its advisors.**

- **The Hearing Panel confirmed that they had all the relevant documentation in order to continue with the Hearing Meeting, including Mr. Watkinson's' response via Edwin Coe Solicitors to the Joint Independent Review Report.**

- **The Panel Chairman informed Mr Watkinson on ~~asked if Mr. Watkinson and her representative were happy to proceed, and this was agreed. On~~ this basis the Hearing Panel would recommence~~d~~ following the adjournment.**

Mr Webster advised the Panel that Mr Peter Davies was available to be called in to the Panel when required.

Mr Watkinson gave prior notice to the Panel of another issue he wished to raise in relation to documentation and said he would do this after Mr Davies had given his comments to the Panel. He advised that it related to his personal performance plan for 2007/08.

Mr Peter Davies was then invited to join the Hearing Meeting [as this was requested and agreed by Mr. Watkinson and his representative that this was an appropriate time] and welcomed by members of the Panel.

Mr Webster asked Mr Davies what the situation was when he took up the post of interim Chairman of RCHT. He asked what legacy he had inherited as Interim Chair and how bad, good or indifferent the situation was at RCHT at that time.

Mr Davies said that he had been appointed as Interim Chair on 19 June 2007 when media headlines showed RCHT as the worst performing NHS Trust in the country. He said that he could catalogue all the things that were wrong and had been identified by the SHA in their

2006/07 review. His job was to make sure there was an immediate follow-on, following Professor Colin Roberts' resignation [*previous RCHT Trust Board Chairman*], and to support Mr Watkinson [Chief Executive] in the turnaround of the Trust. He said there was a very dispirited team and a lack of management. Mr Watkinson had appointed a number of interim people and there ~~were~~was a lot of dissidence ~~dissients~~ within the Board. The Board at 2006/07 was dysfunctional and the worst that Adrienne Fresko had ever seen. (It was explained that she *[Adrienne Fresko*] ran Foresight Consultancy, and had previously been chairman of Croydon SHA). Two NEDs had resigned saying there was dissidence at Board level. If Mr Watkinson was allowed to get on with the job he could turn it round and this was echoed in a letter from Patricia Hewett to Joe McKenna, saying that the Trust had strengthened its leadership with the appointment of Mr Watkinson, who had a proven track record of turnaround. Mr Davies said that he was there to support Mr Watkinson to bring in a new Board of which Mr Gazzard and Mr Wilson were two of them and to bring about a change of culture. It was recognised it would take 24 months to achieve but good progress was being made.

Graham Webster asked Mr Davies how he had found things in respect to the financial position of the Trust.

Mr Davies said finances had been getting worse and worse. In particular, the financial position of the Trust had been deteriorating over the previous 6 years and a massive legacy debt had been accumulated. Ethna McCarthey, previous Financial Director of the Trust, had left prior to his arrival. The SHA had recognised that finance needed strengthening and had brought in Bill Boa~~Byers~~ who worked with the Trust from June 2007 until December when Joe Teape was appointed as Finance Director as a full time replacement. Bill Boa had felt things were moving forward in the right way but the finance team needed strengthening and the Trust invested in the Finance team to get a new director.

Mr Webster asked if there were other interventions from the SHA. Mr Davies listed the following:

- Liz Redfern, Director of Nursing, who workdays closely with Mr Watkinson and Ms Valerie
  Howell on West Cornwall Hospital for around 2 days a week over several months in 2007
- KPMG accountants
- Performance support team led by Maggie Donovan.

Mr Davies pointed out they were constantly under external review with interventions from the NHS Performance Support Team from the Department of Health, KPMG, the Healthcare Commission and the Audit Commission which had all contributed to or noted a continuing and significant improvement. He said that he had weekly meetings and they had all said the Trust was turning round under Mr Watkinson's leadership. They were aware of the issues which needed to be addressed and were being addressed. There was a lot of help and support from the SHA. When ~~T~~the Department of Health came down ~~when~~ the Trust was rated weak/weak under the HCC standards and they were positive about the steps being taken by the Board in tackling the issues. It was extremely difficult because a lot of the staff were temporary and/or seconded. He said that the Trust wanted to get a new Board in place and there was a period when the management was quite fragile. To turn an organisation like RCHT around was bound to mean making enemies and he thought some things were done right and some wrong.

Mr Webster asked Mr Davies if he had been brought in by the SHA.

Mr Davies said this was the case — he had been a NED of the SHA and Sir Michael Pitt had asked him to act as Interim Chair when Professor Roberts had resigned. There was therefore a seamless turnover of chairs.

Mr Webster asked if, during this time of intervention, anyone came to him with concerns about Mr Watkinson and the direction or the Board as a whole.

Mr Davies said no and that Andrew Williamson, Chairman of the PCT, had telephoned him to say that Mr Watkinson needed help and support. One of the old Board members was still quite concerned about Mr Watkinson which went back to issues relating to car parking and things like that. Harold Chapman, who was still a NED, said he would carry on as a NED and said he could see the changes taking place. David Fryer was due to retire and Vanessa Moore had sadly died. She was probably uneasy with Mr Watkinson, which was clearly relating to the history. There was a lot of 'back biting' which came to light when Mr Eric Parkin, Chairman of the Overview & Scrutiny Committee, gave him an anonymous letter he had received which Mr Davies had given to the Independent Enquiry Team together with his reply but they had chosen to ignore it.

Mr Webster asked whether, other than that, there was any evidence he knew of that the individuals from the SHA and external bodies had any concerns with Mr Watkinson being Chief Executive, his management of the Trust or the direction of travel.

Mr Davies said that~~ at that early stage,~~ the answer was no. However, things changed in February/March 20013 and later. He advised that he had personal confidential letters from Sir Ian and Sir Michael which gave the flavour. They said they had noticed the pace of change taking place at RCHT which was dated April 2008 and they were positive letters. Sir Michael's letter had said that progress made at RCHT had been significant and he said he was grateful for Mr Davies' contribution in progressing matters to date. Sir Ian Carruthers had thanked him for the massive contribution he was making as Interim Chair of the RCHT, as progress continued to be made at a page and said he looked forward to continuing the journey. However there was a change of approach to RCHT's position when Upper GI cancer services became an issue. ~~In the interim~~ tThere had been the letter from Mr Eric Parkin dated 5 November 2007 saying that he had received an anonymous letter of allegations. Mr Davies said this related to 'old stuff' relating to issues at the time of the previous Board and he referred the letter to Internal and External Audit. Internal Audit said they did not deal with anonymous things and External Audit made no comment. Mr Davies had written to Mr Parkin on 3 December explaining the issues and spoke to him and he was quite happy. He was asked to provide a copy of the letter to the Panel which he agreed to do but said that it was in confidence.

Mr Davies confirmed Mr Watkinson had good relationships with external stakeholders.

Mr Webster asked whether, other than the letter from Mr Parkin, there were any other issues raised with him by the OSC. Mr Davies said there weren't.

Mr Webster said that, within the organisation, Mr Watkinson was facing an issue of trust and confidence — he asked Mr Davies whether, in his time. as Interim Chair, relationships were good and whether there were other trust and confidence issues relating to him or the Board as a whole.

Mr Davies said that until 10 July, when he had resigned, the answer was yes. Clearly, Sir Ian [NHS SW Chief Exutive] and Mr Watkinson did not 'hit it off' but he was not alone in the South-West in having relationship difficulties with Sir Ian. In response to a question from the Panel Mr Davies confirmed that he did not think Mr Watkinson's relationship with the SHA was irreparable.

Mr Gazzard said that Sir Ian had been very supportive of Mr Watkinson when he first came to the Trust and asked when the relationship changed.

Mr Davies said that he used to have weekly conversations with Sir Ian and it changed in April/May 2008. He said that he thought it was because RCHT was saying that it did not think what the PCT/SHA was doing with cancer service was

right on the evidence that had been given. He said that RCHT had said the process had not been handled properly, there had not been consultation and the service had not been reviewed. Mr Davies said he had tried to meet with the PCT and SHA and asked for a review but all the PCT would say was that the service was unsafe which was subsequently found to be untrue. Sir Ian was driven to bring change. He did not like being crossed. He felt it would have the best outcomes for patients but it was not based on evidence which was subsequently sorted out when all three places were reviewed.

Mr Webster asked **whether any of the NEDs had raised concerns as the end of his time as Interim Chair by which time he had virtually a new Board.**

Mr Davies said the only concern was raised by him when the new Board came in when they had a
day with Mr Watkinson and he had asked people how they rated Mr Watkinson. The only concern
raised was about his health because he was overworked, slightly overweight, doing too much and if he was not there the improvement would falter ~~organisation would collapse~~ because there was no underpinning support there. This was being built in but, with the financial position of the Trust, only limited sums could be invested and huge sums had been put in to support the finance.

Mr Webster asked Mr Gazzard if he had had concerns.

Mr Gazzard replied that, on advice from the Director of HR, it was not appropriate to respond at this Hearing Meeting, as Mr. Gazzard was a Non-Executive Member of the Board and was at the meeting today in a role of Chair of the Hearing Panel.

Mr Webster said Mr Davies was aware of the Bromley report and the issues relating to Mr Watkinson and asked what position had been agreed with Mr Watkinson.

Mr Davies said that Mr Watkinson had kept him fully in the picture and had copied Sir Ian and him in on letters that he was sending. He said that he was asked to agree a statement by Andrew Millward from the SHA which said that when the Bromley report came out the Trust/SHA could state that was then and this is what John Watkinson is doing now and we are satisfied that what had allegedly happened in Bromley was not happening at RCHT. RCHT had a number of agencies looking at it. He had spoken to Sir Ian on 8 February 2008 about the DoH review which showed there was clear improvement. Sir Ian said that the Trust could not be weak/weak again and that the Trust had to achieve fair/fair and they had discussed the Bromley issue. Sir Ian had said that he did not think Bromley was an issue. He had made a comment that Mr Watkinson was 'full of bullshit' but he would ~~promise and~~ deliver. Sir Ian was Mr Watkinson's line manager - Mr Watkinson needed help and support which Mr Davies did not think he was getting. A meeting was arranged between Sir Ian, Mr Watkinson and Mr Davies which never took place. Mr Davies said it was very clear that Sir Ian wanted to know if there were issues and problems that he should be told straight away.

