COMMISSION FOR HEALTH IMPROVEMENT

Gosport War Memorial Hospital (Portsmouth HealthCare NHS Trust)

Briefing Paper

Investigation 2001/02

20 December 2001

1 Contents

1 INTRODUCTION

This briefing paper is intended as an internal document for the CHI Investigation team prior to the site visit in January 2002. It provides some background information on Portsmouth HealthCare NHS Trust (PHCT) and an analysis of the documents provided by the trust under the Terms of Reference for the investigation.

This brief is divided into 4 sections:

1 A National Context

2 A description of the trust's context, including the trust's services, local population and financial position.

3 Review of the documentation provided by the Trust with particular reference to the Terms of Reference for the Investigation

4 Appendices
Appendix 1 - List the documents which have been reviewed
Appendix 2 – List of abbreviations which have been used in this paper
Appendix 3 – Time Line of changes within NHS

Parenthesised figures in the Summary (Section 1) refer to the chapters of this document. Parenthesised figures in other sections refer to the original source document(s) in which the evidence was found (see Appendix 1).

2 NATIONAL CONTEXT

1 Some of the events that have led to the CHI Investigation at Gosport War Memorial Hospital took place in 1998. It is important to note that there have been many changes within the NHS since then, and that the culture and expectations of 2001 may not have been the norm in 1998. In particular, the Care of the Elderly, the NHS Complaints Procedures and Clinical Governance are relevant to this investigation.

2.1 CARE OF THE ELDERLY

1 The standard of NHS care for older people has caused concern since before 1998. A number of reports have found care to be deficient, and particular concerns have been raised about ageism, an inadequate and demoralised workforce, poor care environment, and lack of seamless care, amongst other issues. The National Service Framework for the Care of Older People was produced in March 2001 in response to these concerns, and aims to equalise standards of care across the NHS, enlarging the workforce, improving the care environment, and eliminating ageism. (2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9)

2 The Health Advisory Service 2000 (HAS 2000) report "Not Because They Are Old" was published in 1997. This drew attention to ways in which care of older people on acute wards in general hospitals was adversely affected by insufficient staff with generally low levels of morale.

3 The British Geriatrics Society's document 'Seamless Care – Obstacles and Solutions' was also published in 1997. This drew attention to ways in which NHS care of older people may have been fragmented as a result of the purchaser-provider split (introduced in the 1990 NHS and Community Care Act), and Health Authorities being divided into smaller units (trusts). The document noted that organisational structures that isolate or split elderly services within one or more trusts, or structures that have different budgetary or organisational systems for 'health' and 'social' care may adversely affect care, as may organisational arrangements which create barriers between communities and hospitals, and between hospitals themselves. The diverse care needs of the elderly are an additional factor in being difficult to orientate solely within a particular care environment. The document recommends a multidisciplinary approach to rehabilitative care, including Comprehensive Geriatric Assessment (CGA) – a physical, mental, social, economic, functional, and environmental assessment of older people (2.1, pp1-2).

4 In 1999, HAS published 'Standards for Health and Social Care of Older People', which outlines standards of care to be expected from providers of care for older people. Standards are given for communication with service users and carers, for inter-organisational policies, for clinical practice, staffing issues, and for clinical governance (2.4).

5 The NHS Plan section 'Dignity, Security and Independence in Old Age' (July 2000) outlined government plans for care of the elderly, including commitments to produce a National Service Framework for Care of Older People to eliminate ageism, streamline local assessment processes, and ensure good clinical practice. (2.5, p124)

6 The Standing Nursing and Midwifery Advisory Committee's 2001 report on standards of nursing care for older people focuses on care of older people in

acute settings. It found standards of care provided to older people to be deficient in fundamental aspects of nursing, such as nutrition, fluids, and rehabilitation needs, for reasons such as lack of clinical leadership, inadequate training, and lack of resources. The report identifies particular shortfalls that can be addressed - in nursing education, nursing practice, staffing, and organisational and environmental factors – in order to improve nursing care for older people. (2.9)

7 The National Service Framework for Older People was published in March 2001 and sets standards for care of older people in all care settings. It aims to ensure high quality care and treatment, regardless of age, Older people are to be treated as individuals, with respect and dignity, Fair resources for conditions that most affect older people and easing the financial burden of long-term residential care. The framework places special emphasis on the older patient's, their relatives', and carers' involvement in the care process – including in care planning. There are to be local mechanisms to ensure the implementation of the framework's recommended actions – HImPs, joint investment plans, clinical governance frameworks, best value, and the integration of health and social care services. Progress towards implementation was to have been made by June 2001. (2.6, p25).

2.2 NHS COMPLAINTS PROCEDURE

1 The Complaints procedure which was applicable in 1998 was introduced in 1996. There are basically 3 stages to dealing with compliants:

- Stage 1 Local resolution
- Stage 2 Independent review (if complainant is unsatisfied with local resolution)
- Stage 3 Health service ombudsman (if complainant is unsatisfied with independent review

2.3 CLINICAL GOVERNANCE

1 The concept of Clinical Governance was first introduced in 1998.

3 TRUST CONTEXT

1 Gosport War Memorial Hospital is part of Portsmouth HealthCare NHS Trust (PHCT) which was formed in 1994. PHCT provides a range of community-based and specialised health services for the people of Portsmouth, Fareham, Gosport, and surrounding areas. These services include Mental Health (Adult and Elderly), Community Paediatrics, Elderly Medicine, Learning Disabilities, Palliative care, Psychology and Substance Misuse. PHCT is due to be dissolved in March 2002 and some services (District Nursing, Occupational therapy, Health visiting and Physiotherapy) have already been transferred to Portsmouth City and East Hampshire Primary Care Trusts (PCTs). The remaining services will be transferred to Fareham & Gosport PCT, when it is formally operational in April 2002, and to West Hampshire NHS Trust and the 2 other local PCTs (H2.1, File1 1.1; File1 1.2; File1, 6.4.2,p4, File1 6.5.1,p1).

2 The Annual reports state that the Trust met or exceeded activity targets in 1998/99 and that performance targets were "generally" met in 2000/01 (File1, 4.1; File1, 4.3).

3 The trust mainly serves the people of Portsmouth & SE Hampshire Health Authority (P&SHE HA). P&SHE HA has an estimated population of 544,419 and is ranked 59 out of 99 on the Townsend and 50 out of 99 on the Jarman measure of deprivation. (1= highest deprivation). National indicators show that the local population has a lower rate of illness than the national average and the directly standardized mortality rate is also lower than the average for England.

4 The population of P&SHE HA is predominantly white (98.5%). The age profile is very similar to that of England although the proportion of people over the age of 65 is slightly higher than the England average.

5 PHCT is one of the largest Community Healthcare Trusts in the South of England and employs nearly 5,000 members of staff (H2.1, File1 1.1). Binley's Directory of NHS management states that 3375 wte staff were employed in March 2000.

6 The trust has a budget in excess of £100m and over 20% of its income is spent on Elderly Medicine. This is the highest proportion for any aspect of the services provided. PHCT met its 3 financial targets in 2000/01 and 1998/99, but was £234,000 short of its budget limit in 1999/00 (File1, 4.1, p19; File1, 4.2; File1, 4.3).

4 ORGANISATION AT TRUST

1 The trust is organised into 6 main divisions:
2 Learning Disability
3 Adult Mental Health and Substance Misuse
4 Elderly Mental Health & St James Hospital Site
5 Fareham& Gosport
6 Paediatric, Palliative Care and Family Planning
7 Elderly Medicine.

8 Each Division has a General Manager although it appears that this post was vacant for Elderly Medicine in May 2001. A full Organisational Chart is available in File1 2.2.

9 The two Divisions which are particularly relevant to this investigation are:

10 ELDERLY MEDICINE DIVISION. This includes the Department of Medicine for Elderly People, Queen Alexandra and St Mary's Hospitals and Jubilee House.

11 FAREHAM & GOSPORT DIVISION. This includes Community Services for Fareham and Gosport (Elderly Mental Health, Gosport War Memorial Hospital (GWMH), St Christopher's Hospital, Health Centres, Health promotion, Occupational Therapy, Physiotherapy, Community Enablement Service) and Trust Wide Services (Physical Disability, Night Nursing, Physiotherapy advice, OT advice) (File1 2.2).

12 There are four community hospitals within PHCT, at Gosport, Havant, Emsworth, and Petersfield. All provide GP beds and Outpatient services and all except GWMH have a Minor Injuries Unit. The GP beds and minor injury units are GP led, serving a distinct geographical area. Outpatient services are provided on behalf of PHCT and Portsmouth Hospitals NHS Trust (PHNT). (A.1.2.2, p1)

13 The Fareham & Gosport Locality Division provides:

- Community Hospitals
- Health Centres
- Children's Services
- District Nursing
- Podiatry
- Physiotherapy
- Community Enabling Service
- Health Promotion
- Occupational Therapy (1.5)

14 The Community Hospitals Service within Fareham & Gosport Locality Division encompasses premises, Chaplaincy, Out patients and Nursing (1.5)

15 The Department of Elderly Medicine at Queen Alexandra Hospital and St Mary's Hospital works closely with the Community Hospitals. Acute Care, Stroke care, Continuing care, Rehabilitation, Day Hospitals and Outpatients are provided at Queen Alexandra and St Mary's Hospital. Continuing Care, Intermediate Care, Day Hospital and Outpatients are provided at Gosport War Memorial Hospital (File1 3.2).

16 The trust provided a diagram showing the different 'patient flows' within the various healthcare providers (File1, 3.2; File1, 3.1). Patients can be referred to Gosport War Memorial Hospital from several sources:

17 Directly from Portsmouth HealthCare NHS Trust to Daedalus or Dryad wards (and then possibly to Sultan ward)

18 Admitted via Elderly Medicine Consultant of Portsmouth Hospitals NHS Trust (incl Haslar)

19 GP Referral directly to Sultan Ward

4.1 GOSPORT WAR MEMORIAL HOSPITAL

1 Gosport War Memorial Hospital opened in 1923 and patients were cared for by their GPs. It was extended in 1932 and some facilities modernised and/or enlarged. GWMH became part of the NHS in 1948. Several changes took place in the 1960s – Outpatients and A&E opened, new departments for Physical medicine and X-ray were provided and the Redclyffe annexe was given to the hospital. In the early 1980s the hospital was nearly closed. In 1991 a £10.5m development programme was started which would result in the hospital buildings having the facilities and technology suitable for a Community Hospital in the 21st century. New wards and a Day Hospital for the elderly were provided, maternity services were transferred to a new ward and other parts of the building were either replaced or refurbished. The intention (1995) was for "Gosport War Memorial Hospital to remain THE Hospital for the Community of Gosport" (1.7, 2-3).