Mr Davies had written to Sir Ian in February or March 2008 about Upper GI issues and problems and said that, as Acting Chairman, he had public accountability and explained how it could be taken forward but it was not dealt with. He said that he had not become aware of the issues around Upper GI cancer services as he had not attended the OSC meeting in November 2007. Consultants attended a Board meeting in January 2008 and gave a presentation, following which Mr Davies had tried to meet with the PCT and SHA. He said that it was after the failure of the PCT arranging a meeting that he wrote his letter to Sir Ian. In this letter he set out the issues he saw and made a suggestion as to how to take things forward which was to have an independent review.

Mr Webster asked whether, if there had been a clear strategy, everything that happened

could have been avoided.

Mr Davies ~~said that it had had a huge impact.~~ He said ~~however~~ that, had he been Chair of the Trust when the Bromley report was published, he would also have suspended Mr Watkinson at that time but would not have had such a one-sided review which he considered to have been a means for moving Mr Watkinson on. If Mr Watkinson had been suspended at that time the auditors could have done a review which could have been dealt with very quickly saying that Bromley was not being replicated at RCHT. It may have been that Mr Watkinson could have been given a warning if anything similar happened at RCHT. Mr Davies said that it had been a long drawn out affair which had not done the people of Cornwall any good because it had put the Trust back 18 months.

Mr Webster said that there had been an agreed, position about the Bromley report. He asked, "What changed? Was it Upper GI?".

M Davies said yes. There was a press release agreed with the SHA. In his view it was the change in approach of the ~~that it may have been the content of the report. It was probably a combination of the report and the perceived breakdown in relationship between the PCT and~~ RCHT challenging the PCT and Cancer Network's position over cancer services.

The Panel Chairman said that Mr Davies had mentioned support of Mr Watkinson when he first started.

Mr Davies said that the Report stated that the relationship between the PCT and RCHT was not good. This was not true initially as there were regular positive meetings between Chairs and Chief Executives until the cancer services became an issue when communications deteriorated. At a meeting in January the PCT had agreed one thing and then two days later sent a letter saying the opposite.

The Panel Chairman said that RCHT had tried everything it could.

Mr Davies said that he thought the PCT would put a different slant on it. It had been difficult to pin down the two Chairs and Chief Executives to regular meetings. He said that RCHT had tried to have regular meetings but it soured under Upper GI because Anne James kept stating it was unsafe and that it was being closed. ~~despite RCHT saying it would not.~~

Mr Webster asked if, in the evidence given to the review team, he was promised a copy of the draft report on which to comment and to ensure accuracy.

Mr Davies said he had seen a copy and had sent his comments back via the RCHT Director of HR *[acting on behalf of the RCHT as custodian of the report].* He said that his comments had been on the draft report which had not included the conclusions so the final report was very different.

Mr Webster asked whether, given the conclusions of the report, Mr Davies accepted that the Board and Mr Watkinson were heading for corporate failure.

Mr Davies said, "No, absolutely not".

Mr Watkinson said that the whole discussion about. Upper GI was very predicated on him. He asked whether it was the case that the Trust Board took a view that it was unhappy, and in particular some of the NEDs were more vehement in that respect.

Mr Davies said that he was charged as Chairman to have dialogue with the PCT but they would not discuss it. He had written to Sir Ian Carruthers asking for further discussion as the Trust Board was clear it supported a single centre. He said that his resignation had come about because, at a meeting, he had been told to stay in the room until he had agreed a statement supporting the transfer of services to Derriford which he had circulated. The NEDs, and he believed this was most NEDs, agreed that the Trust Board should not support it and he, as Acting Chair, had no option but to resign.

Mr Watkinson said that the crisis was generated by bullying Mr Davies into agreeing a statement which he could not support.

The Panel Chairman said that there were certain behaviours discussed in the Report, particularly with internal managers and executives 1 for which Mr Watkinson had been criticised.

Mr Davies agreed and said that was Mr Watkinson's style and that he was "a bit of a Maverick". He said that it was not gross misconduct and could have been dealt with managerially. In terms of the enquiry he had been specifically asked about Mr Watkinson. He had said he was 100% committed to the NHS and patients, he was a strong leader, clinicians and the public were supporting him, he was industrious, he was loyal to the NHS and the SHA, several were loyal to him and he got on with most people but not all. He had added that Mr Watkinson was very self-reliant and highly motivated to make RCHT succeed. On the downside he lacked gravitas and was not high on sartorial elegance.

Mr Wilson asked. Mr Davies what, at his last day in July, the trust and confidence with the wider NHS community and the relationship with stakeholders was. He asked whether, at that that point, there was a potential damage situation as a consequence of the factors.

Mr Davies said that the relationship with Sir Ian Carruthers was difficult but Mr Watkinson was not alone in the south-west in being in that position. As far as NHS stakeholders were concerned Eric Parkin recognised that Mr Watkinson was doing a really good job but it had all become clouded by cancer services. Mr Davies said that RCHT had been told to get A&E figures up to 98%. Mr Watkinson had got it there but that and other good Issues were not mentioned in the Report~~.~~ leaving it inaccurate and unbalanced. He said that clinicians were not always the easiest of people to deal with and would only work Christmas and Bank Holidays if they believed in someone as a leader. He said that the relationship between Mr Watkinson and the PCT Chairman was good as Mr Andrew Williamson had a lot of time for improving some of the issues faced by individual patients. Mr Williamson could see there were issues which had not ironed out and was very much more supportive. The NHS community saw Mr Watkinson as a complete change in the way of engagement of RCHT. The Report was unfair in saying that Mr Watkinson said yes to everything.

Mr Wilson said that, if he stripped out the performance management comments, there was a breakdown with the SHA rather than the stakeholders.

Mr Davies said that he did not know but suspected the breakdown was with the SHA Director of Finance and with Sir Ian. He believed the Chief Executive of the SHA could have continued to work with Mr Watkinson. They had previously worked with each other. He said it was also about the Chairmen of the two organisations and he did not think there would have been a problem. He said that the issue of cancer had definitely clouded and damaged the relationship, but not irreparably.

THE MEETING WAS ADJOURNED,

The Panel Chairman said that, in relation to the Bromley Report, Mr Davies had mentioned that the SHA had agreed a position statement but, when the review was published, this was not used.

Mr Davies said that when they knew the Bromley report was coming out it was a question of managing it and what was in it. The view expressed in March was that it would probably not be a problem and he had agreed a form of words and a press statement which would be in the organisation somewhere. He said that the Bromley report had come out after he had resigned.

The Panel chairman asked whether the SHA had had a copy of the Bromley Report in March but Mr Davies said he did not know.

Mr Watkinson said he had responded to two drafts of that report. The first one was in February and the second was on 10

April and all the letters had been copied to Sir Ian Carruthers. In his replies, which he could produce, he had replicated the essence of the allegations and repeated them so it would be the case that the SHA knew the essence of the report from February onwards.

The Panel chairman asked whether the final report had changed from the drafts.
Mr Watkinson said they had hardly changed at all.

The Director of HR asked the Panel for clarity on when Mr Watkinson's response had been shared with Mr Davies - was this in June 2007. Mr Watkinson said the first report was in February 2008. It had taken a year after he left in December 2006 to activate the review. The first draft was in February and second in March and it was finalised in April but not published until September. A press release had then been put out which was defamatory and related to a period when he was not in Bromley.

Mr Watkinson said that the HCC feedback session had been changed to the day before he was suspended (it had been moved forward to a day before the SHA would be in Truro),

Mil Wilson ~~Davies~~ said during the period since September, Sir Ian had advised him that he had been approached by RCHT executives in a period prior to Mr Watkinson's suspension raising concerns about his style and suppression of information. The only person he knew who had one to ones with Sir Ian was Valerie Howell which was, he assumed, because she had been a Chief Executive. Sir Ian had clearly taken an interest and wanted to see her settled and was pushing Mr Davies to get her appointed permanently at RCHT. Mr Davies had asked her what happened during her meetings and she advised that it was purely mentoring. Bill Boa may also have had one to ones because he was employed by the SHA.

Mr Watkinson said that it was slightly slanderous of him and asked whether there were any specifics of the particular information that he had suppressed and when.

Mr Wilson said that he only had the statement from Sir Ian. He said that Mr Watkinson had said that corporate failure was not feasible. He said that if they went back to April, May, June 2008, when there was some feasibility on the financial position being satisfactory. ~~It was too early in May to take a view but in June the results suggested RCHT were bordering on irrecoverability at that stage.~~Mr Watkinson said the results could not have been irrecoverable as the Trust made a surplus in 2008/9.

Mr Davies said that whatever was looked at you could find things you don't want to find. He said that the Board knew things were not right and there had been a different culture where clinicians and groups had done their own things and had their own budgets. With Joe Teape and his team in they were uncovering things and putting them right. Everything was being done for the best of the organisation. They had started from zero and were trying to build the organisation up. Governance was not perfect but the performance support team had agreed that the Trust had moved forward. When he had started with the Trust there had been no Finance Committee — given a couple of years with the Board and the confidence of District Audit, Internal Audit, HCC, things were moving forward.

Mr Davies said that he had not looked at the five areas marked down by the HCC but he had heard the evidence given by the team and he would say you could have put them above or below the line. He suspected that someone had told them to put it below the line. He said that if it had been done independently in another hospital the failures would not have been registered.

Mr Wilson said that on the financial side he would echo that it was moving forward. He said that the reality that the Trust would not meet its financial position must have crystallised after Mr Davies left. Mr Davies said that the Board had been hopeful of property sales with the SWRDA which had been delayed and he did not agree~~agreed~~ that the inexorable failure had crystallised after he had left. ~~, so going towards corporate failure was not relevant.~~ Indeed, the "failure" was a fantasy of the Review Panel and the Hearing Panel. Mr Watkinson again pointed to the fact there was no "reality" that the Trust would not meet its financial target, as it did.

Mr Webster said that not only did Mr Davies, the Board and Mr Watkinson start to restore things, it had also started to restore confidence in the wider community which needed to be acknowledged because people actually believed RCHT was going in the right direction.