2 GWMH provides in-patient, out-patient, day care and rehabilitation services

4.1.1 In-patient services at GWMH (1.8, 2-3)

Dryad Ward

Continuing Care Ward for frail elderly patients.
Patients are cared for by Consultants from Department of Elderly Medicine and Clinical Assistants
Admissions arranged following referral by patients' GPs or Consultants from Elderly Medicine, often following admission to Acute Assessment

Wards in Portsmouth Hospitals

Sultan Ward

Gosport patients under the care of their own GPs
Admissions arranged by GPs directly with Ward Staff

Daedalus Ward

Continuing Care and Slow Stream Stroke Rehabilitation for elderly frail patients
Patients cared for by Consultants from Department of Elderly Medicine
Admission arranged by Consultants, by GP or Consultant referral

Redclyffe House

Continuing Care accommodation for Elderly Mental Health clients

Mulberry Ward

Assessment Ward for Elderly Mental Health clients from Gosport and Fareham

Blake Ward

Maternity Ward

4.1.2 Wards at GWMH:

Ward Name	Ward Type	No. of beds	Medical Staff
Daedalus	Geriatric Rehabilitation	24	Consultant: Dr Lord Staff Grade: Dr Yikona
Dryad	Elderly Medicine, Continuing Care	20	Consultant: Dr Ravindrane Staff Grade: Dr Yikona
Dolphin Day	Elderly Medicine	15	Consultants: Dr Lord & Dr Ravindrane Staff Grade: Dr Yikona Clinical Assistants: Dr Ross, Dr Anadan, Dr Rogers
Sultan	GP beds	24	All GPs on Gosport bed fund
Mulberry	Elderly mental health assessment	27 – functional illness 13 – organic illness	Consultant: Dr V. Banks Staff grade: M. Scott Brown Specialist Registrar: Jill Emerson SHO: Vivek Parmer

4.1.3 Day Hospitals at GWMH:

4.1.4 Day Hospital Facilities at GWMH (1.8, 2-3)

Phoenix Day Hospital

Elderly Mental Health clients
Admissions arranged by Consultants or Community Psychiatric Nurses

Dolphin Day Hospital

Multi-disciplinary service to elderly patients
Referrals are via Consultants of Department of Elderly Medicine

4.1.5 Other Facilities at GWMH

Outpatient Services

Outpatient Dept
Imaging Dept
Phlebotomy
Specimens

Rehabilitation Department

Physiotherapy and Occupational Therapy
Speech Therapy

4.1.6 Criteria for Admission to GWMH

1 A PHCT memorandum with guidelines for admission to Daedalus Ward (04/10/2000) has been supplied. The aim of the ward is stated as being to "provide inpatient interdisciplinary rehabilitation for older people in Gosport with a view to optimising function and maintaining independence. A PHCT memorandum with guidelines for admission to Daedalus Ward (04/10/2000) has been supplied. Daedalus Ward at GWMH has, from 01/11/00, admitted patients for fast and slow stream stroke rehabilitation as well as general rehabilitation. Continuing Care patients are to be admitted to Dryad Ward. The aim of the ward is stated as being to "provide inpatient interdisciplinary rehabilitation for older people in Gosport with a view to optimising function and maintaining independence". The ward's patients are those over 65 years old, suffering from a stroke or other condition requiring inpatient rehabilitation. The ward's catchment is those patients who belong to Gosport PCG. There are eight fast stream stroke, eight slow stream stroke, and eight general rehabilitation beds on the ward. Transfers to the ward are actioned from QAH. Dr A Knapman and partners operate an on-call service between 5pm and 9pm Monday to Thursday and between 5pm on Friday and 9am on Monday. (G.4.2)

2 Sultan ward has 24 beds for patients whose care is managed by their own GP. A Sister manages the ward. Support staff on the ward are Health Care Support Workers (HCSWs), a Ward Clerk, and Domestic staff. (G.1.1)

3 Criteria for patients admitted to Dryad and Daedalus wards are:
- Patients must be over 65
- Patients must be registered with GPs within Gosport PCG

4 AND: for Dryad:
- Patient must have a Barthel score of under 4/20
- Patient must require specialist medical and nursing intervention

5 For Daedalus:
- Patient must require multidisciplinary rehabilitation for strokes or other conditions (G.4.2, p4)

5 MANAGEMENT OF HEALTHCARE

5.1 TRUST STRATEGIC MANAGEMENT

5.1.1 Leadership

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 4.1 of Level II, that *"There is a clear management structure which works effectively to support services"* There should be a clear line management structure and service leaders should have relevant skills and experience (2.4, p26)

2 A 2000 PHCT Staff Survey found that, when asked whether they had confidence in the Trust Board's ability to manage the Trust, 32.8% of respondents replied 'yes', 10.1% replied 'no', and 57.1% were 'not sure'. (X.4.1, p6)

5.1.2 Accountabilities and Structures

1 The trust Board consists of Chair, 5 Non Executive Directors, Chief Executive and 4 Executive Directors (Operations, Medical, Nursing and Finance) and the personnel Director. A few changes to membership of the Board have been noted (File1 2.1).

Table 5.1 The Trust Board (May 2001)

Title	Name
Chairman	Ann Monk
Chief Exec	Max Millett
Non-Executive Director	Sandra Jones (Vice Chair)
Non-Executive Director	Ray Palmer from Oct 2000 David Lee to Oct 2000
Non-Executive Director	Andrew Silvester
Non-Executive Director	Vacant (2000/01 Annual Report Graham Heaney)
Non-Executive Director	Vacant (2000/01 Annual Report Anne Monk)
Operational Director	Ian Piper Anthony Horne to March 2001
Medical Director	Dr Ian Reid
Nursing Director	Dr Eileen Thomas
Finance Director	Andrew Wood Ian Piper to March 2001
Personnel Director (co-opted)	Peter King (non-voting)

Source: (File1 1.2, File 1 2.1)

1 The Trust Board meets throughout the year. Some of the meetings are open to the public but in-between the board has Strategic Briefings that are not. There are no meetings in August or December and the Board has an Awayday in March. The trust supplied the agendas for these meetings in 1999- 2001. Items on the agenda for public meetings included:

- Performance Indicators
- Report on Nursing Practice Development project and Clinical Leadership Development Programme
- Clinical Governance (national guidance, baseline assessment, minutes of CG panel, annual report)
- Reconfiguration of services
- Reports from specialist panels
- National strategies and papers (Incl NSF, District Audit, PEAT etc)

2 Items on the agenda for Part II of Board Meetings and Strategic Briefings included
- Closure of Haslar Hospital
- Reconfiguration of services
- Detailed summaries of complaints, action plan following Independent Review panel, risk events, legal claims in progress etc
- Fair Oak Challenging Behaviour Service Investigation
- Security Review, Caldicott
- Media coverage of events and Investigation at GWMH
- Mental Health Commission Visit
- DNR Policy
- Elderly medicine Nursing Review

3 The following groups are accountable to Portsmouth HealthCare NHS Trust board, undated:
4 Business case panel
5 Financial audit panel
6 Clinical governance panel
7 Risk management group
8 Finance and performance panel
9 Pay and remuneration panel
10 Mental health panel (F1.1).

11 Portsmouth Healthcare NHS Trust district medicines and formulary group have shared membership with the trust medicines and prescribing committee, together comprising medicines management. The district medicines and formulary group is led by the medical director and the trust medicines and prescribing committee is led by the medical director and the clinical risk adviser (F1.1).

12 The district medicines and formulary group also has shared membership with the clinical governance panel who, in turn, are accountable to the trust board. The trust medicines and prescribing committee also has shared membership with the risk management group, which is accountable to the trust board. The risk management group and the clinical governance panel have shared minutes, undated (F1.1).

5.1.3 Strategic Direction and Planning

1 PHCT participates in the development, management, and provision of various ongoing intermediate care schemes, including an ongoing initiative in 2000/01 to increase the number of “step down” beds at GWMH. (A.1.2.1, p15)

2 Tackling the recommendations made by the NSF for Older People has identified as a priority for PHCT in 2001-02. (A.1.2.1, p15)

3 PHCT has supplied a paper on SaFF cost and service pressures, containing an analysis of anticipated cost pressures facing PHCT in 2001/2002. Analysis is provided on the basis of national cost pressures, local issues and ongoing commitments. Appendix one provides a breakdown of the cost pressures for each area and appendix two provides a calculation of inflation funding requirement 2001/2002. Appendix three covers SaFF priorities which include dual diagnosis, assertive outreach, CAB advocacy and primary care liaison (A 5.1).

4 National cost pressures to be funded via SaFF include pay awards for 2000/01 and 2001/02, superannuation and NSF for Older People. Local issues include Intermediate care funding shortfalls, Medical records strategy implementation and Elderly medicine clinical nursing establishment (A 5.1)

5 The ongoing commitments of PHCT are specialist registrar posts, king villa upgrade revenue costs and learning disability issues. The paper also outlines other funding pressures including place of safety arrangements, prison HIMPs, the implementation of NSF protocols and access to treatment in accordance with royal college recommendations. A table of mental health pledges is also included (A 5.1).

5.1.4 Health Economy Partnerships

1 Fareham and Gosport PCGs have supplied a proposal for intermediate care and rehabilitation services, May 2000. The document notes that service objectives for the latest district wide joint investment plan for older people cross agency boundaries. The objectives include promotion of independence and prevention of disability, avoidance of preventable admissions and better use of hospital capacity through improved assessment, use of staff, physical capacity and discharge planning (A 3.1).

2 An integral part of the service proposal is the development of a community enabling service (CES). The CES would provide a single point of contact for the delivery of all rehabilitation programmes in community settings. The service would focus on patients over 65 and be multi-agency. It was proposed that falls, fractured neck of femur, complex orthopaedic conditions, elective surgery, amputees, other surgical patients and strokes could potentially be managed by the CES as well (A3.1)

3 The CES proposal would aim to free up a maximum of 15,000 acute hospital bed days. Currently, GWMH provides 36 continuing care beds, 8 slow stream beds and 22 GP beds. This would be reconfigured as follows: Daedalus ward to provide 24 community rehabilitation beds, Dryad ward to provide 20 continuing care beds and 24 GP beds to continue to be provided on Sultan ward (A 3.1).

4 The proposal outlines how the CES would be comprised, the development and delivery of the service, its availability and funding requirements both recurring and non-recurring. The paper notes it is envisaged that after twelve months the management responsibility for the CES will transfer to a service manager within PHCT (A 3.1).

5 PHCT provided several documents on proposals for new PCTs, transfer of services from PHCT to other organisations and the dissolution of PHCT.

6 A proposal to establish a Fareham and Gosport PCT from the Fareham and Gosport PCGs was provided, July 2001, produced in conjunction with Isle of

Wight, Portsmouth and South East Hampshire Health Authority. The proposal highlights the vision for Fareham and Gosport, which includes delivering health improvement, developing primary care, commissioning secondary care, developing community based services, working with social services and working with non-statutory partners. (A 5.2).

7 An NHS consultation document covering 'proposals for the transfer of management responsibility for local health services in Portsmouth and South East Hampshire from Portsmouth Healthcare NHS Trust to local Primary Care Trusts and West Hampshire NHS Trust' was supplied (Sept 2001) (A 5.3).

8 PHCT, Portsmouth City PCT and East Hants PCT have agreed a combined five-year capital programme. This document has been provided by the trust (C4.1).

9 Transition of services provided by PHCT to other local organisations is occurring in two phases. Phase one was to be in place by April 2001 and transferred many services to the 2 PCTs. The Phase two transfer would include Elderly Medicine, Palliative Care and Mental health (Adult and Elderly) (A1.2, p5, p14).

10 A PHCT dissolution project proposal has also been supplied with a checklist of high-level tasks and the lead project teams responsible for these.

5.1.5 Patient Public Partnerships

5.2 SERVICE STRATEGIC MANAGEMENT

5.2.1 Leadership

1 GWMH has action-learning meetings for which notes have been provided from June to November 2001. The minutes of clinical managers' meetings (November 2001) and Minutes of Sultan and Daedalus ward meetings for April to August 2001 have also been supplied (D 3.2).

2 It was noted at the GWMH clinical managers' meeting in November 2001 that staff were not always informed about recent issues. A patient survey action plan was discussed. Ward specific action plans were to be distributed to ward staff (D3.2).

3 Minutes of a Sultan ward meeting, 10th April 2001, have been provided. The Crown Prosecution Service is mentioned in relation to an investigation of the claim that records were being destroyed inappropriately. The system has, apparently, since been rectified. However, staff were told to be aware of visitors and questions. The minutes state that 'staff need to be aware of communication needs with patients and relatives and thereby hope/aim to alleviate worries'. ENB and mental health course availability is also mentioned as well as changes to catering (D 3.2).

4 Minutes of a Sultan ward meeting, 2nd May 2001, have also been supplied. They note the emergency procedure, catering, new resuscitation guidelines, that care plans should be left at the end of beds to be countersigned and that eating is not allowed on the ward – otherwise disciplinary action will be taken (D 3.2).

5 Notes from a team leaders meeting, 5th April 2001, are given for the Daedalus ward. Issues arising include:

6 The confusion concerning the current ward round split

7 The named nurse split could be used with greater effect with specific areas of care, namely communicating with relatives, discharge planning, referrals and other actions, discharge letters and dressings

8 The need to move patients between different teams was flagged up as problematic

9 The decision to incorporate clinical supervision in team meetings was also agreed (D 3.2).

10 Ward objectives were also outlined including the introduction of a night duty rotation as of 6th May 2001, the use of a discharge-planning sheet for all patients, a re-organisation of nursing notes and paperwork and a revision of pre-printed care plans. It was also agreed that booking and recording of training could be transferred to team leaders (D 3.2).

11 The notes from a Daedalus ward meeting, 6th August 2001, have been supplied. It has been noted that nurses raised concerns regarding staffing levels on the ward, particularly that 10 risk event forms have been completed in the last week describing incidents that have occurred. A backlog in administration has been flagged up and addressed (D 3.2).

12 The August 2001 minutes also note pressure from QAH elderly services to fill bed-blocking forms, a request was made for a simpler form for unaltered information. The amount of out of hours bleep calls that trained nurses have to deal with was raised, particularly the amount of requests for records/visiting times/patients needing GPs etc. It was suggested that an auxiliary could carry out this role and this can be further discussed. Nurses working in their weekends off was raised as problematic and tiring, and the option of bank staff was suggested in response (D 3.2).

5.2.2 Accountabilities and Structures

5.2.2.1 Fareham & Gosport Locality Division

1 Several services are provided within this division and an Organisational Chart has been provided (File1 2.3). The General Manager of the Fareham & Gosport Division is Fiona Cameron who is accountable to the Nursing Director and the Operational Director of the Trust. The Service Manager for the Community Hospitals aspect of the Division is Jan Peach (Nurse) who is responsible to the Division General Manager. All staff at St Christopher's and GWMH, and clinical staff at Redclyffe and Summervale report to the Community Hospitals Service Manager. (*Note: Another document (1.8) stated that the Community Hospitals Service manger is* Code A Code A *– dates are unclear*) The Service Manager is responsible for the overall management of St Christopher's and Gosport War Memorial Hospital. Key responsibilities are to

- Manage human resource
- Manage IPR system
- Manage the budgets
- Develop systems of clinical supervision in line with the CG action plan
- Provide nursing leadership across the Community Hospitals in the Division
- Undertake investigations and enquiries as necessary (D1.6)

2 There are two Admin and Support Services Managers for GWMH and Redclyffe, and St Christopher's, Sylvan and Summervale (File1, 2.3-2.4). **Code A** is the ASSM responsible for Premises at GWMH and Redclyffe House. **Code A** is the ASSM responsible for Premises at St Christopher's, Sylvan, and Summervale (1.5)

3 The Senior Nurse at GWMH (Toni Scammell) reports to the Service Manager for the Community Hospitals (Jan Peach). There are 4 wards at GWMH (Dolphin, Sultan, Dryad, Daedalus). The Lead Nurses (Ward manger – titles not given) report to the Senior Nurse. They are Sharon Bosier (Dolphin), Ann Haste (G Grade Sultan), Gill Hamblin (G grade Dryad) and Philip Beed (G grade Daedalus) (File1 2.4; 1.5, X.3.3).

5.2.3 Stratgeic Direction & Planning

1 The August 2000 Divisional Review noted that initial proposals had been developed by clinicians and managers in the division to provide a 'community enablement service' and intermediate care / rehab beds at GWMH and St Christopher's Hospital (B2.1 Section 7).

2 The August 2000 Divisional Review noted that the GWMH minor injury unit would close on 31/07/00, with activity transferring to Haslar (B2.1 Section 4).

3 The August 2000 Divisional Review, clinical governance action plans for elderly mental health included a focus on projects including Multi Disciplinary Team (MDT) assessment; a user involvement project on Mulberry, Ark Royal in conjunction with the clinical effectiveness department; and inpatient units now using hip protectors to reduce injuries from falls as advised by an assessment carried out by the Falls Group (B2.1 Section 3.2).

4 The November 2000 Divisional Review stated that there was a multi-disciplinary "falls group" working to raise awareness, monitor trends, develop an action plan, and contribute to trust-wide work on falls (1.13.3 Section 3.4.3). The February 2001 Divisional Review stated that work continued with the multi-disciplinary working group is meeting across community hospitals. A review of the times of falls had been undertaken and information shared with clinical managers. In addition, an assessment tool had been developed based on current evidence, with training undertaken by staff (1.13.2 Section 3.7). The May 2001 Divisional Review noted that work on the management of falls is progressing and a report produced (1.13 Section 3.6). The August 2001 Divisional Review noted that falls remain high on Collingwood and Sultan wards. Discussion centred around the effectiveness of the Falls Working Group. It was agreed that the working group would be advised to link with Eileen T regarding the commissioning of a 'falls' video (1.13.1 p2)

5 The February 2001 Divisional Review noted that the first draft of the bed rails audit would be submitted to the community hospitals service lead group in February 2001 for discussion and action planning (1.13.2 Section 3.3). The May 2001 Divisional Review noted that recommendations from the first draft of the bed rail audit report included linking future bed rail work with falls work (1.13 Section 3.3).

6 The February 2001 Divisional Review noted that the community hospitals service lead group held an away day. This was intended to review the groups' role and determine service elements that required a continuing district wide focus in the transitional year moving towards primary care trusts

(PCTs). The outcome of these discussions was presented as a governance framework (1.13.2 Section 3.7).

7 The February 2001 Divisional Review finance report noted that areas of concern / overspend were being reviewed. These were Daedalus, Dryad and Sultan wards, GWMH premises and St Christopher premises. It was also stated that GWMH wards had increased their bed occupancy by 8% per ward in 2000/01 (1.13.2 Section 5.1).

8 The May 2001 Divisional Review noted that the first meeting of the gerontological nursing development programme had taken place in March 2001. Next steps included identification of members of an advisory group of stakeholders; generation of critical companions person specification; identification of the critical companions. The project management group was scheduled to meet for the first time in June 2001 (1.13 Section 1).

9 The May 2001 Divisional Review noted that the use and appropriate storage of oxygen at GWMH had come under scrutiny, as it had risen to three times the requirements of 1999. Actions so far had been to request quotations for improving the current storage; building a brick built new store; and costing for three wards to have piped gases (1.13 Section 3.4.3).

10 The August 2001 Divisional Review noted that concerns had been expressed regarding the effect of the closure of Haslar medical take. Specific concerns were that there might be an increase in OPD referrals at GWMH, increased day hospital referrals and increased admissions out of hours to peripheral beds (1.13.1 p2).

5.2.4 Health Economy Partnerships

1 PHCT recognises that local health economy partnerships are important and an introductory leaflet to the trust states that they will continue to "*develop the way the trust works with other organizations, play an active part in modernizing local health services and involve people in developing services and respond appropriately to complaints*" (File1 1.2).

5.3 CLINICAL GOVERNANCE

5.3.1 Trust Organisational Responsibilities for Clinical Governance

1 Trust provided a copy of a memo (June 1999) and enclosures from the Chief Executive to a wide set of staff inviting them to take part in a clinical governances reference group. The memo outlined the actions the trust had already taken and still needed to take during 1999/00. Appoint lead clinician, set up CG committee, carry out baseline assessment and implement corresponding action plan, ensure reporting arrangements to trust board and in Annual report. The new Clinical Governance Panel was to meet for first time in summer 1999. The panel's main task was to agree framework for next phase of CG development (File1, 1.6.1).

2 In September 1998 a brief paper outlining how the trust planned to begin to develop a framework for clinical governance was shared widely across the trust, aiming to include as many staff as possible (File1, 1.6.2).

3 By the end of December 1998 each contract lead group was to have taken time to "stock take where the service/care group was against the British

Association of Medical Mangers checklist for CG, current business plans etc, and plan a process to involve staff across the service in discussing what the implications of it all were". Between Jan and March 1999 there should have been discussion with staff and by end of May 1999 the Trust Board had to produce a draft formal clinical governance framework for the trust

4 Trust provided us with a Draft Action Plan for 1999/00 for Developing Clinical Governance. The CG panel had now been set up as a formal committee of the Board with support form a Clinical Governance Reference Group. Actions planned include:

5 Review job descriptions of Lead consultants, Professional Advisors and General Managers to clarify CG role
6 Support District CG Committee. – Regular Trust reps are Medical Director and Quality manger
7 Baseline assessment for CG
8 Develop Action Plan following baseline assessment
9 Review Trust's performance indicators package reported to Board
10 Review divisional performance review function
11 Review need /role of Quality Forum, Clinical Services Advisory Group and Risk management Group
12 Review links with Medial Advisory Committee, Nursing advisory Committee, Service Reference Group, Operational management Group
13 Identify group of staff in trust to undertake the post grad certificate in clinical governance run by School of Post Grad medicine
14 Design next phase of Clinical Nursing Practice development Programmes
15 Review arrangements for Health Records
16 Review relevant policies and procedures to include reference to CG requirements
17 Review the Supervisory/management development programme to reflect CG
18 Ensure that library facilitator service and internet accessibility widely advertised (File, 1.6.2)

19 A Clinical Governance Panel was established. Members included 2 Non-exec directors, Medical director, nursing director, CHC member. The Quality Manager was to be Secretary and Trust Chair and Chief exec are in attendance. A standing reference group was established to work with the panel. The panel's main aim was to oversee the overall clinical performance of the Trust by ensuring that systems are in place to monitor and improve the quality of clinical practice. Specific aims included

20 Ensure CG incorporated in objective setting for teams and individuals
21 Ensure clear monitoring/reporting process in place for CG
22 Approve annual clinical audit plan
23 Review the clinical performance of each division/service and the trust as a whole against agreed targets
24 Review reports from external agencies (eg NICE, Royal Colleges)
25 On behalf of Trust Board investigate any aspect of Trusts; services and act accordingly
26 Support promotion of c culture within Trust that encourages best practice, professional development and learning from experience (File1 1.6.2)

27 The CG Development Plan 2001/02 states that the Trust has a CG Panel that is supported by the CG Reference Group. Membership of this includes

representatives from each clinical service and professional group plus personnel and education /training. Each Clinical service has its own CG Committee led by a designated clinical and includes wide clinical/professional representation. Plans were in place for the clinical services and professional groups to continue to meet via managed clinical networks (File1, 6.5.1, p2)

5.3.2 Service Clinical Governance Arrangements

1 PHCT has developed a clinical governance programme. There is a clinical governance group in place within each clinical service. Baseline assessments have been carried out in each specialty. An action plan in response to the baseline assessment has been produced. (A.1.2.4, p4, p5)

5.3.3 HA Role as moves to PCT

1 A proposal to establish a Fareham & Gosport PCT states that the 'well established' arrangements and structures for clinical governance at PHCT will help form the basis for clinical governance in the PCT (A 5.2, p5).

2 There are district-wide, HA-led Clinical Governance and Effectiveness committees, into which PHCT feeds input. (A.1.2.4, p12)

5.3.4 Clinical Governance strategy

1 The trust began to implement clinical governance during 1998/99. The Quality Strategy "Improving Quality – Steps towards a First Class Service" was revised in September 1998 as part of the trust's initiative to implement clinical governance. It gives a simple framework of what quality means for the Trust and how they were working towards it. The strategy lists some achievements of the previous 4 years. These included:

2 Clinical Audit Introduced
3 Risk Management process started
4 Patients charter monitoring introduced
5 Service Standards developed
6 R&D links created
7 Work on seeking user/carer feedback and involvement
8 Quality measures in service contract
9 Focus for improving quality shifted from locality divisions to contract lead groups
10 Quality reporting/monitoring embedded into mainstream service planning /contracting/performance review process
11 Improving the Quality of Care (Draft 1) developed from Trust Forum Away Day Nov 97 accepted throughout Trust as the way forward
12 Working definition of quality based on Trust values (File1, 1.6.1)

13 The Medical Director (Dr Ian Reid) was appointed lead for Clinical Governance and a Clinical Governance Panel was established as a sub committee of the Trust Board.

14 Each contract lead group had to prepare a quality action plan during autumn/winter 1998/99. Achievements would be reviewed at the end of quarter 3 and included in report to the Health Authority. A Clinical Nursing Practices Development programme was being launched. The quality budget would be used to support change (File1 1.6.1) (File1, 1.6.1).

15 A Clinical Governance Reference Group was established to support the CG Panel. Membership included all Lead Consultants, all Lead Nurses for CG, all professional Service Heads, All general managers, the Executive Team, Non-executive directors of the Trust Boards and the secretary of the CHC. The 1999/00 Clinical Governance lists some workshop-style meetings of the group.

16 The first meeting for the group was in October 1999 when the results of the baseline assessment were considered. Five key themes were identified for action: CPD, Training and development; Clinical Audit; Evidence Based practice; Patient and user involvement and Clinical Risk management. Two further areas for action were identified during 2000/01 (Workforce issues and Information) (File1, 6.4.2). The CG Reference Group recommended that a tool/template to report on clinical governance performance should be available and the format of the template was defined. It would include Service Objectives (eg implementing NSF, reducing waiting times), Clinical Performance (eg NICE guidance, Protocols, Outcomes, CG Action plans, Record keeping, clinical risk assessments, critical incidents), user experience (Patient's charter, local standards, complaints, user views, CHC reports etc) and team functioning (CPD, PDP, Supervision, team working, recruitment/retention, skills development). Achievements, exceptions and action plans were to be completed for each of these. A further workshop discussed CPD and the need to systematically identify training needs and co-ordinate systems to meet those needs. A workshop on user involvement was planned (File1, 6.4.1,p2).