Mr Wilson asked Mr Davies, in relation to the NHS community trust and confidence, whether it was his view that the broad community was disconnected.

Mr Davies said that this was not the case and if anything it was stronger. He said that it was also with prospective parliamentary candidates. He said that everyone wanted RCHT to succeed and they could see it moving in the right direction and they were welcoming and supportive I was not aware of any information held back from me or the Board as I told Mr Watkinson that I did not want any surprises or secrets.

Mr Wilson asked Mr Davies whether, in his opinion, the; only significant breakdown was with the SHA and Mr Davies said that he thought so.

Mr Davies was asked if he wished to add anything else. He declined and was then thanked for attending.

MR DAVIES THEN LEFT THE MEETING.

Mr Watkinson asked if the Panel could deal with the performance plan issue at this point as he said it was relevant to trust and confidence,

He said that clearly there had been a period of time, after Mr Davies had left, before he was suspended, and that was why the performance plan was important. He asked whether the performance plan he had been given (as requested from the Director of HR) was a mistake or whether the Trust did not have a copy of the latest one which brought the trust and confidence thing up to date.

The Panel Chairman said that it had been made clear that the issue was not a disciplinary relating to lack of performance. It was trust and confidence.

Mr Watkinson said that Mr Davies, the previous Chairman, had said he had done an excellent job.

The Director of HR said that she thought there had been ,a mistake in the information she had received late yesterday from Mr. Watkinson which was when she had been asked to provide this information. She said that it had not been made clear that it was to be made available to the Panel. It had been her interpretation of the communication by email but she did not have a copy available. She would however obtain a copy and make it available. She said that in terms of those at the meeting Mr Davies had made the position clear.

Mr Watkinson said that the Trust was alleging that trust and confidence had broken down between him and the Trust Board. A relevant consideration to that was the most up to date performance plan that he had post Mr Davies leaving which was for 2007/08. It *had* been signed by the Acting Chairman, Mr Mills, post Mr Davies leaving. He said he was talking about the regime of the then Acting chairman, Mr Mills. It was a relevant document to view whether there had been a breakdown in trust and confidence.

The Director of HR said that the Hearing Meeting was about trust and confidence rather than performance so it was not part of its task. Mr Watkinson said it was signed by Mr Mills, the Acting Chairman after Mr Davies, and that it must be available in the organisation.

Mr Webster asked whether a copy was available on Mr Watkinson's personal file. Mr Watkinson said that this was a key document in which it showed whether or not there was an issue of trust and confidence between him and the Board. He said he had asked for a copy of it. The Director of HR said Mr. Watkinson had clearly articulated what items he wanted for the panel and that this had not been asked to be available to the Panel and reiterated that it was a misinterpretation on her part.

The Panel Chairman asked Mr Watkinson for a copy, as he had a number of copies with him.

Mr Watkinson said that it was a fundamental point. If it was the case that the Panel had not been given this document and not taken it into consideration because it was central to the judgement of whether there was trust and confidence. It had been signed by John Mills and stated that he did an excellent job and had excellent relationships with the health community. Mr Watkinson said the lack of this paper was a massive omission.

The director of HR agreed to check whether there was a copy on Mr Watkinson's personal file. It was accepted by the Panel that they had not taken Mr Watkinson's Performance Plan into account as they had not been briefed with or about it. Mr Webster asked if the NEDs had had an opportunity to look at Mr Watkinson's personal file and the Director of HR said this was not relevant. She again requested a copy of the paper that Mr Watkinson had.

Mr Webster said that he and Mr Watkinson were finding the Hearing Meeting laboured and stressful. He said they had hoped the Panel would be up to speed on the document discussed earlier and this latest document. He pointed out that they had not asked for any adjournments but there had been three at the request of the Panel. Mr Watkinson said that it was another facet of bullying and harassment. Mr Webster suggested the Hearing Meeting should stop and reconvene another day. Mr Gazzard said the Panel would agree to a short adjournment but not to reconvene another day as there were not many more questions that the panel needed to put forward to Mr. Watkinson. It was agreed there would be a short adjournment.

THE MEETING WAS ADJOURNED.

It was agreed to continue.

13. **What assurance was provided by you as Chief Executive to the Board regarding the principle of contracting out the management of the car park, particularly around the issue of accounting and reducing the Trust's debt? —** *Roger Gazzard*
Mr Watkinson said this was totally covered in his submission. He said that, as Mr Davies had indicated in his evidence it was not about this but was about Upper GI and whistleblowing.

14. **What did you do, knowing that there was disagreement with the Non-Executive Directors and what action did you take to unite the Board on this matter?** *Roger Gazzard*
Mr Watkinson said this was covered in his submission. He was asked whether there was a specific comment about uniting the Board in his submission and Mr Watkinson said that his answer was contained in the submission.

15. **Given three resignations from Non-Executive Directors what action did you then take to address concerns? —** *Roger Gazzard*
Mr Watkinson said this had been dealt with.

16. **How do you respond to the issue that under your leadership as Chief Executive, the Trust reported an over-optimistic view of the financial performance during 2007-08?** *—Patrick Wilson*
Mr Watkinson said this was fully documented, Mr Wilson asked whether paragraph 58 on page 3 of Mr Watkinson's report was his full response to the question. Mr Watkinson said there were a number of paragraphs that related to it and what he had said was sustained with the view of the District Auditors. Mr Wilson said that he would struggle to get the best value from this written document and asked whether Mr Watkinson could help to find the relevant section in his response or expand on his response. Mr Watkinson reiterated that he had been told that the Board had the document six weeks ago and that he had replied fully in that paper and he believed this to be a phoney processes and that it was all about upper GI and whistleblowing.

17. **How do you respond to the key trust leadership error with too little reliance on central financial management controls? —** *Patrick Wilson*
Mr Watkinson said, "See my report". Mr Wilson said there was nothing in the report about that. Mr Watkinson said, "Yes, there is". Mr Wilson said that said that in repeated conversations with him in the Finance Committee when raising the issue regarding central financial controls it was left unanswered then and asked whether Mr Watkinson could help him in this now. Mr Watkinson said there was a clear response to that point and had nothing

more to add. Mr Wilson said the Panel would by and extract some information from his written response.

Mr Webster said that, if in considering that reply, there were specific questions the Panel wished to raise Mr Watkinson would be happy to respond after the Panel had considered his written response and assimilated it.

18. **How do you respond to the comment from the Review Report that the Trust has had a tendency on occasions to present an over confident picture of the organisation's achievements? —** *Patrick Wilson*
Mr Watkinson responded that, as contained in his submission, it was supported by the view of the District Auditor, particularly in view of the financial performance. The District Auditor signed off the accounts without qualification and the Board, SHA and the DoH adopted the accounts. **Mr Wilson said it was about how it was presented externally as no qualification was provided about it being done with full support.** Mr Watkinson referred Mr Wilson to his written response and informed him that there had been no support provided in 2007/8 as set out in the signed off accounts.

19. **The report states that under your leadership as CEO, the Trust has a tendency to externalise strategic problems and challenges, for example blaming other organisations such as the PCT or SHA. How do you respond to this? -** *Patrick Wilson*

Mr Watkinson said that it was as contained in his submission. Upper GI generated massive change in the relationship with the SHA and was all triggered by upper GI.

20. **As CEO you made a commitment in West Cornwall about providing 24 hour Doctor cover, this has not been achieved. What actions did you take to attempt to deliver?** — Mr Watkinson had nothing to add to his statement.

21. **When this commitment was made, it was unclear how it would be implemented or appropriately funded, given the financial constraints of RCHT how do you reconcile this?** - *Roger Gazzard*

Mr Watkinson said the answer was contained in his written response.

22. **Did you create a Strategic Business Case and what mechanism did you use to agree this with the Board? —** *Roger Gazzard*

Mr Watkinson said it was covered in his report.

23. **Do you feel that your behaviour as CEO represents good leadership style and role model?**

Mr Watkinson answered, "Yes".

24. **Please can you comment upon the statements made in para 60, regarding the 'team within a team' of Executives? —** *Roger Gazzard*

Mr Watkinson said this was covered in his submission.

25. **In pare 61 there are some serious comments regarding your behaviour towards Executives and Managers who were outside of the core team, please can you comment on this? —** *Roger Gazzard*
Mr Watkinson said this was covered in his submission. He asked what evidence there was.

He said that question had been asked of the Independent Review Panel and they have produced none. He said it was a scurrilous attack on him personally and was an unsubstantiated allegation put forward.

26. **Given the information contained within the report about style of leadership, and negative impacts on services and the health community, do you believe you could persuade the health community and its public about its Trust and Confidence in you as a Chief Executive and key leader, stakeholder within the NHS Cornwall community? -***Patrick Wilson*
Mr Watkinson said it was the only way the Board will regain trust and confidence. He said that he had never lost the trust and confidence of the community. He said he did not lose the trust and confidence of the Board. He said that the Board would have an issue if he was unfairly dismissed because he was a whistleblower in terms of Upper GI, particularly as he was following the policy of the Board. **Mr Wilson asked about the broader impact - not upper GI.** Mr Watkinson said that he believed he had not ever lost the support of the community. The SHA position was repairable and he did not believe there was any impediment to his returning as Chief Executive other than the will of the Board itself.

27. **If you returned to your role as Chief Executive at RCHT and taking on Board the comments contained within the Joint Review Report, particularly in relation to valuable lessons in leadership, what would you do different in the future? —** *Patrick Wilson*
Mr Watkinson said that as this had all been generated through his protected disclosure and that he believed the Board had been correct in its stance. Exeter will now support a single centre which was always supported by the Board. Provided there was public consultation he believed the Board could look back and feel it was correct. He said there was massive bullying in the system and you had to stand up to the bullies - he said that his protected disclosure was correct and the Board's position was correct and it had done the right thing by Cornwall's people and the healthcare services. He said the lesson was that they had taken the correct position.

Mr Wilson asked how Mr Watkinson would restore the relationships to mitigate the potential breakdown in trust and confidence. Mr Watkinson said that he would work with the new Board and chairman and they could say they took a principled and correct stance in respect of Upper GI and the Board would support Upper. GI going forward, providing there was proper consultation because it was illegal which was what the PCT and SHA were asking the Trust to do. He said he would like to work with the Board to improve relationships with the SHA. He said that he had said many times that the Trust would never prosper by being confrontational with the SHA. He said that he did not regret what he did as he thought it was correct and he had the full support of the Board when he was doing it.