17 The quarterly Divisional Review system was modified to include reporting on Clinical Governance. The Medical Director and Clinical Governance Manager attend the Divisional Review meetings and important issues emerging are reported back to the CG panel (eg audit, critical incidents and service issues that impinge on quality of care (File1, 6.4.1,p2). CG Panel also receives reports on complaints, risk management, infection control, prescribing; and external reports (Royal Colleges, National audits etc) (File1, 6.4.1,p3).

18 The CG Annual report 2000/01 states that the trust uses its Divisional Review process to "manage" clinical governance. The emphasis at Divisional Reviews now on reporting on the elements of clinical governance. Mechanisms have been put in place to ensure that where poor performance has been identified there is a regular review to ensure that improvement has occurred. Each division/service has its own clinical governance group (File1, 6.4.2, p1).

19 Trust produced an action plan for CG by May 2000 and a progress report submitted to RO in March 2001.

20 During 2001/02 the CG Panel planned to support clinical services in the development of robust clinical governance activities, actively involve new PCTs etc in the work of the group and establish Managed Practitioner Networks to ensure the delivery of effective clinical services across organisational boundaries (File1, 6.5.1, p2)

21 The CG Development Plan 2001/02 states that trust was to concentrate on transferring clinical services in a safe manner and working in partnership with stakeholders and successor organisations to ensure existing clinical governance strategies were able to continue and to be built upon (File1, 6.5.1, p1).

22 Trust provided a copy of the minutes of the Clinical Governance Panel meeting in May 2001 (File1, 6.6.1). The CG Reference group reported its meeting of March 2001 to CG panel. It was unlikely that the reference group would meet again. Each Lead consultant presented a report (not supplied) of how clinical governance was progressing in their service. Apparently there were no major concerns about medicines management – it is handled very professionally across the district. The minutes of the ICC were received. It was noted that a proactive rather than reactive approach to infection control was being encouraged (File1, 6.6.1).

23 The February 2001 Divisional Review included the following clinical governance action:

- Standards have been agreed relating to the seven pillars of clinical governance as part of the clinical network for community hospitals planned for 2001. This will include sharing the results of complaints, reviewing audit results and in particular this year, the bed rail audit and audit of IPR process.
- The practice development facilitator group has been expanded to include H grade nurses in community hospitals and functions both as an operational group and as an action group.
- Staff training and development as a result of ongoing intermediate care development continues to have a high profile. Staff have attended courses on ALERT, ECG, cannulation, and intravenous therapy management.
- The Action Learning Group has been reviewed with the H grade now the facilitator. Topics discussed were – GP communication; to resuscitate or not; and self-rostering. The emergency response protocol has been developed (1.13.2 Section 3.2).

24 Away days for senior community hospital staff and Health Care Support Workers (HCSWs) have been held in 2000/01, in order to raise awareness of Clinical Governance and generate Clinical Governance action plans. (A.1.2.2, p2)

25 Sub groups are in place for pursual of near misses. Incident reporting now comprises near misses. COSHH assessments have taken place at the community hospitals. (A.1.2.2, p2)

26 Locally sensitive clinical governance performance indicators are to be developed within the community hospitals in 2001/02. (A.1.2.2, p4)

27 District Audit carried out an audit of the trust's Clinical Governance arrangements in 1998/99. The report (Dec 1999) states that the Trust had fully complied with requirements to establish a framework for Clinical Governance. A CG panel had been established which reported to Trust Board. A Baseline assessment was produced and workshop /conference for the launch of a Clinical Governance Reference Group in October 1999 when findings of baseline assessment were to be discussed and way forwards agreed. The report also stated that the Trust's document 'Improving Quality – steps towards a Fits Class Service' was of a high standards and reflected a sound understanding of CG and quality assurance (File1, 6.x)

28 The District Audit Review of CG at the trust noted that the work on gathering user views needed to be more focussed and the processes strengthened (File1, 6.x, p3)

29 The District Audit Review of CG at the trust noted that the "clinical governance loop needed to be closed in some areas to ensure that strategy, policy and procedure result in changed/improved practice:
30 Protocols written and published but not always implemented by staff
31 Results of clinical audit not always implemented and re-audited
32 Lessons learned from complaints and incidents reported not always used to change practice or procedure
33 R&D does not always lead to change in practice (File1, 6.x, p3)

34 The District Audit Review of CG at the trust noted that technology was generally a weak area in need of development to support clinical governance (File1, 6.x, p3)

35 The District Audit Review of CG at the trust stated that more work needed to be done with the clinical staff on openness and supporting staff alerting senior management of poor performance (File1, 6.x, p3)

36 The District Audit Review of CG at the trust noted that more supervision of nursing staff was required – particularly those in the community (File1, 6.x, p3)

37 The District Audit Review of CG at the trust noted that ongoing CPD or all clinicians was needed (File1, 6.x, p3)

38 Following the District Audit Review of Clinical Governance the trust drew up a trust-wide action plan in Dec 1999 which included, priorities, designated leads and time scale. It focussed on
39 Widening the involvement and feedback from nursing, clinical and support staff on Trust protocols and procedures
40 Making greater use of R&D, clinical audit, complaints, incidents and user views to lead to changes in practice
41 Continuing to develop quality and information strategies (File 1, 6.x, p4)

5.3.5 Components of Clinical Governance

5.3.5.1 Clinical Audit

1 The 1999/00 CG annual report states that improvements needed to be made in 2 main areas for clinical audit: Setting the audit agenda and ensuring that audits were undertaken to robust standards and that action plans were likely to lead to improved outcomes. The Trust planned to develop a 3 year plan for audit.

2 Twenty three audits were carried out in 1999/00. Audits within Elderly medicine included
- Re-audit of Elderly medicine day Hospital
- Neuroleptic prescribing in Continuing Care
- Compliance with Handling Profile Guidelines
- Detection of Depressive symptoms in Elderly patients
- National Sentinel Audit of stroke (File1, 6.4.1, p3).

3 The 2000/01 Clinical Governance Annual report states that prioritisation of audit topics on the basis of HImP and NSFs had begun. Risk management issues were being built into the audit programmes within clinical services and audit processes strengthened with introduction of new system of approving audit proposals and audit of implementation of action plans. All members of

Clinical Audit Group had received training on how to review audit projects and reports. Audit reports were to be graded as red/amber or green depending on findings. 31 audits were carried out in 2000/01 (File1, 6.4.2, p2).

4 The terms of reference and modus operandi of the clinical and service audit group were reviewed to meet the requirement of clinical governance. The review of the CG Action Plan 2000/01 (March 2001) states that all consultants have audit time in their work programme and junior doctors are all involved in audits. The audit group was to construct a programme of audits that would be discussed by CG panel and Trust Board. They planned to include patients and carers in the development of clinical audits and as a first step the chairman of the CHC had joined the CG Panel. There was evidence that audit did not inform clinical practice and it was planned that there should be greater number of re-audits to ensure that action planed and clinical practice was improving. A key action for the trust was to finalise the audit programme by 30/9/00 and submit it to CG panel. This was done. A Clinical Audits framework was developed and introduced clarifying associated group and individual roles, responsibilities and prioritisation of audit projects (File1, 6.3.3)

5 The 2001/02 CG Development Plan states that each service has a programme of new or re-audits for 2001/02. Clinical Services implement evidence based practice through their clinical governance groups via care pathways, benchmarking, national practice guidelines and local guidelines and protocols. Plans for 2001/02 include evaluation of new clinical record format, NSF Clinical Guidelines in conjunction with GOPS, staff and service users (Adult Mental Health and an audit of the Opiate Substitute Prescribing programme (Substance misuse) (File1, 6.5.1, p4)

5.3.5.2 Research & Effectiveness

1 The 2000/01 Clinical Governance Annual report states that a review of training opportunities in critical appraisal skill was to be undertaken in March 2001. A project was completed in 2000/01 to enhance staff access to library services including electronic access to a knowledge base. Local bench top libraries were being upgraded and updated (File1, 6.4.2, p3). The review of the 2000/01 CG Action Plan (March 2001) states that it was planned when new evidence emerges or where recent evidence has emerged that improvements in clinical practice can be made, audits in such areas of practice should be undertaken (File1, 6.3.3, p4)

5.3.5.3 Risk Management

1 The trust provided copies of its Risk Management (RM) strategies for 1998/01, 1999/02 and 2000/03. The strategy documents describe the vision, aims and critical success factors for risk management. Changes have been made during this time to incorporate clinical risk into the overall process. Many of these were highlighted in the 2000/03 strategy.

2 A Risk Management Group was established to "provide a focus for the trust's Risk management activities" – ie to develop and oversee the implementation of the trust's RM strategy, provide a forum in which risks can be evaluated and prioritised, and monitor the effectiveness of actions taken to manage risks. Membership of the RM Group includes nominated Executive Directors,

Senior Clinicians and Senior managers. The Group has links with other focus groups within the trust (eg Trust Board, H&S Committee, Clinical and Service Audit Group, Medical Advisory Committee, Quality Forum and clinical advisory groups, and since 2000/03 the Clinical Governance Panel and Clinical Nursing Governance Committee). The group is chaired by the Finance Director and meets every 2 months.

3 The Finance Director is the Executive Director for Risk Management and is supported by Medical Director and Director of Nursing.

4 Originally the Finance Director had joint responsibility for strategic risk management with the Quality Manger. However, this was changed in 2000/03 so that both the Finance Director and Medical Director have joint responsibility for strategic risk management issues with the Quality manager. The 2000/03 strategy also states that the Medical Director is designated as the Executive Lead for Clinical Risk and the Operational Director has input for non-clinical risk issues.

5 The Quality Manger is responsible for ensuring that the strategy and objectives are implemented within the overall quality management framework. He is the secretary of the RM group, and was the Line Manger for the Risk Advisor and ensured that all links with other quality management activities and groups were in place.

6 A Risk Advisor coordinated the Risk Management activities across the trust. However, in the 2000/03 strategy there is a corporate risk advisor and a clinical risk advisor.

7 Divisional General Mangers also have responsibilities and are supported by the Risk Advisor. Each Division has a nominated person to coordinate risk management activities and progress specific issues and problem areas. A nominated senior Clinician from each Contract (or Service Group) is to take lead for clinical risk.

8 Clinical risks associated with an individual patient's treatment and care are coordinated by a designated key worker who develops a risk assessment and action plan with the involvement of the patient, their family and all other clinicians who have input into the patient's treatment and care. This assessment and plan forms part of the patient's clinical record.

9 The 2000/03 strategy also states that "all staff have a role to play in identifying and responding to risks. An open and proactive approach to resolving problems is encouraged and expected, within a supportive and learning work environment" (File 1, 1.5.3, p8).

10 The 2000/03 RM strategy states that clinical and non-clinical arrangements are in place to ensure risks are identified and assessed. Detailed Risk assessments are completed once a year for all services, care groups and premises and results fed into a risk register which is used to analyse and prioritise risks for action. CNST assessment, and Controls assessments and CG assessment can identify risks. A Risk Profile is completed for the trust as a whole once every 5 years, to focus on key strategic and global risks. A quarterly analysis of all risk events is provided for discussion at TB, CG Panel, Divisional Reviews, in Trust Quality report and at RM Group. This is used to identify patterns, trends and problems. Key Risk issues from each Services are identified and analysed at the Divisional Review and actions planned/taken to prevent reoccurrence reported. The Annual Risk

Management Report is presented to RM Group and Trust Board (File1, 1.5.3).

11 The RM objectives for 1998/99 included:
12 Revise Risk Strategy to incorporate Clinical Risk Issues
13 Establish a database that includes information on Risk Events, Complaints an litigation
14 Monitor H&S issues within trust and ensure recommendations received from H&SE are implemented
15 Evaluate the Critical Incident Reporting system
16 Action plan towards achieving Level 2 of CNST
17 Work towards integrating individual Clinical Risk Assessments into clinical records
18 Monitor CPR training contract with PHCT (File1, 1.5.2)

19 The RM objectives for 1999/00 included:
20 Clarify Framework for Risk Management, in consideration of the requirements of Clinical Governance and Controls Assurance
21 Complete CG Baseline assessment and develop a Trust Wide Action plan
22 Complete the baseline self assessment of compliance with the NHS Executive Management and Operational Contract Standards
23 Complete either CNST level 1 re-assessment or CNST level 2
24 Complete Trust Wide H&S safety audit based on previous H&SE review/action plan
25 Clarify local and Trust Wide responsibilities and arrangements for clinical and non-clinical risk assessments
26 Consolidate new risk events reporting system by review and revision of the risk events report forms associate policy and guidance for staff and development of monitoring reports
27 Complete work of the 2 year Safety and Security Project (File1 1.5.2)

28 The RM objectives for 2000/01 included:
29 Clarify Role of RM group in consideration of establishment of PCTs
30 Build on CG Programme to facilitate continuing improvement in patient care
31 Achieve Year 2 requirements of NHSE Organisational Controls Assurance Standards
32 Work towards Level 2 CNST
33 Embed the revised Risk Assessment procedure and Risk Event Reporting System in all Trust Activities and at all levels of organisation
34 Continue work of Safety and Security project
35 Continue to Review CPR Training contracts with Portsmouth Hospitals NHS Trust an the local policies and procedures for CPR
36 Review Performance against Controls Assurance Standard
37 New Infection Control Committee to review performance against Controls Assurance standard
38 Major Incident and Emergency Planning arrangements revised in consideration of establishment of PCTs (File1, 1.5.3)

39 The 1999/00 CG annual report states that the trust achieved CNST level I in 1999/00 and was working towards CNST level 2 (File1 6.3.3, p2; 6.4.1, p4).