Mr Webster said that he did not represent the complete people of Cornwall but as Chair of Health Initiative Cornwall he [Mr. Webster] represented a large chunk of active health campaigners and he thought it was relevant to this situation to hear what people thought out in the community.

The Director of HR said that Mr Webster had made it clear at the beginning of the Hearing Meeting that his role was as a friend and was here to support Mr Watkinson and not in any other guise. She said that she did not think it appropriate therefore for him to put such comments forward. Mr Webster said that the question about how it would be perceived by people had been asked.

The Panel Chairman apologised but said that as advised the Hearing Meeting must move on

to the next question.

28. **Given the independent review focus on poor corporate leadership - what part do you believe you have played, if any, in poor corporate leadership? -** *Roger Gazzard*
Mr Watkinson said that it was an issue to do with Upper GI. He did not believe corporate leadership was a problem.

29. **Is there a correlation between your style of management and over-confident approach as outlined by the Review Report, and the lack of basic management systems & processes within the organisation? —** *Roger Gazzard*
Mr Watkinson said that dealing with the last point, which related to section 88 of the report, he had prepared an appropriate response to that with his lawyer. Paragraph 88 referred to the point made about follow through of the Organisation and Development programme. It was too early to make a judgement even though the divisional structure was implemented a few months before the report. He said that the report was selective and biased. He said it was at odds with putting in good heads of service, ie Julia Dutchman-Bailey was praised in paragraph 63 and Joe Teape was praised in paragraph 64. There was general acknowledgement of positive statements towards appointed staff. He said it was too early to have consolidated. Putting the divisional structure and good service heads overtime would have consolidated and the Trust would have seen the benefits flowing through.

Mr Watkinson said the first point was covered in his statement. The key point was that it was too early to make a judgement about the ongoing process.

30. **How do you respond to the summary, page 20, para 92 - in relation to your management and leadership style? —** *Roger* Gazzard
Mr Watkinson said he would need to look at it before he could specifically reply and requested an adjournment.

THE HEARING MEETING WAS ADJOURNED TO ENABLE MR. WATKINSON TO CONSIDER THE REPORT AND QUESTION RAISED ABOLOVE.

The Hearing Meeting was reconvened. Mr Watkinson said that the basic point about the consequences was that because the report was so inaccurate and unbalanced the conclusions

and recommendations were relatively worthless and he therefore did not feel it was worthy of a reply. The report invalidated the recommendations and conclusions.

31. **As Chief Executive, you are responsible for the direction of travel of the leadership and management of the organisation. The Review Report suggests that under your leadership, the direction of travel is towards corporate failure, how do you respond to this? —** *Roger Gazzard*
Mr Watkinson said he would respond the same way as Mr Peter Davies had responded.

Mr Wilson said that Mr Davies had agreed that this had crystallised after he had left and asked for Mr Watkinson's response in the light of that.

Mr Watkinson said that Mr Davies had said the organisation was not going towards corporate failure as he had said and his reply remained the same. He said the issue was about protective disclosures about Upper GI and whistleblowing. He said the organisation was improving and going in the right direction.

32. **Can you describe your working relationship with external stakeholders? -** *Patrick Wilson* Mr Webster said that he was asked not to respond to that point. The position in the wider community was that the Report was, as far as they were concerned, discredited because many of the interviewees were promised the opportunity to see a draft copy of the report to ensure accuracy before publication but it did not happen. There were numerous people who did not receive a copy of the draft report. Had they done so they would have wanted to challenge a number of inaccuracies. The wider community does not agree with the conclusion of the report that RCHT was heading for corporate failure. The community acknowledged the problem inherited and that it would not turn around overnight and acknowledges the good work Mr Watkinson and the Board had made significant progress in a relatively short period of time. The wider community had not called for Mr Watkinson or the Board to be sacked and had been supportive of the work they were doing. He said that they felt it was a great injustice for the Trust to have accepted the conclusions of the Joint Review. They did not believe Mr Watkinson was a bad Chief Executive or that RCHT had a bad Board. He said that they felt that united they were the best people to take RCHT forward and the community would support the Board if it concurred with that view.

33. **In your opinion, can you continue 'to have relationships with external stakeholders as CEO of RCHT given the publication of the independent review, and the similar issues raised In this report based on the report from your previous employer? If yes, you say relationships are still there, but you did choose to bring about libel actions against both individuals and the two organisations, and this tends to suggest that there is a different view. Do you concur with that view? —** *Roger Gazzard*
Mr Watkinson said that he had not brought a libel action against anyone. He said that there had been some inappropriately critical press releases put out *by* RCHT and the SHA when he
was suspended but no legal proceedings had been initiated at this stage, he was simply complying with the relevant pre-action protocol ~~for bringing about~~ in respect of libel ~~actions.~~issues.

34. **Do you believe that there is a breakdown of Trust and Confidence in your opinion between the Board and yourself? -** *Roger Gazzard*
Mr Watkinson said he did not think so. He said that Mr Davies had demonstrated that and he also thought the performance review signed by Mr John Mills demonstrated it.

Mr Watkinson said that he did not believe all this was as a result of trust and confidence but was because of the stance taken on the issue of Upper GI and other cancer services. He said that the Board had wanted to see appropriate process of consultation and a reasonable plan in place and that is what the PCT supported. The Bromley report was nothing and was going to be handled but because of the disagreement between RCHT and the SHA and his protected disclosure this had generated negativity and victimisation. He said it would be possible for his to return as Chief Executive. If he did think the Board had not supported him or he had not done a good job he would not believe that. He believed he had done a good job and had evidence to show it. It was down to the Board - he had taken protected disclosure and was supported by the Board. It was a matter for the Board. Mr Watkinson said there was no other impediment to him going back because he had done nothing wrong.

Mr Webster again said that the organisation should have a copy of Mr Watkinson's latest signed performance report. He said that if the Trust wanted a copy it would have to be requested through the respective lawyers.

The Director of HR suggested that, in the spirit of openness and transparency, that they be given a copy for information, particularly as Mr. Watkinson/Mr. Webster had at least 3

copies available. Mr Watkinson said he had requested a copy in advance and that it may be a genuine mistake but if the Trust wanted a copy they would have to make a formal request through the lawyers.

The Director of HR asked for a copy of his written statement that he made at the beginning of the Hearing Meeting but this was refused. Mr Webster said that he hoped the notes would be approved by both parties and after Mr Watkinson got a copy, if there were any issues to correct then hopefully the Panel would be happy to take this on board.

The Panel Chairman asked if Mr Watkinson wished to add anything else and he replied 'No'.

The Panel Chairman said that the Panel would have to report back to the Trust Board about the Hearing Meeting and the Trust Board would then make a decision which would be Friday 17 April 2009 at the earliest.

Mr Watkinson and Mr Webster were thanked for attending.

The Trust & Confidence Hearing Meeting was closed.

Appendix N RCHT performance timeline: 2006-07, 2007-08 and 2008-09

South West Strategic Health Authority

Royal Cornwall Hospitals NHS Trust
Performance Timeline: 2006-07, 2007-08 and 2008-09

1.1 It might be helpful to describe the architecture of the NHS in England over the period being reviewed. This is set out below.

- the Department of Health holds Strategic Health Authorities to account for the operational and financial performance of their regions. There are monthly performance meetings between the Department of Health and Strategic Health Authorities where the performance of both regional and individual organisations is discussed. The NHS Chief Executive signs off the Annual Plan of the Strategic Health Authority for each financial year following a series of challenge meetings.

- Strategic Health Authorities are accountable for the operation of the NHS in their region. They do this by assuring themselves that Primary Care Trusts are commissioning high quality services that meet the needs of the population and that they are holding all providers (NHS Trusts, Foundation Trusts, independent and voluntary sector) to account for performing against contracts. They also have a direct performance management responsibility for NHS Trusts.

- Primary Care Trusts are responsible for securing the provision of services to meet the needs of local populations by commissioning from registered providers. They assure themselves that providers are meeting their contractual obligations and have a statutory duty to secure continuous improvement in the care that they commission. They are also responsible and accountable for making decisions about changes to health services;

1.2 There are also two independent regulators which assess the performance of organisations:

- the Healthcare Commission was the independent regulator at the time which evaluated the quality of services being provided across the NHS against a defined set of standards which were published every year for organisations to assess themselves against. The assessment review used the scoring mechanism of weak to excellent, and organisations would receive two scores, one for use of resources and one for quality of services. The Healthcare Commission also had powers of inspection. The Healthcare Commission has now been replaced by the Care Quality Commission.

- the Audit Commission is the external financial regulator who appoints external

auditors to NHS organisations. Their role is to establish if public money is being used appropriately and if financial duties are being met, and financial statements represent a true and fair view.

2006-07

1.3 2006-07 was a year of change for the NHS, including the Royal Cornwall Hospitals NHS Trust. The NHS Trust had ended the previous financial year (2005-06) having failed to achieve its agreed plan to break even, even though it had received £17.361 million of planned additional financial support during the year. In the event, it reported a deficit of £15.6 million. The Chief Executive, Brian Milstead, resigned in June 2006 in the light of these difficulties. John Watkinson was appointed as his successor and took up his post on 1 January 2007.

1.4 New Strategic Health Authorities and Primary Care Trusts were also established during 2006. The South West Strategic Health Authority was established on 1 July 2006 by merging three predecessor Strategic Health Authorities. The new Strategic Health Authority inherited an accumulated deficit in income and expenditure terms of £174 million and a forecast in-year deficit of £112 million. 21 organisations were in deficit. A third of its organisations were rated as weak and there was inconsistent performance in relation to meeting national standards. Cornwall and Isles of Scilly Primary Care Trust was established on 1 October 2006 by merging four predecessor organisations.

Agreed financial plan for 2006-07: The agreed financial plan was for the NHS Trust to deliver a £20 million deficit for 2006/07.

Timeline

12 October 2006	Healthcare Commission announce that the Royal Cornwall Hospitals NHS Trust is assessed as weak for both quality of services and use of resources for its performance in 2005/06. The NHS Trust is one of eight organisations rated weak/weak within the South West and one of 25 nationally.
1 January 2007	John Watkinson takes up post as Chief Executive, the Royal Cornwall Hospitals NHS Trust
March 2007	The Royal Cornwall Hospitals NHS Trust declares itself compliant in 13 out of 44 standards laid down by the Healthcare Commission (HCC) as core standards to be met by NHS hospitals.

Financial Outturn: The financial position at the end of 2006-07 was that the NHS Trust reported a deficit of £36.6 million. This was after receiving additional unplanned financial support of £14.4 million.

2007-08

1.5 2007-08 was the first full financial year in which John Watkinson was Chief Executive of the Royal Cornwall Hospitals NHS Trust. There was a significant financial challenge, given the poor financial performance in the previous year. In addition to this, the Healthcare Commission announced its assessment of NHS Trusts for 2006-07 in October 2007. The Royal Cornwall Hospitals NHS Trust was assessed as weak for both use of resources and quality of services for the second year running. This resulted in action from the Secretary of State for Health, Ministers, the NHS Chief Executive and other Department of Health officials. Recovery plans were prepared and these formed the basis of monitoring by the Department of Health. In addition, the Healthcare Commission undertook an investigation into the NHS Trust.

1.6 At the end of the financial year, a new policy for financially challenged NHS Trusts was developed by the Department of Health. Seventeen NHS Trusts were designated as Financially Challenged and the Department of Health asked each Strategic Health Authority to agree a local strategy to ensure that all NHS organisations achieved a cumulative break even position, and repaid cash loans owed to the Department of Health. To evaluate these plans the Department of Health commissioned a variety of private accounting firms to evaluate the financial plans of the Financially Challenged NHS organisations. In the case of the Royal Cornwall Hospitals NHS Trust, KPMG undertook the financial evaluation.

Agreed financial plan for 2007-08: The agreed plan was for the NHS Trust to achieve a surplus of £1.2 million.

Timeline

30 April 2007 **1 May 2007** **12 June 2007**	3 Non Executives resign: Martin Watts Susan Hall Professor Overshot
13 June 2007	Professor Colin Roberts resigns as Chair
14 June 2007	Peter Davies is appointed as Interim Chair
11 July 2007	Healthcare Commission write to South West Strategic Health Authority expressing 'profound concerns about the Royal Cornwall Hospitals NHS Trust' on behalf of themselves, the Audit Commission and the Health & Safety Executive. Letter included as Document 10.
20 July 2007	South West Strategic Health Authority holds a meeting with Healthcare Commission, Audit Commission and Health and

	Safety Executive to discuss their concerns about the Royal Cornwall Hospitals NHS Trust. Follow up action was agreed.
14 August 20007	Peter Davies writes to Ian Biggs at the Healthcare Commission, introducing himself and asking for a meeting to discuss items of "mutual concern". Letter attached as Document 11.
11 September 2007	Healthcare Commission writes to John Watkinson expressing 'serious concerns' in relation to the Royal Cornwall Hospitals NHS Trust's performance against core standards for Better Health. They subsequently launch a formal investigation.
18 October 2007	Healthcare Commission announce that the Royal Cornwall Hospitals NHS Trust has been assessed for 2006/07 as weak for quality and weak for use of resources in the Annual Healthcheck for the second year in a row. The NHS Trust was one of two organisations within the South West assessed as weak/weak in both 2005/06 and 2006/07. Secretary of State, Alan Johnson MP, announces he has asked the NHS Chief Executive David Nicholson to 'urgently meet the four NHS Trusts who have been weak on both quality and use of resources for two years running'. Secretary of State asks the SHA to publish and implement an action plan within 30 days for the Royal Cornwall Hospitals NHS Trust.
November 2007	The NHS performance standards team report on their recent inspection of the NHS Trust and say that it has made progress in key areas although there remains much to be achieved and comment that management systems are improved and that leadership is overt by the chairman, chief executive and the executive team.
3 December 2007	Following a meeting on 19 November 2007, David Nicholson, NHS Chief Executive, writes to Peter Davies, Interim Chair of the Royal Cornwall Hospitals NHS Trust, copied to the South West Strategic Health Authority, setting out the minimum performance expectations for the NHS Trust for the remainder of the financial year. These include remaining in monthly run-rate balance and being in surplus by the end of the year. He states that 'failure to make the necessary improvements cannot and will not be acceptable.'
4 January 2008	John Watkinson responds to David Flory, Director General of Finance, Performance and Operation at the Department of Health, confirming that the Royal Cornwall Hospitals NHS Trust have now submitted a plan in response to David Nicholson's letter of 3 December 2007.

	John Watkinson highlights that 'risks to delivery have been identified' and 'in conclusion I am satisfied that the plan represents good progress towards the turnaround of the Royal Cornwall Hospitals NHS Trust and establishes a basis on which the NHS Trust will deliver excellent high quality cost effective patient care'.
4 February 2008	Senior officers for Department of Health visit the Royal Cornwall Hospitals NHS Trust to assess progress against their recovery plan. An updated plan is requested by 22 February 2008.
21 February 2008	Alan Hall, Director of Performance at the Department of Health writes to South West Strategic Health Authority expressing doubt that the Royal Cornwall Hospitals NHS Trust will improve on its weak/weak rating for 2007/08.
13 March 2008	The NHS Trust declares itself compliant with at least 34 of the 44 core standards set by HCC and anticipate that they will be compliant with all 44 by 31 March 2008. Concern is expressed by non-executive directors of the NHS Trust that the executive directors might be being overly rigorous in certain of the specified areas.
15 March 2008	The NHS Trust declares itself fully compliant with 35 out of the 44 standards.

Financial Outturn: The planned surplus of £1.2 million was achieved after the NHS Trust received £8.3 million of additional financial income above the 2007/08 contract level. Failure to deliver a surplus would have resulted in the Royal Cornwall Hospitals NHS Trust being assessed as tweak' on its use of resources. This would have led to the organisation being rated as weak on both quality of service and use of resources for the third successive year. This would have been unique. For completeness please see attached Board paper from the Royal Cornwall Hospitals NHS Trust of September 2008 that identifies the additional resources received by the hospital and the briefing the Board received, attached as Document 12.

2008-09

1.7 2008/09 presented continued challenges in addressing quality of services at the Royal Cornwall Hospitals NHS Trust and the delivery of its financial plans. The publication of the investigation into Maidstone and Tunbridge Wells NHSTrust in May 2008 significantly heightened publicity and political concern about the responsibility and governance of NHS Boards and their response to specific issues such as the rate of hospital acquired infections. Reducing infections had been a Department of Health priority in previous years, but the publication of the Maidstone and Tunbridge Wells report emphasised the importance of Boards managing these issues. This brought additional focus onto the Royal Cornwall Hospitals NHS Trust as, at the end of the first quarter of 2008/09, the NHS Trust had reported 17 cases of MRSA against a target of six. By the end of August 2008, there had been a total of 26 cases, against a target for the financial year as a whole of 24. Concern about this performance, as well as concerns on financial performance, led to Bill Shields, Director of Finance and Performance at the South West Strategic Health Authority, writing to the NHS Trust on 12 September 2008 to raise these concerns as progress was not being made despite the issues being raised at regular monthly performance review meetings.

1.8 The Healthcare Commission undertook a risk based assessment on 8 July 2008 of the declarations made by the Royal Cornwall Hospitals NHS Trust on five standards, subsequently qualifying these declarations.

Agreed financial plan for 2008/09: The agreed financial plan was for the NHS Trust to deliver a £4 million surplus for 2008/09.

Timeline

7 April 2008	Healthcare Commission publishes 'Summary of the Intervention at the Royal Cornwall Hospitals NHS Trust'. The report identified that progress is being made that there are a number of significant challenges ahead. The report highlights the need to ensure compliance with care standards and that the board should review the information to them so that it can discharge its functions effectively. Copy attached.
May 2008	Report of independent review into board leadership of Maidstone and Tunbridge Wells NHS Trust published.

16 June 2008	The Royal Cornwall Hospitals NHS Trust issues a news release stating that the NHS Trust has 'topped a league table of the most improved hospital trusts in the country'. Copy attached as Document 13.
July 2008	An internal performance review is conducted by the NHS Trust revealing that very substantial progress has been made in many areas. The district auditor's report for 2007/8 confirms that the NHS Trust is performing well in financial terms and has achieved a surplus. Copy attached as Document 3.
3 July 2008	John Watkinson receives a telephone call from the Healthcare Commission inviting him to consider whether the NHS Trust should reconsider its self-declarations. This conversation is not reported to the chair of the board or any of the non-executive directors. Subsequently the HCC visit on 8 July 2008 and inspect the Treliske Hospital in Truro and determine that the NHS Trust is not compliant in four of the standards in which it had earlier declared compliance.
3 July 2008	At a regular meeting of Chairs and Chief Executives, Sir Michael Pitt chair of the SHA board and Sir Ian, at the request of Cornwall and the Isles of Scilly Primary Care Trust, meet John Watkinson, Peter Davies, chair of the NHS Trust board, Ann James and Andrew Williamson. The SHA suggest that a joint statement on upper GI is prepared, to ensure a consistent NHS position or clarify where differences existed. Concern about wider performance at the NHS Trust is also raised, particularly the concern that energy is being diverted into an issue which affected a very small proportion of the population, whilst performance and quality of all other services are not improving at sufficient rate. The draft statement is circulated to the NHS Trust's non-executive directors. None agree to it and the majority actively decline to accept it. As a consequence Peter Davies feels that his position is untenable and on 10 July he writes to Sir Michael tendering his resignation and making it clear that he does so because the draft statement does not have the support of the non-executive directors. He suggests that John Mills, vice-chair of the board, should take over as chair, which he does.
September 2008	The Healthcare Commission determination of noncompliance (see 3 July 2008 above) is notified to Sir Ian. There is no evidence that he immediately communicated the misgivings to John Mills or to John Watkinson. HCC would routinely brief the SHA in confidence about the outcome of HCC reviews across the South West. The HCC would contact the NHS Trusts directly as this was their preferred and normal handling arrangements.