40 The 1999/00 CG annual report states that during 1999/00 trust had started to use a computerised critical event reporting system (CAREKEY). However,

there was "a need to encourage certain groups of staff to report adverse incidents" (File1, 6.4.1, p3).

41 The trust has an operational policy for "Recording and Reviewing Risk Events" and provided some Risk Event Forms and Continuation Sheets for reporting Clinical and Non-clinical incidents and accidents. One copy of the form is forwarded to the Ward/Dept manger and then to Service Manager for further action and completions. It is finally entered in Trust's Risk Event Database. Trust employees are responsible for reporting any untoward incident or event as soon as possible after it has happened and for co-operating with the trust in investigating risk and critical events. A list of Risk Event Definitions is given and all incidents involving patients should be recorded in their notes. These include

42 Any Clinical procedure or treatment that results in an adverse outcome

43 Any clinical or non-clinical incident that is a deviation from the normal pattern of events or that has occurred due to a breakdown in recognised procedures and that results in significant harm or injury

44 All drug and Medication errors

45 Any Infection control outbreak

46 Distress caused as a result of verbal abuse, threatening behaviour

47 Near Misses

48 Serious Incidents (such as unexpected death of a patient)

49 A review of the systems and processes for assessing clinical and non-clinical risk was undertaken during 2000/01. The 2000/01 CG Report states that new reporting forms for risk events were introduced in April 2000. Risk events occurring within individual services are formally reviewed every 3 months and the Risk Management Group and Clinical Governance Panel review the risk event reports for the whole trust. A risk management and education plan was being developed. CPR training and Infection Control were two issues being addressed (File1 6.3.3, p2; File1 6.4.2, p2).

50 The 2001/02 CG Development plans states that the focus of Risk Management in 2000/01 was the safe transfer of services to successor organisations and the active involvement of PCTS and PCGs in the trust's Risk Management Group. Significant achievement (relevant to this investigation) have been in the area of:

51 Medicines management

52 Replacement of sub-standard medicines cupboards in a number of clinical areas

53 Launching of a pain management policy which identifies strategies to manage pain in a risk managed manner – building on lessons learnt from a critical incident review. An audit was planned for 2001/02

54 Purchase of ambulant syringe drivers. Ongoing training in their use was planned

55 Significant increase in the number of staff receiving training in Life support (File1, 6.5.1, p4)

56 Meetings had been scheduled with representative from each successor organisation to discuss and agree future arrangements of activities managed or undertaken by PHCT – Risk event reporting, health and safety, infection control, manual handling, medical devices management, medicines management, life support, major incident plans, COSHH, radiation protection (File1, 6.5.1, p4).

5.3.5.4 Use of Information

1 The 2000/01 CG Report states that access to the Internet for clinical staff was extended during 2000/01 and would continue to July 2001. The trust planned that all professional staff should have easy access to the internet (File1 6.4.2, p3)

2 The review of the 200/01 CG Action Plan (March 2001) states that "in common with many trusts key information on clinical activity is patchy and systematic collection of key information and quality is virtually non existent" The trust has been working with other organisations in developing a Local Implementation Strategy for information management and technology. The LIS includes proposal s for electronic patient record. (File1, 6.3.3, p3)

6 QUALITY OF PATIENT CARE

6.1 QUALITY INDICATORS

6.1.1 Staff Attitude

1 The trust conducted a staff opinion survey in 1998 in the Community Hospitals. 145 staff members answered the questionnaire.

2 50% agree that PHCT supports its staff through its policy and procedures, 11% disagree and 35% neither agree nor disagree

3 44% believe their department could make improvements to the service within existing resources, 26% neither agree nor disagree and 27% disagree

4 83% enjoy their work

5 84% feel they have enough authority to successfully perform their job

6 67% think it is possible to have an open and frank discussion with their manager about issues facing the department, 17% disagree

7 24% believe all resources are used wisely, 54% disagree and 20% neither agree nor disagree

8 87% are clear about their roles and responsibilities at work, 8% disagree

9 27% have confidence in the ability of the trust board to manage PHCT, 51% neither agree nor disagree, 8% disagree and 10% don't know

10 40% of staff have had the Trust's business plan explained to them

11 65% feel they are receiving adequate training to do their job, 17% neither agree nor disagree and 17% disagree (C1.1)

12 Staff attitude was raised as a concern by patients in the October 2001 Patient Survey at GWMH, particularly in relation to nurses. Patients commented that they overheard conversations between them about the nurses' private lives, and one patient felt that the nurses "do not speak to me very kindly". Consequently, the hospital planned for awareness of the issue to be raised at the Clinical Manager's meeting by November 2001, information to be cascaded by the Clinical Manager to Ward Teams through the Ward Meeting by the end of November 2001. The ward team were then to take action to identify inappropriate behaviour and take remedial action. These actions are to be evaluated through future patient surveys. (G.2.1, p2, p6)

6.1.2 Effectiveness and Outcomes

1 The 1999/00 and 2000/01 CG annual reports included discussions on the clinical indicators which were produced in July 1999 and July 2000. The CI for "% of patients discharged to usual place of residence within 56 days of emergency admission with a stroke (aged 50 yrs or over)" showed poorer performance for the trust than average. However, the trust argue that this is not an indicator of **quality** of care and refer to the fact that PCHT is in top 10% of trusts reviewed as part of National Sentinel Audit of Stroke 1998-1999 (File1 6.4.1, p4; File1, 6.4.2, p3).

2 The 1999/00 CG annual report sates that the trust participated in the National Sentinel Audit of Stroke in 1998 and 1999. The audit examined a number of different aspects of stroke care. Overall the results in 1998 showed PHCT to be in the top 10% of Trusts and results in 1999 showed a further improvement. The 1999 National Sentinel Audit of Stroke showed that PHCT scored well above the mean national values recorded for trusts for process of care and organisation. (File1 6.4.1, p5; X.6, p2).

3 The 2000/01 CG Annual report considered clinical indicators which were published in July 2000. The emergency readmission rate within 28 days of discharge from hospital for PHCT was slightly poorer than the average for England and Wales. The trust carried out an audit of its readmissions and found that most readmissions to the trust were due to the emergence of anew problem rather that due to a recurrence of the presenting problem on the first admission (File1, 6.4.2, p3).

4 The Dryad (09/01), Daedalus (22/05) and Sultan Wards (09/05) all had their nursing practice audited this year. The results were very positive and of the 40 points available they scored 37, 37 and 39 respectively. The Senior Nurse Specialist from infection control services commended the wards although warned against the dangers of re-sheathing needles (E6.1).

6.1.3 Access to Services

1 The August 2000 Divisional Review noted that physiotherapy waiting lists were beginning to come down now that the new locality manager for Fareham and Gosport was in place. Long waits at Gosport WMH were still causing some concern (Section 3.5).

6.1.4 Organisation of Care

1 A final monitoring report for intermediate care has also been provided, March 2001, source unknown. The report focuses on schemes that finished in March and were funded for the winter months only. Lessons for future investment, which are also relevant to implementing the NSF for older people included Geriatric Team managing outliers at QAH. Several issues were raised relating to the outliers at QAH. Patient issues, particularly the impact of multiple moves, handovers and premature decision-making were identified as problematic. Clinical issues identified as problematic included attitudes of staff in general medicine and on the host ward to outliers, multi-disciplinary notes being taken apart, lack of 'joined-up' ward rounds, communication problems and concerns about a lack of knowledge about nursing older people. Organisational and management issues include concerns about accountability but also recognising that the medical assessment unit works well and could have a specific prevention role (A 3.1).

6.1.4.1 Stepping Stones

1 GWMH) have developed 'Stepping Stones', a group for patients who have been discharged from the ward and want to continue with exercise activities. The Team Leader in Physiotherapy and the Assistant Physiotherapist is leading this project. The pilot group is made up of 8 discharged patients who have all experienced a stroke. The programme is divided up into 6 sessions, once monthly. Transport has been arranged so patients can attend their preferred events. The group have attended a tea dance and an over 50s instructor has invited all members to attend activity groups (E7.3).

6.1.4.2 NSF

1 The May 2001 Minutes of the CG panel states that there is a District Implementation Group for the NSF for Older People. The NSF was welcomed but concerns were expressed as to how to achieve the cultural change required (File1, 6.6.6,).

2 The Trust supplied information about the IOWPandSEH HA NSF Older People Steering Group (B1.1) The terms of reference stated that the group would:

- Produce an agreed district-wide framework
- Oversee a baseline of current services
- Ensure that implementation of the NSF is embedded into mainstream plans and accountability arrangements in represented and partner organisations

3 In addition, task oriented groups would look at specific areas on stroke; falls; single assessment; prescribing; equipment; and mental health.

4 The steering group met on 9 July and reported progress on setting up of each of the locality implementation teams. Key milestones listed were:

- Stroke service and falls - initial meeting has taken place regarding NSF requirements for stroke; delegates from each LIT were requested. Work on falls is at an early stage, and programmes of work from each of the localities would need to be integrated.
- Single assessment process – names had been suggested for the sub-group. It was noted that there was an opportunity to design a local tool.
- Prescribing issues – some names for the sub-group had been suggested, although GP nominations were still required. A meeting was required between mainland and island pharmacists.
- Equipment – one of the steering group members had attended two meetings of an equipment sub-group set up by Portsmouth City. There is an issue around pooled budgets and different VAT rules. A joint workshop was planned for 25 July 2001. A continence service sub-group would be set up from the equipment group.
- Mental Health – not yet underway.

5 The steering group received a regional office consultation document on suggested performance indicators. It was noted that some of these overlapped with social services. A quick response to the document was required.

6 A representative of the health authority presented the regional office local modernisation review. There was no firm RO guidance on completion of this,

however it was expected that, while there may be some local interpretation, the overall views across the health economy should match.

7 The trust also supplied a progress report (undated) on the Older Persons NSF Fareham & Gosport Locality Implementation Plan (B1.2)

8 The (undated) progress report states that the group has met twice, agreeing terms of reference and membership. Progress in implementing the NSF has included:

- Work on age discrimination in access to services
- Formation of a sub-group and development of a project brief to review information available on services to older people
- A review of intermediate care service, including holding a workshop in September *{2001?}* and carrying out interviews with service users
- Work on falls prevention
- The formation of a locality stroke group
- Agreeing a local communication plan (B1.2)

9 Gosport is part of an ortho-geriatric development group to improve the care of older people with orthopaedic injuries in the NSF. The group want to re-designate 40 T&O beds as a jointly led Ortho-geriatric ward and 27 geriatric rehabilitation beds are ring-fenced for referrals from the acute ortho-geriatric ward only. They would also like to expand intermediate care facilities to ensure the capacity for referral and care of patients with less complex needs. The group has drafted a timescale and investment proposal for consideration by the Patient Access Group and the Older Person's NSF Implementation Group (E7.1).

6.1.5 Humanity of Care

1 In 1996, there was a clinical audit of shoulder pain (it is unclear if Gosport were involved). As a result there was a planned stroke guidelines review. Training needs were also identified for physiotherapy. Documentary evidence was also lacking and medical notes were not completed to a satisfactory level (E6.9). In 1998, a PHCT re-audit of Hemiplegic shoulder pain was carried out, including 3 patients from the Daedalus ward of GWMH. This pain can impede rehabilitation and result in depression and withdrawal from a programme of care. Clinical leaders conducted a physical exam of the patient to ascertain presence of pain and shoulder joint movement; they then checked the healthcare records. Results showed a reduction of incidence of shoulder pain since the last audit, 30% compared to 42%. It recommended that a lead clinician in each discipline ensure that discussion takes place and action is taken and also identify training opportunities. The re-audit was scheduled for 1999 (E6.6).