11 September 2008	It emerges that a total of 20 MRSA infection cases have occurred within the NHS Trust and Bill Shields, Director of Finance and Performance for the SHA advises that financial performance is giving cause for concern. There is an unexpected variation from plan which represented a worst case scenario of £6.4m deficit against a current forecast overspend of £1.9m.
16 October 2008	The Healthcare Commission announce that the Royal Cornwall Hospitals NHS Trust has been assessed for 2007/08 as weak on quality of services and fair on use of resources. The South West region is highlighted as the 'most improved NHS region' in relation to the quality of services. There are no 'weak'/'weak' organisations within NHS South West
17 October 2008	The Department of Health write to the South West Strategic Health Authority requesting action plans for the three organisations who have been assessed as weak on quality, including the Royal Cornwall Hospitals NHS Trust.
30 October 2008	The NHS Trust board meets and considers a number of issues including the Healthcare Commission report. One issue is infection control and it is decided that a microbiologist be appointed. There is also the prospect that the NHS Trust may be reporting a financial deficit in the near future. The need for firmer control is emphasised.

Financial Outturn

The planned outturn of £4 million was not delivered. A surplus of £2 million was achieved after the NHS Trust received £12.5 million of in year financial income above the 2008/09 contract level. Failure to achieve its financial plan would have resulted in the Royal Cornwall Hospitals NHS Trust being reclassified as 'financially challenged'. This would also have likely led to a 'weak' rating by the Healthcare Commission for use of resources. This would have meant the Royal Cornwall Hospitals NHS Trust being the only weak/weak organisation in NHS South West.

Appendix O Letter from Ian Biggs, HCC, to Sir Ian Carruthers

Sir Ian Carruthers
Chief Executive NHS South
West SW Strategic Health
Authority Wellsprings Road,
Taunton,
Somerset.
TA2 7PQ

11 July 2007

Dear Sir Ian

Royal Cornwall Hospitals NHS Trust (RCHT)

Following discussions with the Audit Commission and Health & Safety Executive, I am writing to express our shared and profound concerns about RCHT and to offer our support in finding a way forward. The letter includes information from each of the three regulators.

At the south west area risk summit held in February with Concordat partners RCHT was identified as the highest risk organisation. Recognising the scale of the problems facing the trust and knowing that new leadership was in place it was felt at the time that the trust should be given some time and space to address the task and consequently regulatory activity should be kept to the minimum necessary. However we now perceive the situation at RCHT to be deteriorating to the extent that we seriously doubt the trust's capacity and capability to improve and given that view we wanted to share our concerns with you.

Whilst we have all identified our separate and serious issues with the trust they all ultimately fall within the common theme of leadership and governance. Obviously we recognise and appreciate the impact of the trust's financial situation but that is context rather than cause in terms of our concerns. Without getting into detail we would like to offer the following examples of the issues.

The Audit Commission's ALE assessment for 2006/07 has concluded that the trust is inadequately performing in each of the five areas assessed (financial management, internal control, value for money, financial management and financial reporting). This represents a deterioration from last year and makes RCHT the worst performing trust nationally. In particular, the trust's financial position is a grave cause for concern. There is a real question of whether the trust's 2007/08 plans are realistic and deliverable and the continued absence of a medium term plan for recovering the trust's substantial accumulated debt raises significant doubts over the trust's ability to secure the necessary improvements in its performance. There are also a number of serious governance issues which has

left the trust seriously exposed. These include the mishandling of the bone and joint solutions contract and the early termination of the former director of finance's contract without a permanent appointment being found.

As you will be aware the trust has declared it is not compliant with 31 of the 44 core standards for better health. This marks it as the worst performing trust nationally. There has been recent contact from the trust over advice they believe they had received from both the strategic health authority and the Healthcare Commission's regional staff regarding what category of non-compliance to declare (insufficient assurance or not met). This, along with statements in the media that they will be fully met on all standards next year, leads us to question whether the trust's management team fully understand what is required to achieve this position. We are not confident that the trust can manage improvement on such a scale. For example concerns we raised last year around the accountability and governance arrangements for maternity services, and the potential impact of this on quality of service delivery, still appear unresolved.

The waiting list review is perhaps the most serious of the Healthcare Commission's current concerns in terms of the issue itself, the time taken to address it and whether the trust board has been fully informed of the situation. This review raised grave concerns about patient safety as well as issues and themes central to how the trust is operating and governing itself. There appears to have been an emphasis on operational processes rather than a strategic whole systems approach to the organisational and cultural issues identified. It also seems to us that the emphasis has been on identifying cause at the expense of action to identify the patients affected when in our view the patient safety aspects should have been paramount.

The Health & Safety Executive has again decided not to complete a health and safety audit of the trust this year in recognition of financial pressures, changes in leadership and possible regulatory overload. However the Health & Safety Executive has been involved in several interventions over the last 12 months that have caused them to question the effectiveness of health and safety management in the organisation. For example:

1) The trust was recently issued an improvement notice regarding serious concerns over the management of transport on site, particularly vehicle and pedestrian segregation. The improvement notice was issued after the investigation of an accident in which an employee, using a designated pedestrian crossing, was hit by an internal site vehicle. The outcome of the investigation highlighted significant health and safety failures and raised particular concerns about roles, responsibilities and accountability in terms of health and safety. This accident happened in March 2007 and was only reported in May 2007 after the employee involved pursued the matter. This causes concern as to the adequacy of the trust's system for identifying, investigating and reporting incidents to Health & Safety Executive as legally required.

2) The management of work related stress. The trust volunteered to take part in a joint project with the Health & Safety Executive to help the organisation

manage stress at a corporate level. However after six months the trust were unable to demonstrate that they could provide either the commitment or resource to the project and this work was halted.

3) The trust was asked by the Health & Safety Executive to produce a health and safety strategy in 2005. Repeated requests have failed to produce such a document leaving the Health & Safety Executive to conclude that the trust does not have a clear direction and plan for managing health and safety.

We have noted, from the trust board minutes, that RCHT is holding 356 whole time equivalent vacancies and also that agency and locum costs were halved between January and February. We are aware of the recent departure of two newly appointed non-executive directors together with the departure and imminent departure of a number of the executive team. Taken together with all of the above we are concerned about the capacity of the trust to move forward constructively.

The breadth and depth of the issues facing the trust are, in our collective experience, unprecedented and consequently will need a new and different approach. I am conscious of risks for RCHT of further regulatory burden, however we are all clear that it is imperative to protect patient safety. We would welcome the opportunity to meet and discuss what can be done.

Yours sincerely

Ian Biggs
Head of South West
Region Healthcare
Commission

c.c. Simon Garlick, Audit Commission
Paula Johnson, Heath & Safety Executive

Appendix P RCHT progress report dated March 2009 in response to HCC intervention report of April 2008.

Royal Cornwall Hospitals NHS Trust

Progress following the Healthcare Commission's intervention report

March 2009

The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- Be independent, fair and open in our decision-making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

Background

In April 2006, the trust's initial assessment against Department of Health core standards was that it was fully compliant for the year 2005/06. However, the trust initiated a review shortly afterwards, which led to the trust being identified as meeting just 25 of the 44 part of the core standards. A new chief executive was appointed in January 2007 and other key changes to the leadership followed, including an interim chair in June 2007. The new chief executive ordered a further review of the trust's compliance with the standards. This found that, for the year 2006/07, the trust could only confidently declare that it was compliant with 13 of the 44 parts of the standards.

This saw the trust being ranked as "weak" for quality of services for the second year running in the annual health check. It was also scored "weak" for its use of resources, partly due to an accumulated deficit that impacted on the financial standing of the organisation. There were also weaknesses in the trust's financial management, reporting and internal control systems, which meant that it was unable to demonstrate that it was providing services that were good value for money.

The purpose of the intervention was to ensure that, in the light of such poor compliance, services were safe, and to establish whether, in recognising the extent of the previous problems, the trust was now taking the necessary action to deal with them. Since the intervention visit, the trust's chief executive and also the acting director of nursing have been suspended, following the publication of a report on financial management and governance at their previous trust. Currently an interim chief executive and a further acting director of nursing are in post.

Methodology of the follow up visit

Members of the review team included staff from the Healthcare Commission and two independent experts, in infection control and governance respectively.

The follow up of the intervention involved:

- Reviewing documentation — prior to the follow-up visit, we requested a number of key documents from the trust to show the rate of progress against the recommendations of the intervention report.
- A follow-up visit to the trust in early December 2008, when we interviewed 47 members of staff; as well as representatives from the Cornwall and Isles of Scilly PCT, the maternity services liaison committee and the patients' forum, and revisited wards at both the main hospital and west Cornwall sites.

- Review of statistical information in relation to MRSA and *C.difficile* infection rates.
- Review of serious untoward incidents (Slits) at the trust recorded between January 2007 and December 2008.

Findings

This update follows the order of the original recommendations published in our intervention report.

Maternity Services

Recommendation 1

The trust should urgently complete work necessary to bring the maternity services building to the required standards and should commit to a strategic plan to provide suitable alternative accommodation for these services. Urgent works must be complete by the end of April 2008 and the estates plan completed by December 2008.

The maternity unit (neo-natal, delivery suite and post natal units) has undergone a major refurbishment. Aside from essential works, the total internal fabric of the unit has been renewed and equipment replaced. The result is an improvement on the environmental challenges under which the maternity members of staff worked previously and the team noted an overall general satisfaction with the new environment.

The director of estates and facilities has started to produce an overall estates strategy for the hospital site that will include the relocation of the maternity unit and a mixture of new build and relocation of existing accommodation. This strategy gained board approval in June 2008. A significant determining factor in achieving the overall strategy will be the way in which the trust's substantial historic financial deficit is handled to avoid delays to necessary capital investment arising from the strategic plan.

Recommendation 2

The role of the maternity services liaison committee should be developed to ensure it discusses how local maternity services could be improved and make suggestions about areas for review and monitoring. The effectiveness of the committee should be reviewed in September 2008.

The maternity services liaison committee (MSLC) was re-launched in January 2009. The committee has strengthened ties with the PCT, coming under its auspices in January 2008. We found no evidence of a mission statement or terms of reference for this committee. There is also no website to publish and promote the work of the MSLC. Our view is that the MSLC chair would benefit from assistance from the PCT and the acute trust to develop terms of reference, a mission statement and a website.

The MSLC will be a key influence in the planning of the new maternity unit and we feel that the trust should encourage the involvement of the MLSC in this role. There are particular issues in relation to the integration of maternity

services across the remoter areas of Cornwall and this too is an area for the MSLC to address, given that it represents service users and individual user groups across the county.

Services for older people

Recommendation 3
The trust's board should implement their "Let's Respect" programme in relevant clinical areas throughout the trust and take further action by the end of October 2008 to promote the privacy and dignity of older people receiving care and treatment.

The "Lets Respect" programme started as a collaboration between several eldercare nurses at the trust looking after patients with dementia, stroke, learning difficulties and any other conditions that could inhibit communication. The spread of the programme has improved, but does not yet cover all wards at the trust. This is because no protected time was allocated to allow coverage on the wards when trainers were training. The trust has now committed to protected time to roll out the programme to the rest of the trust between January and March 2009.

The overall philosophy and practice of the "Lets Respect" programme has contributed to improvements in patient care for the elderly at the trust. Members of the patient advisory liaison services (PALS) team reported a significant drop in complaints relating to the care of older patients. Instead of complaints being received in themes, only individual complaints were being received in relation to older patients housed in wards that are not designated for older patients, for example the medical assessment unit, A&E or surgical wards. There has been a similar drop in complaints relating to ensuring the dignity of patients. The PALS team also reported that complaints relating to mixed sex wards were now less frequent and limited mainly to emergency admissions.

The management and control of infection

Recommendation 4
The trust's board must immediately assure itself that the trust has satisfactory arrangements in place to prevent and control infection, and review the arrangements in June 2008.

Recommendation 5
The trust should take further steps to ensure that, by August 2008, it has a substantive director of infection and control, who either has the expertise in infection control or has ready access to that expertise, and is accountable directly to the board, reporting to the chief executive.

Recommendation 6
The trust should review its arrangements in relation to the requirements of the hygiene code and consider whether the resources devoted to controlling infection are adequate in terms of the demand on the team. A business plan should be submitted to the trust's board for approval by the end of March 2008.

Progress has been made in relation to raising the profile of infection control, coupled with real improvements at ward level. Despite the suspension of the director of nursing who was also the trust's director of infection prevention and control (DIPC), the current interim DIPC has not only managed to maintain impetus with his high profile presence and availability to promote "ground floor work", but has also been able to continue the work begun on infection control policy and planning. It is noted by reference to the tables below that, while there has been some improvement, the measures taken so far have yet to bring healthcare-associated infection rates down to the same level for similar trusts.

We saw evidence in all the locations we visited of examples of good cleaning standards, good state of cleanliness of commodes, and evidence from cleaners that hygiene and cleaning are being carried out and audited on a very regular basis. An isolation ward has been set up for cases of *C.difficile* and there is a computerised system for prioritising the availability of side rooms across the trust to enable patients who need to be isolated to be located in available side rooms.

An external consultant and a consultant nurse have been brought in to assist in developing policies on hand washing, general infection control and antibiotic prescribing.

There are still challenges ahead. The infection control team is still not large enough for a trust of this size, lacking an infection control consultant and insufficient microbiologist cover. The absence of these posts is posing a threat to the team's overall ability to focus on key risk areas. A lack of sufficient personnel is causing problems of stress, including long-term sickness absence within the team. The infection data update shown below indicates that this lack of resource may still be a factor in below average performance by the trust in this area, despite the measures already taken. The trust still needs to ensure that the infection control team has sufficient capacity to address these challenges.

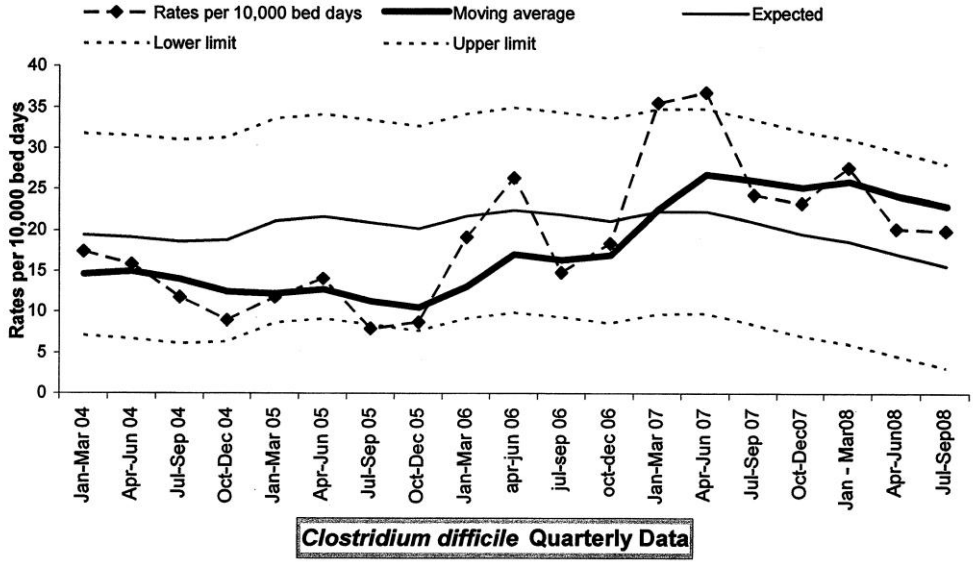
Infection data update — Royal Cornwall Hospitals NHS Trust — January 2009

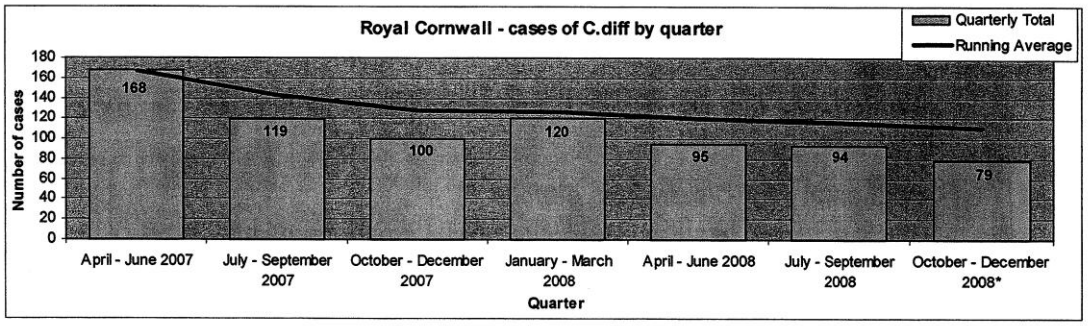
Commentary for *Clostridium difficile*

The trend data graph for *Clostridium difficile* (below) shows that, since April 2007, rates for the 65+ age group have shown an overall reduction. This is also supported by the `amber' z-score for *C.difficile* relative to short-term trend, and the table and graph showing raw counts of *C.difficile* (for all ages) over the last seven quarters from April 2007 to December 2008. However, rates of *C.difficile*

for this trust are still above the average for similar trusts, and their rates have increased overall during the last 10 quarters from March 2006 to September 2008. This is further illustrated by the 'red' flagged z-score of +3.06, which indicates the extent that their rate has increased over the long-term compared to the national average trend for similar trusts, which has in fact reduced over the same period. The trust, in common with some other trusts, tends to show a peak in rates over the winter months, and there is some evidence in the graph to suggest that the extent of their winter peaks might be beginning to ease if January to March 2008 is compared with January to March 2007. However, although the trust are now reducing their rates and appear to have begun to move in the right direction, it is difficult to predict whether this trend will be maintained, particularly over the higher risk January to March 2009 period.

Trend data for *Clostridium difficile* for the 65+ age group *(EWMA= exponentially weighted moving average)*

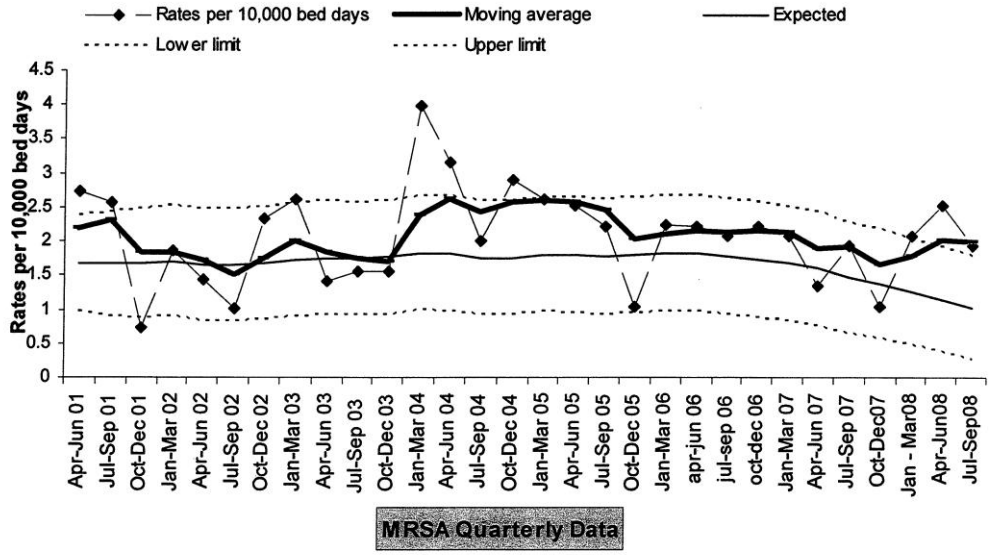




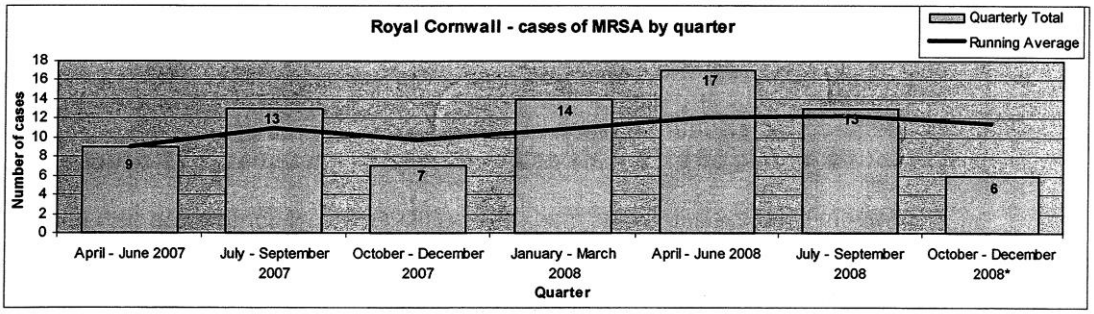
Commentary for MRSA bacteraemia

The trend data graph for MRSA bacteraemia (below) shows that rates for the last three verified quarters (January 2008 to September 2008) were high compared to the previous 10 quarters for this trust, and high compared to current national level for similar trusts, with a 'red' flagged z-score of +3.83. This peak in rates has put the trust above the 'upper expected limit' for similar trusts and this is further illustrated by the 'red' flagged z-score of +3.18 for MRSA relative to short-term trend. Rates over the long-term have also incurred a 'red' flagged z-score of +3.23 due to the moving average for the trust not reducing as quickly as for similar trusts over the last 10 quarters from March 2006 to September 2008.