2 In 1998 the trust re-audited compliance with handling assessment guidelines in a sample of clinical settings across the PHCT including Community nursing, Community Hospitals and Elderly medicine. A secondary aim of the audit was to identify areas of handling assessment that require manual handling training. The overall action plan was the responsibility of Suzanne Hogg and the manual training advisors. One area for action was to reinforce the importance of the initial assessment 24hrs after admission. Target area for training were

- Record of the patient's weight and diagnosis
- Regular evaluation of the assessment
- Adequate assessment of the environment

- Record of patient preference
- Record of patient's ability at the worst level (E6.7).

3 In 1998, the trust audited the detection of depression in elderly rehabilitation patients. The prompt recognition of depression should reduce length of stay and increase mortality and patient well being. This was a multidisciplinary audit with involvement from consultants in elderly medicine, elderly mental health, clinical psychologists and members of the rehabilitation scheme. The sample included 5 patients form the Daedalus ward at GWMH. The conclusion was that less that a quarter of patients who scored over 6 on the Geriatric Depression Scale were recognised as depressed by the rehabilitation team. An action plan was devised with timescales and responsibility for implementation. They proposed re-audit for 2000/2001 (E6.5).

4 An audit of compliance with bed rails guidelines in Community hospitals was published in August 2001. Considerable variance in the level of knowledge and practice relating to the use of bed rails was found. Long-term actions have been identified and clinical leads assigned to implement the majority of them. The actions include developing a link to the Community Hospitals Falls Strategy Group to develop an assessment tool for using bed rails and to develop a training programme to incorporate all the standards (E6.3).

5 A PHCT wide audit on oral hygiene for stroke patients was completed in April 2000. The audit concluded that documentary evidence of inspection and provision of oral hygiene was lacking and only 15% of patients had an oral hygiene care plan. Issues to be addressed were patient involvement in their care, lack of clear knowledge about the most appropriate treatment options and poor documentation (E6.8).

6 The October 2001 and July 2001 Patient Surveys at GWMH showed a disparity in patient views about catering services at the hospital. Although some commented that meals were "very good", or "splendid", others found the food "dry and stodgy", in need of variety, and criticised the lack of choice. In response to this, the hospital planned ongoing action for the Catering Supervisor to undertake monthly monitoring of patient satisfaction of food by ward. The Support Services Manager was to undertake ongoing monthly monitoring of food and refrigerator temperatures. (G.2.1, p4)

7 The July 2001 Patient Survey at GWMH showed patients felt beverage rounds to be too infrequent. To tackle this, action was to be taken to establish a 24-hour beverage system by April 2002. (G.2.1, p2, p4)

8 GWMH has a hospital shop operated by Volunteers of the WRVS (1.8, p2)

9 GWMH has a chapel for private use of clients & visitors. There is also a hospital chaplain (1.8, p2)

6.1.6 Environment

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 2.7 of Level II, that, *" Domestic services provide a high standard of cleanliness and hygiene in all premises".* Routine and special cleaning arrangements should be in place (2.4, p24).

2 The August 2000 Divisional Review, Key Governance indicators noted that GWMH taps were a risk issue in July 2000, as many clinical areas do not

have mixer taps and scalding water is emitted from both mixer and non-mixer taps in some areas. A complete review of taps was scheduled to be undertaken in September 2000 with action plan for any required work (B2.1 Section 2). The February 2001 review noted that the review of all taps was undertaken and replacement costs calculated (1.13.2 Section 3.4.3).

3 No formal external PEAT visits have been undertaken. The original Trust-wide inspection in 2000 provided a baseline assessment. As a result, to improve hospital food Gosport was to carry out a patient satisfactory survey. In September 2001, the progress report did not specify any real areas for concern at GWMH. The trust action plan has allocated a priority score to the action required. High priorities were linen distribution, review of existing support services contracts and internal tidiness and cleanliness. The PHCT Cleanliness in Hospitals score is yellow (C2.1).

4 All wards at GWMH hold maintenance logbooks to record all maintenance requests. The trust has a planned maintenance programme that details the areas within the hospital and how frequently these assets must be inspected and maintained (C3.1).

5 Concerns about environment raised in the October 2001 and July 2001 Patient Surveys at GWMH were:
- "Smelly pillows"
- Restrictions on smoking
- Ward temperature sometimes too high
- Noise from machinery above
- "The Air Bed" (G.2.1, pp2-3)

6 The October 2001 and July 2001 Patient Surveys at GWMH showed praise from patients for:
- Chairs and furnishings
- Equipment in the bathroom
- Cleanliness (G.2.1, pp2-3)

7 Concerns were raised in the October 2001 GWMH patient survey about "smelly pillows". The hospital consequently planned for Rosemary Paxton to identify the source of the problem and take remedial action, by November 2001. (G.2.1, p5)

8 The results of the October 2001 GWMH patient survey included concern that the ward was too hot. Consequently, the hospital included in its Patient Survey Action Plan plans to place thermometers strategically around the ward by December 2001, to monitor and record the am/pm temperature of the wards following the purchase of these thermometers, and to disseminate these results to the Estates Manager by May 2002. (G.2.1, p2, p5).

6.2 STAFFING AND ACCOUNTABILITY

6.2.1 Workforce and Service Planning

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 3.1 of Level II, that, *"There are sufficient numbers of staff who are knowledgeable and well trained".* Sufficient staff should be available at all times. Staffing should be appropriate in terms of grading, experience and numbers. Staffing levels should be appropriate across the disciplines and in line with national guidelines. Staffing levels should be

reviewed regularly. Users should report that primary or named nurses have enough time to spend with them. Staff should have skills to respond to users special needs – eg deaf patients. A named person from each discipline should care for the user wherever possible. Trusts should have a nominated person who is responsible for monitoring delayed and premature discharges. Staffing levels and skill mix in long term care should have been assessed to meet the needs of users, not on purely financial or historical basis (2.4, p25).

2 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 3.2 of Level II, that "*There are mechanisms in place to review casemix and workload of staff team and individuals".* This includes ensuring that shift patterns and other hours of working are based on the needs of older people and not convenience of staff (2.4, p25)

3 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 5.1 of Level II, that *"Staff Moral is Good"* Vacancies and sick leave should be monitored and investigated. Staff should have access to a staff support system and appropriate occupational health advice (2.4, p26).

4 In December 1999, a four-month review of the nursing staff retention and workload began in the Department of Elderly Medicine. Nursing workload measurement methods were reviewed, results of the staff interviews and questionnaires were presented and trust reports and information from literary sources were also provided. It was widely recognised that in 1999, nursing staff morale was low. Due to the low response rate, the results from the questionnaires have little statistical power but can be used as a baseline assessment against which to compare staff perceptions in the future. It is unclear if any staff from GWMH were part of the process. The results show that although the immediate problem is staff shortages, the underlying problems also need addressing because there were implications for patient record completion, discharge planning and administration of medications. The report made recommendations to address some of the issues that lead to a shortage of clinical nursing time and a programme of systematic development in gerontological nursing practice is proposed (D7.3).

5 A year later, in September 2001, the issue was re-visited. It was clear to the review that many changes had taken place within the division, most of which were in direct response to ward sisters request to develop aspects of their role. The trust has managed to avoid bed closures since October 2000 and have reduced their dependency on agency and bank nurses in 2000/2001. A new senior management team started work between Jan and March 2000, and a new clinical leadership structure was established in August with H and I grade nurses. Other significant achievements are:

- Monthly meetings between general and clinical managers
- Regular clinical supervision
- Specialist Gerontological Nursing Development Programme for F and G grade nursing
- Creation of working groups on key topics, like education
- Changes in the bleep-holder system

6 The 2000 report recommended more forward planning for periods of staff shortages, even though agency staffing costs have fallen, they are still too high and concentrated on night nursing at weekends and sickness cover. The skill mix remains disproportionate between junior and experienced staff

on the wards and non-nursing duties are continuing to distract nurses from their primary function of direct patient care (D7.4).

7 The Department of Elderly Mental Health conducted a similar assessment of nurse staffing in May 2001. The aim was to evaluate the staff nursing and suggest ways to improve nursing services. The report concluded that there were both numerical and skills shortages in the division. The nurses interviewed highlighted variations in leadership style and a lack of clinical supervision, long standing staff shortages and low morale as factors that have an effect on the delivery of patient care. Observation also highlighted the lack of clinical supervision and leadership, there are also issues caused by the differing management styles between Fareham and Gosport and St James. The report recommends that the department be run as a whole unit with locality management reporting to general management, a mental health gerontological programme is introduced for all F and G grade nurses and a new clinical nurse career ladder created consisting of one I grade and 2 H grade staff in accordance with the DoH Modern Matron Initiative. As the department is merging to become part of East Hants PCT, a steering group may be necessary to implement some of the recommendations (D7.5).

8 The May 2000 Divisional Review highlighted the following workload issues:

9 Physiotherapy – pressure on staff due to high referral rates. Long consultant waiting lists at QAH and GWMH, reflecting an increase in T&O consultants, with no increase in physiotherapy allocation.

10 OT affected by a blip in maternity, loss of activity to Mencap Home, errors (now coming under control), provision of individual rather than the more effective group therapy (B2.2 section 3).

11 The August 2000 Divisional Review included a proposal to reorganise how the occupational therapy service is delivered across the district (B2.1 appendix 1).

12 Concerns that staffing levels were too low were raised in the July 2001 and October 2001 patient surveys at GWMH. An action plan to address concerns included the following commitments:

- To undertake skill mix reviews in Dryad, Daedalus and Sultan wards by December 2001
- To undertake proactive management of duty rotas (on an ongoing basis)
- To establish baseline staffing levels necessary for safe patient management by the end of November 2001
- To initiate an ongoing protocol for a Senior Nurse or bleepholder to be contacted in the event of staffing levels falling below the safe working establishment, and for a Risk Event Form to be completed in the event of staffing levels remaining below this level
- To undertake quarterly analysis of data collected from the Clinical Effectiveness Department (G.2.1, p4)

13 The 2000/01 CG Report states that the trust had made “huge recruitment efforts” in 2000/01 and employed 60 nurses from overseas. They had all taken part in a “rigorous” induction programme. In March 2001 the trust had an unfilled consultant post in Elderly medicine (File1, 6.4.2, p2).

14 The review of the 2000/01 CG Action Plan (March 2001) states that all staff have contracts and the trust has robust procedures to ensure that all clinical staff have their qualifications and registration checked. The trust has reviewed the balance between workload and staffing levels and skill mix in

all clinical areas where there are, or have been, problems and this would continue. Workforce issues that affect services are reviewed regularly at the Executive Team meetings (File1, 6.3.3, p2)

15 The 2001/02 CG Development plans states that "in common with all trusts achieving adequate number, grade and skill mix of staff within clinical services remains a challenge". Extensive recruitment initiatives were planned for mental health nurses. Significant numbers of staff had transferred to the PCTS and plans were in place to transfer the remaining staff by April 2002 (File1, 6.5.1, p5)

16 Staffing projections were also highlighted at an action-learning meeting held on 8th October 2001 at GWMH (D 3.2).

17 A skill mix review of the intermediate care services at Gosport has been completed (No Date). There will be a change in the use of beds within Daedalus ward to provide 24 community rehabilitation and post acute beds. Dryad ward will have the only continuing care beds at GWMH. The review anticipates an impact on Sultan and Dolphin Day Hospital. In addition there was scope to improve the occupancy of Sultan. The spilt of the 24 beds in Daedalus was planned at 8 slow stream care, 8 fast stream care and 8 post acute beds. The resource implications were estimated at £160,500. The risk issues were identified as:

- Consultant cover – unlikely to recruit a suitable individual prior to January 2001
- Medical risk – more specialist intervention may be required as a result of the change in patient groups. Clear protocols will be required for urgent transfer of patients and timescales within which medical cover can be obtained
- Preparatory Training – Relates in the main to qualified nursing staff. A course, 'alert' has been identified for staff to develop their skills in relation to assessment of changes/deterioration in patient's conditions.

18 The training needs were identified as ECG recording, Orthopaedic rehab, Cannulation and blood transfusion monitoring. In general, they identify other areas in need of a review, including the resuscitation policy and procedures, additional wheelchairs, review of medical supplies and improved daily drug ordering (D7.2).

19 The May 2001 Divisional Review noted that the review of night staff skill mix at GWMH following the closure of the minor injuries unit had now been completed. This had established some grading issues and recommendations will be implemented following discussions with staff concerned (1.13 Section 5.1 / 6.2).

20 PHCT has pledge status for Improving Working Lives. (A.1.2.1, p12)

6.2.2 Medical Staffing and Accountability

1 The medical accountability lies ultimately with the Trust Medical Director. The Lead Consultant for Elderly Medicine reports to the director and is responsible for the Dryad and Daedalus wards. The Elderly Medicine consultant in each ward reports to the Lead Consultant. Junior doctors are accountable to the Consultant in Dryad ward and Local GP practice contact for out of hours medical cover is accountable to the Consultant in Daedalus ward (1.2).

2 The Lead Consultant job description has 12 different areas for the individual to manage. These include leadership, service development, staff management, quality, complaints and corporate. The description clearly states that the job is a major challenge for a 'very part-time role'. The post-holder is not expected to carry sole responsibility for discharging these functions and it is recognised that all consultants will contribute to many of the tasks (1.3).

3 The trust has provided the GP contracts for trust working, for all GPs. They are legal documents, and describe very little about their role, only that they can admit patients to GP beds and must care for all patients in GP beds (D6.1a, D6.1b, D6.1c, D6.1d). They have also sent the leavers from the bed fund since 1.1.98 (D6.1e).

4 The trust has provided the contract for services agreed between GWMH and the GP practice which serves the Daedalus and Dryad wards (D6.2).

5 The GWMH has a clinical assistant post, whose role it is to attend the day hospital in the mornings to deal with ongoing medical problems of the visiting patients, review the drug regimes, co-ordinate referrals and discharges and help formulate a new treatment plan for all new patients (D6.3).

6 The role of the staff grade physician is to look after 20 continuing care/slow stream general rehabilitation patients on Dryad. Duties will include:
- Admitting patients transferred from other wards
- Day-to-day medical care of these patients
- Communicating with patients and relatives
- Liaison with EM and other departments (1.4).

6.2.3 Nursing Staffing and Accountability

1 The trust has supplied a nursing accountability structure. Nurses are accountable to a clinical manager in each ward of the hospital. The clinical manager is accountable to the senior nurse, Toni Scammell, who is in turn accountable to the Service Manager Jan Peach. She is responsible for GWMH, OPD and St Christopher's hospitals and is accountable to the General Manager for the Fareham and Gosport Locality Division. The General Manager is accountable to the Nursing Director and the Operational Director (D1.1).

2 The H Grade is responsible for the Continuing care, Rehabilitation and Day Hospitals at GWMH, accountable to the service manager. They key responsibilities are to
- Work closely with service manager, EMH co-ordinator, St Christopher's H grade and Clinical managers to develop services
- Ensure staff understand and adhere to Trust and departmental policies
- Co-ordinate recruitment and workload within designated area of responsibility
- Take part in audit, ensure action plans are implemented and monitored
- Advise management team on clinical issues and developments (D1.7)

3 The key responsibilities of the Clinical Manager (Grade G) are
- To take continuing and overall responsibility for the maintenance of appropriate standards of care
- To provide leadership to the nursing staff
- Ensure adequate skill mix
- Ensure completion of Nursing Care Plans and Discharge care plans

- Plan and participate in the induction programme for staff
- Ensure nursing staff receive regular training in fire prevention, emergency procedures and control of infection
- Formulate training plan for the ward (D7.1).

4 The key responsibilities of a Senior Staff Nurse Night Duty (Grade F) are:

- Deputise for night sister as required
- Participate in training and support of junior staff
- Monitor performance of staff and participate in annual appraisals
- Participate in the writing, application and monitoring of nursing standards and audits as requested (D7.1)

5 Currently, the breakdown of staff on each ward for day duty is: (Volume Y)

	Sultan Ward	Daedalus Ward	Dryad Ward
Clinical Manager	1	1	1
Senior Staff Nurse	1	1	1
Staff Nurses	8	5	6
Enrolled Nurses	1	3	1
HCSW	12	12	8
Bank/Student Nurse	0	1	0
TOTAL	**23**	**23**	**17**

1 Night Duty Staffing is:

	Sultan Ward	Daedalus Ward	Dryad Ward
Clinical Manager	0	0	0
Senior Staff Nurse	1	1	1
Staff Nurse	3	4	4
Enrolled Nurse	0	1	2
HCSW	6	6	7
TOTAL	**10**	**12**	**14**

6.2.4 AHP Staffing and Accountability

6.2.5 Other Staffing and Accountability arrangements

1 PHCT have a staff support framework. Occupational Health has introduced a Risk Identification form as part of the recruitment and selection process to ensure the right person for the job is selected. The framework states that all staff should be aware of the need for risk assessments, including on a day-to-day basis as different circumstances arise. All staff should have safety awareness training as part of their Induction programme and line managers should receive additional training in providing support to staff. Following an incident, a review should take place as soon as possible and should include an incident de-briefing session with all staff involved. Managers should follow up after the debrief to ensure that those staff who need support are receiving it (D4.4).

2 There is an operational policy for the use of bank and agency staff for the Fareham and Gosport division. There must be a monitoring system in place

in all clinical areas to ensure the appropriate use of staff (D5.1). The strategy for employing locum staff states that in order to minimise risk, locums will be recruited locally, trust staff will be used or locums must come from a known and trusted agency (5.2).

6.2.6 Out of Hours arrangements

6.2.6.1 Night Staffing

1 A GWMH key objective for 1997/98 was to enable E grade nurses to be in charge at night if necessary. E grade nurses therefore received training and an ongoing commitment was made to support them in 'acting-up'. (A.1.2.13, p4)

2 In November 2000, the Senior Nurse Co-ordinator (Sue Hutchings) completed a night skill mix review in GWMH following the closure of the Minor Injuries Unit. The objective of the review was to identify the grades on each ward, how the grades are distributed across wards and how clinical managers should take 24 hr responsibility for their ward. The Night sister was based on the Sultan ward and it was decided that two F grades would be needed to support her on the Dryad and Daedalus wards. The F grades work opposite shifts to each other and the G grade to ensure the hospital has cover. The night sister confirmed that E grades do have to take charge of the Hospital quite regularly.

3 The clinical managers have responsibility for their ward and at the time of this review, the clinical managers on the Daedalus and Dryad ward were responsible for their night staff off duty. The Night Sister on Sultan ward takes on this responsibility for the ward.

4 The distribution of staff across the three wards revealed that Sultan had less E grade hours and no F grade but they did have 1 WTE F grade. Daedalus has .67WTE for F grade but unable to fill the post and so an E from sultan has been 'acting up' to F full-time until 31.10.00. All three D grade posts were vacant. Dryad had less E grade than Daedalus but has got .67WTE F grade in post.

5 Issues raised from the November 2000 study were:
- D grades were regularly taking charge of wards at night.
- Only one trained nurse on wards at night, and this could be a D grade
- Is there still a requirement for a G grade on nights?
- Was there a trained nurse establishment deficit?

6 Further analysis was undertaken to answer the resulting questions. These issues were all investigated in Dryad and Sultan wards. In Dryad, through Maternity Leave and Sickness, two nurses were absent from work. The review concluded that this ward had been short of an E grade since 1999 as a result. D grades have filled the gap of these staff members. There were no vacancies on this ward. On Sultan ward, two staff nurses, Sn Dolan and Sn Dunleavy do take charge on frequent occasions, but not always on their own ward.

7 To cover all wards safely, GWMH require a minimum of two trained with support from two unqualified. At present (28/03/01) the only ward with this ratio is Daedalus. However, this ward does have vacancies of 50 hours D grade. These posts have been unfilled since September 2000.

8 The analysis reviewed the use of G grades on night duty and concluded that they are still responsible for emergencies when they arise, completing night rotas and covering the breaks but these hours could be converted to an F grade.

9 Skill mix gaps were identified at a cost of £44,310. If the gaps are not funded, the D grade will be required to continue to 'act up' and the use of bank/agency staff will continue. If bank/agency staff cannot be arranged to cover, the Hospital will continue to be vulnerable.

10 The report recommended that the G grade be downgraded to an F grade to enable the funding of upgrading D to E on Sultan. 30 hrs D grade to be upgraded to E grade on a temporary basis until a decision has been made regarding the member of staff on sickness leave. All night rotas to become the responsibility of the clinical manager. These actions were due for completion by April 2001 and July 2001 for the downgrade from G to F (D7.1).

6.2.6.2 Other

1 The trust's response to a complaint (on Sultan ward) states that GWMH did not have doctor or a pharmacist on site twenty-four hours a day. Medical cover is provided by the admitting GP, who visits regularly (usually daily) and when requested by the nursing staff. Twenty-four hour medical cover is provided through the general practitioner practice on-call arrangements. A pharmacist also visits the hospital regularly and pharmacy deliveries are made daily (Z1.2).

2 A memorandum from PHCT for 'senior managers on call' has been supplied, 29th September 2000. The memo alerts senior managers to a new divisional on-call bleep effective from 2nd October 2000 (D 2.3).

3 A memo regarding duty doctors outlines procedures in the Sultan, Daedalus and Dryad wards and the minor injuries unit, date and source unknown. In the Sultan ward, patients are looked after by their own GP and the after hours emergency number for the practice should be contacted. For the Daedalus and Dryad wards, patients come under the care of Dr Barton and if required after hours the practice number should be contacted. The memo also refers to requests from doctors that any equipment or dressing borrowed should be logged, and drugs should not be provided unless in an emergency situation (D 2.3).

4 A further memo refers to bed availability in the Sultan ward, date and source unknown. It states that during the 'handover' period, 8.15pm-8.30pm, it should be known what beds are available should a doctor request an admission during the night. The bed statement book can also be referred to for this purpose. Refused admission should be logged in the Bed State Book. Admissions to the elderly service beds are dealt with by the geriatric office and the Mulberry ward arrange their own admissions (D 2.3).

5 If a patient is transferred from an acute ward on a Friday after 2pm, the patient will not be seen until Monday morning (E1.1)

6 Memos in relation to the 'emergency procedure in the event of telephone system failure' for GWMH and for the estates services emergency call-out maintenance facility are also supplied, dates and sources unknown (D 2.3).

7 An out of hours procedure for obtaining medical records is provided, date and source unclear. It gives the bleep number at the main hospital records department at QAH, a short guide to file numbering and a floor plan of the medical records department (D 2.3).

8 Reception cover at weekends and bank holidays was discussed at an action-learning meeting at GWMH held on 8th October 2001 (D 3.2).

9 It was noted at the GWMH Clinical managers meeting (November 2001) that all clinical managers have 24-hour accountability (D3.2)

6.2.7 Team Working

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 2.2 of Level II, that "*Each staff team has a stated purpose, aims and objectives that relate to the service"* Each team should work to a shared philosophy of care that is responsive to the needs of older people and ensures that they are actively involved in the care they receive (2.4, p23).

2 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 2.1 of Level II, that "*Arrangements are in place for effective liaison between disciplines, departments and levels of care*". There should be effective multidisciplinary clinical meetings, of adequate frequency. There should be evidence of good communication within and between all levels of staff. Staff from hospital geriatric departments should be involved in hospital management arrangements to ensure efficient use of resources, regardless of organisational structures and responsibilities (2.4, p23).

3 PHCT's Training on Demand – Working in Partnership document has been provided. This is a guide for trainers in how to provide the Working in Partnership training session. The session is aimed at all staff providing direct care to elderly patients, and aims to increase awareness of partnership working and enhance the quality of such working. The session is to enable participants to state the qualities/skills necessary to facilitate effective partnerships, to prepare a Charter for effective partnerships, and to identify and be able to deal with issues preventing them from implementing this Charter. The course is designed to focus on the underpinning principles of partnership working, and therefore does not have great emphasis on day-to-day working. There is no evidence of uptake for this course. (G.3.2, p2)

6.2.8 Recruitment and Retention

1 There were difficulties in recruiting staff to the Department of Elderly Medicine throughout 1999-2000, due to a national shortage of trained staff. One ward at PHCT **[doesn't say which]** had to be closed during the winter due to staff shortage. (A.1.2.4, p3)

2 Recruitment into Community Hospitals and GP Bed environments is a problem throughout PHCT, but the problem is particularly acute in Fareham and Gosport. (A.1.2.4, p17).

3 The February 2000 Divisional Review noted that staffing vacancies on night duty at GWMH had caused the closure of the minor injuries department on three occasions (B2.3).