Trend data for MRSA for all ages
(EWMA= exponentially weighted moving average)



Source: Health Protection Agency



Race equality

Recommendation 7
The trust's board should formally approve the latest version of the race equality scheme, with clear timescales for action agreed in the plan by the end of June 2008.

Recommendation 8
The trust should assess its current position in relation to compliance with race equality legislation and update the action plan within the race equality scheme to reflect this. The trust should then incorporate the action plan into its governance and assurance process, to ensure it appropriately monitors progress towards compliance with race equality legislation with the relevant core standards by the end of May 2008.

The trust race equality scheme was presented to the board in March 2008. The trust has reviewed the scheme and we were told that a draft of the new scheme was about to go to the trust strategic resources committee before submission for board approval. We were disappointed to note, that while some progress had been made, this has not been a key priority for the trust. The director of human resources provided assurance that the trust is currently looking to improve the situation by seeking to embed the race equality scheme within the culture of the organisation rather than just leaving it as a policy, and to this end the trust held an equality and diversity conference in November 2008. The trust has identified 20 members of staff to be trained as equality and diversity champions.

Language line and interpreters are available and being used by front line staff and the race and disability schemes are now part of mandatory training for new staff. We were also told that the trust has leaflets in relation to equality and diversity, and multi-language leaflets in maternity. The trust also takes part in a Cornwall-wide forum to promote equality issues.

Governance

Recommendation 9
The trust's board should ensure that plans in place are sufficient to ensure compliance with core standards and that it receives clear information about any lack of progress and action taken in response. In addition, action should be taken to promote awareness of the core standards among all staff. This action should be immediate and ongoing.

The interim chief executive has made the achievement of compliance with core standards one of three main objectives for the trust, along with infection control and financial performance. This follows the qualification by the Commission of five declarations of compliance by the trust against core standards in a follow up

visit undertaken as part of the 2008 annual health check. The executive team meets weekly to review each core standard in turn and to ensure that there is sufficient evidence against each one. In addition, the executive team intends to add governance committee meetings in the final quarter of the year to reinforce the compliance processes with a non-executive director view of assurance, as well as building in further external challenge via the PCT. They will also take part in an SHA-wide assurance programme with other trusts for sharing of knowledge.

There is an undoubted redoubling of efforts by senior managers within the trust to achieve core standard compliance. One member of staff, however, said that, while they felt core standards were about improving patient care and evidencing it, the evidence gathering still seemed to occur "at the last minute" and there was a growing recognition that evidence gathering was a continuous process.

Recommendation 10
The trust's board should, in the light of this report, review the information presented to them to ensure that it is clear and accurate and enables the board to discharge its functions effectively. This action should be immediate and reviewed in October 2008.

We found evidence of an improvement in the provision of information for use in monitoring the performance of the trust and to engage in more meaningful planning of services. A daily dashboard of key indicators of performance based on quantitative targets is produced. In addition a monthly estates and facilities report goes to the trust's board. There are also, for example, weekly reports to the executive team on the time from GP referral to treatment performance by clinical specialty as well as other performance indicators, such as A&E targets. This information is provided by the seven newly instituted clinical divisions (plus one non-clinical support division) of the trust via the director of service delivery to the executive team and trust's board. The divisional teams are much greater in number but smaller, with a wider remit, and are an improvement over the previous structure of three general managers who were too thinly spread to ensure either the necessary improvements or the provision of adequate information to the board.

Following approval by the board, the trust has set itself the ambitious target of fully integrating clinical and corporate governance by April 2009. Each division has already begun to produce a quarterly governance report which is made up of elements including major incidents, levels of compliance with National
Institute for Health and Clinical Excellence (NICE) guidance, complaints trends and clinical effectiveness. The first reports varied in terms of accuracy and completeness of information and these issues are being addressed individually by the assistant medical director (governance).

Other governance groups provide similar quarterly reports. These include infection control, research and development, PALS, informatics, finance and cleanliness. The interim chief executive assured us that the quarterly governance report which goes to the trust's board is a significant improvement.

His view is that this encouraging improvement needs further development with an executive information system providing direct information to the board and executive team.

There are still issues for the trust to consider in relation to both the integrated governance structure and the information which the board receives. For example, there is no trust risk manager, a post that would normally be expected to drive forward many of the fundamentals of governance and risk management within the trust. For example, during our follow-up visit, we undertook a review of serious untoward incidents (Ws) at the trust recorded between January 2007 and December 2008. We found that, generally, the standard of documentation was inconsistent. There appeared to be no standard system in place apart from the initial report. While there was evidence of action plans to implement learning, there was no record of follow up to confirm that implementation of those actions had taken place.

While we were impressed by the enthusiasm and determination to overhaul the trust's governance system, we feel that it would benefit from external collaboration and validation in conjunction with the SHA, and Cornwall and Isles of Scilly PCT, who are keen to further develop partnership working with the trust.

Organisational and personal development

Recommendation 11
The trust's board should continue to invest in organisational and personal development to ensure that clinician managers and middle managers have the attributes, skills and behaviours to succeed in their roles. A business plan should be submitted to the trust's board by the end of March 2008 and progress reviewed in October 2008.

A triumvirate structure at the head of each of the new divisions, comprising (with the exception of support division) a divisional general manager, a divisional nurse manager and a divisional doctor (clinical director), now reports to the board through the director of service delivery and is the first stage of the organisational development programme. The trust has indicated that the programme of organisational development, which stalled temporarily following the suspension of the chief executive, has been revived and has been devolved to the director of human resources. There is a commitment to complete the divisional structures at a lower level and we were told that a programme of individual development will be re-instated. Senior, middle and front line management roles have been defined by generic job descriptions.

This second stage of organisational development below divisional manager level is at an early stage. The organisational development plan as outlined in the 2008/09 business plan will further drive training plans for individuals within the trust.

Conclusions

Unsurprisingly, the suspensions of the chief executive and acting director of nursing have been unsettling for the trust. Nevertheless, the interim chief executive has minimised the effects of this and has continued to lead a concerted effort, resulting in substantial progress against the recommendations of the intervention report.

The refurbishment of the maternity unit has been successfully achieved and has resulted in high levels of satisfaction expressed by service users, members of maternity staff and elsewhere within the trust. The maternity services liaison committee was due to be re-launched at the time of writing of this report and we have made suggestions, earlier in this report, for its further effectiveness with the support of the trust and the PCT.

The "Lets Respect" programme has had a positive impact on care for older people at the trust, with a reported drop in numbers of complaints in relation to the care of older patients as well as issues of respect and dignity. The trust now has the opportunity to spread the philosophy and practice to all areas of the trust, including those wards not designated for older patients but where older patients and patients with communication difficulties are treated.

There has been progress in infection control practices and standards of hygiene at the hospital. The trust should ensure that this impetus is maintained and that the work of the current team is commensurate with its capacity, concentrating on key risk areas. The trust should seek to fill key posts in order to further develop this area of practice. There are still significant challenges over the long term in relation to the trust's improved infection control performance.

The trust has reviewed its race equality scheme and has recognised that further work is necessary to ensure that it complies with latest race equality legislation and that race equality is more embedded within the culture of the organisation.

The trust has made a promising start to improving information to the executive team and the board and to achieving an integrated governance structure. There are still areas to be embedded in integrated governance. There is an undoubted willingness and determination at senior level to achieve compliance with core standards and there needs to be continued and increasing effort to ensure that the same level of ownership and understanding of core standards is apparent at all levels within the trust.

The trust has re-instated its organisational development process in order to further develop the structures below divisional lead level. We conclude that this is at an early stage.

Despite the substantial progress that has been made, there are still challenges ahead for the trust in the areas that we reviewed directly. The trust has

demonstrated to the satisfaction of the investigation team that it has shown determination to continue the improvements already achieved against the recommendations of the intervention report. In view of this, we feel that the future formal review of progress should rest with the Strategic Health Authority in conjunction with our operations staff in the south west. The Strategic Health Authority has confirmed that it will actively review further progress against the recommendations of the intervention report.

In reaching this conclusion, we have the following observations:

- The future leadership of the trust needs to demonstrate a high level of commitment, currently evident under the interim chief executive, to allow the progress we saw to further develop into stable and sustainable improvement.
- Over the past few years at least, there has been insufficient strategic vision in relation to this trust to enable a picture to emerge of the shape and extent of health services that the trust should provide to the community it serves over the next 10 to 15 years. This is a process that needs to develop rapidly once the long-term leadership of the trust has been resolved.
- The financial deficit that was allowed to develop in recent years is a clear handicap to future realisation of plans and strategic vision for the trust, involving substantial capital investment and service development. It is not for us to suggest how such a solution to this problem may be achieved. However, we can say that it is a solution that requires the involvement of the whole commissioning, provider and SHA economy working together, and which is an essential prerequisite for the trust to provide high-quality care on a sustainable basis.