4 There were 9.3 wte vacancies in Fareham & Gosport Community Hospitals in 1999/2000. An Open Day was planned in March 2000 in response to recruitment difficulties. (A.1.2.5, p2).

5 The November 2000 Divisional Review highlighted, amongst other human resources issues, that it was difficult to recruit qualified night nurses. At the end of the quarter there were 11.8 wte vacancies for qualified nurses. This included the new demand for the intermediate care service. There were four exit interviews received from the twenty-two staff leaving the division in quarter two 2000/01. During 2000/01 absences were consistently lower in the Fareham & Gosport division than the overall trust figures (1.13.3 Section 6.1).

6 The February 2001 Divisional Review noted that there were four exit interviews received from the thirteen staff leaving the division in quarter three 2000/01. Absences continued to be consistently lower in the Fareham & Gosport division than the overall trust figures (1.13.3 Section 6.1).

7 The May 2001 Divisional Review noted that absence due to long-term sick leave had been high on Sultan ward during that quarter due to the clinical manager and senior staff nurse being away for a lengthy period (1.13 Section 6.2)

8 The August 2001 Divisional Review noted that following complaints at GWMH, staff morale remained low, with ongoing support being given (1.13.1 p1).

9 The PHCT Annual Plan for 2001/02 states that, despite staffing pressures, staffing levels across all services provided by PHCT have remained acceptable. 29 Filipino nurses were trained and started work in 2000 in the trust's Department of Elderly Medicine, with more to arrive in March 2001. However, in contrast, the Community Hospitals Service Plan notes that the increased requirements of the intermediate care agenda meant that Gosport, Havant, Emsworth, and Petersfield Community Hospitals all failed to recruit to the required establishment of staff in 2000/01. (A.1.2.1, p12, p14, A.1.2.2, p2)

10 The trust has supplied a list of all current staff within the GWMH and staff who have left Sultan, Dryad and Daedalus wards since 1998 (volume Y):
- 15 staff have left Sultan ward (3 retired, 3 stayed within the trust)
- 18 staff have left Dryad ward (1 dismissal, 4 stayed within the trust)
- 32 staff have left Daedalus ward (1 dismissal, 3 retired, 9 stayed within the trust).

11 No wte qualified nurses left PHCT from Daedalus ward between 01/10/00 and 30/09/01. 3.2 wte (28%) of qualified nurses on Dryad ward left the Trust between 01/10/00 and 30/09/01. 1.8 wte (15.5%) of qualified nurses on Sultan ward left the trust between 01/10/00 and 30/09/01. (X.2.1)

12 The Hospital has provided sickness levels by ward for the period 1998-2001, in quarters. These levels are unstable for all wards and have been for the entire period. On the Sultan Ward, since 1998 the levels have fluctuated from as low as 1.7% in June, July and August 1999 to their current level July, August and September 2001, of 16%. From the 2nd to the 3rd quarter of 2000, the figures almost doubled from 4.2 to 8.1%. By the end of the 2nd quarter 2001, the figure had doubled again to 16.0%.

13 The Dryad Ward levels have also fluctuated, especially during the 3rd and 4th quarters of 1998, from 5.6% to 9.5% and over the 4th quarter 2000 to the 1st quarter 2001, the levels rose more than three-fold from 3.0% to 10.3%. Having fallen sharply to 1.8% in the following quarter, they saw a similar increase in the 1st quarter 2001. They are currently at 6.8%.

14 Daedalus Ward sickness levels are currently at their highest since 1998, at 12.6%. There was a large increase from 2nd quarter 1998 to 3rd quarter 1998 from 5.8% to 9.1%. (D9.1)

15 GWMH have provided weekly vacancy levels for qualified and unqualified nursing staff from 1999 to 2001. The levels are also broken down by ward. This information is difficult to summarise and establish a true figure for vacancies although it does appear that the levels are quite low (D8.1).

Sickness absence statistics for Daedalus, Dryad and Sultan wards for 2000/01 (X.3.2):

	% Absence by ward		
	Daedalus	**Dryad**	**Sultan**
Oct-Dec 00	8.1	8.3	8.1
Jan-Mar 01	5.0	8.9	11.2
Apr-Jun 01	7.1	10.3	14.1
Jul-Sep 01	12.6	6.8	16.0
Average for year	8.2	8.6	12.4

6.2.9 Schemes of Delegation

6.3 GUIDELINES, PRACTICES & PERFORMANCE MANAGEMENT

6.3.1 General

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 1.1 of Level III, that "Written policies are in place for all relevant aspects of the planning and provision of services" (2.4, p21). Policies should be in place, and regularly reviewed, that include admissions, discharge, caseload, casemix, abuse. Policies for referring patients to day hospitals should be in place. Policies, guidelines and practices should be in place for effective assessment, care planning and review of continuing care. Drug protocols and guidelines should reflect the needs of older people. There should also be evidence that protocols are used effectively. Standard 1.2 states that "There are implemented policies on risk assessment and management" Clinical Risk assessments systems should be in place, ensuring that all areas of risk have been identified, analysed, documented and communicated to all staff service users and visitors where relevant. Staff should be able to identify and manager risks effectively (2.4, p22).

2 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 4.2 of Level II, that "best practice human resources processes are in place" Employers should ensure that there is a clear supervision and appraisal framework" (2.4, p26).

3 PHNT has a corporate policy, adopted in June 1995 and revised in August 2000, setting out the arrangements for the management and development of trust policies. The policy adopts the following principles:
- Integration with the trust's normal management and clinical governance arrangements
- Communication with staff to ensure understanding of the reasons for policy development
- Availability of policies to all staff who need them
- Regular review and audit to ensure compliance

4 The policy identifies the business manager in the trust central office as responsible for maintaining a central register of policies, sets out what information is to be kept on this register, and how policies will be distributed to relevant people in the trust. The policy also sets out which headings should be used to group the contents of policies that are being developed, which groups should be involved or consulted with, and how often they should be reviewed (2.4.1).

6.3.2 Patient Transfer

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 7.3 of Level II, that *"monitoring systems are in place to review and ensure the effectiveness of discharge planning"* (2.4, p30).

6.3.2.1 Standard Procedures

1 Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts have a joint generic transfer document dated November 2000. Patients who are ready to leave an acute ward but not ready to return to full independence are transferred to a GP step-down bed to create acute capacity and provide post acute care close to the patient's home in a more appropriate setting. Medical cover is provided by the patients' own GP. 24hr medical cover is not available on site. The document lists criteria for transfer:
- Medically stable for at least 24hrs but not fit for discharge
- Expected length of stay 4-14 days
- Patient must not be confused or behaviourally disturbed
- Discharge date and destination known
- Patient and carers consent to transfer
- No outstanding results from inpatient investigations (E1.1)

2 The initial decision to transfer should be taken from the consultant together with a multi-disciplinary assessment and with informed consent form the patient and carer (E1.1)

3 Gosport War memorial has locally agreed arrangements for transfer to the Sultan Ward. The document states that rehabilitation personnel and an Enablement service have been developed to compliment the existing transfer process. In 1998 strict criteria were developed for the transfer of orthopaedic patients and these were refined in 1999 for surgical patients. The criteria to meet are
- No intravenous line
- Haematologically stable
- Apyrexial
- No discharging wound

- Not recently stated on anticoagulation
- Not suffering from an unstable medical condition
- Not catheterised
- MRSA free
- Not confused
- Anticipated medically fit for discharge in 7 days

4 The document also lists the items that must be provided on transfer. It included complete medical notes, care pathways, drug chart, non-stock medication, follow up appointment etc. (E1.1).

5 If a patient arrives after 2pm on Friday, they will not be seen by a GP until Monday.

6 PHCT have a procedure for the initial management of medical emergencies in GWMH, detailing the roles and responsibilities of the member of staff discovering the emergency and the team response. There are also recommendations for educational needs and for post event actions (E8.1). No date on the document.

7 Guidelines for admission to Daedalus Ward were produced on 04/10/00 to be implemented on the Ward's beginning to admit fast and slow stream stroke patients as well as those for general rehabilitation. (G.4.2) There are to be no direct admissions to the ward. Instead, patients are to be transferred to the ward following assessment by a Consultant, SpR or Staff Grade in Elderly Medicine. Admissions to the ward must take place in the morning, or before 4.30pm at the latest, and will be seen by Nursing and Medical Staff on the day of admission. Notes, Xrays and any other relevant documentation are to be sent with the patient on transfer, any information on special diets, enteral feeds, pressure sores, handling requirements or oxygen therapy is to be phoned through to the ward before transfer. (G.4.2, pp2-3)

6.3.2.2 Admission and Discharge

1 The Health Records Core Standards and Procedures document was produced in December 1998 and updated in May 2001. It provides guidelines on admission and discharge procedures. The admission process is in accordance with national and local requirements and explains who can admit a patient, whose responsibility that patient is and how to enter their details into the hospital records. The document also states that a Discharge Summary form should be generated when a patient is admitted and is kept on the ward until the patient is ready for discharge. The form is completed to inform the GP of discharge details, a copy is given to the patient and kept in their record. The form is also now being used to send to pharmacy for TTOs. Details on the form should include the follow-up care e.g. dates of further appointments, follow-up arranged with the primary care team and day hospital (E2.4). Guidance notes for completing the summary form were also provided (E2.5)

6.3.2.3 Other

1 The trust has a referral form for the transfer of elderly patients to old age psychiatry (E4.1).

2 An urgent consultant memo for all medical and nursing staff on Daedalus and Dryad wards at GWMH has been provided, dated 19th November 2001. It outlines what to do in the event of a suspected fracture and/or dislocation in a patient on the ward. Guidelines are as follows:

3 Ensure the patient is comfortable and pain free

4 Call out the Staff Grade or duty doctor (out of hours)

5 If after a medical examination a fracture and/or dislocation cannot be confidently excluded an urgent X-Ray must be arranged. If this is not possible at GWMH, the patient must be transferred to the nearest A&E department irrespective of the time of day

6 If, for any reason, this is not done this must be discussed with the next-of-kin and documented in the medical and nursing notes

7 If there is any concern about making the right decision the duty geriatrician should be contacted via the QA switchboard (D2.1).

8 A similar urgent memo was circulated for the Daedalus and Dryad wards at GWMH from the same consultant on December 20th 1998. The only instruction that was different was number (2) which directed staff to contact Dr. Jane Barton or the duty doctor (D2.1).

9 The May 2001 Divisional Review noted that discussions have begun with service managers within Portsmouth Hospitals to introduce a more client centred service delivery, which should produce more robust discharges (1.13 Section 3.6).

10 The May 2001 Divisional Review noted that Sultan ward had been participating in the Portsmouth Hospitals planned hip replacement pilot, where surgery is carried out at Nuffield hospitals and the patient then transferred back to GWMH on day 5 (1.13 Section 7.1.1).

6.3.2.4 Winter Escalation Plans

1 Portsmouth Healthcare NHS Trust have provided a copy of their winter escalation plans for elderly medicine and community hospitals, undated. The document outlines the process for dealing with bed shortages in elderly medicine, which has a consistent bed occupancy of 90-95%. Elderly medicine should contact community hospitals, PHT and the nominated executive director, and community hospitals will be asked to identify the number of empty beds and patients who could be discharged at short notice (D2.2).

2 Community hospital managers should alert rehab teams and transfers of patients should ideally be within the patient's locality. Patients who are willing to be transferred to a different locality can then be identified and, in extremis, transfers to other locations may be necessary without consultation. GPs will be alerted if their beds in community hospitals are needed and patients requiring emergency medical admission will be admitted to PHT in the first instance if there are beds available (D2.2).

3 The document also notes that elderly medicine should take account of bed shortages in PHT. PHT will be responsible for notifying it's alert stats to elderly medicine in this instance and elderly medicine will, in turn, alert the community hospitals (D 2.2).

4 There are three levels of escalation to alert status. The duties of eldely medicine, community hospitals and therapy services, for each of these

levels, are outlined in the plan from level 1 to level 3 - red alert status (D 2.2).

5 Red alert status is defined as total occupancy of QAH, St Marys and Haslar Hospitals of over 100%, with trolley waits in A&E of over 12 hours. The processes for dealing with this, including occurrences during out of normal working hours, are specified. Processes for referrals of elderly patients for inpatient admissions are included in these red alert guidelines (D 2.2).

6 Staffing contingency arrangements, both day and night, are given in the appendix of the plan along with monitoring advice, and the duration of the arrangements is specified as 2-4 weeks in agreement with other staff while other resolutions are planned (D 2.2).

7 The GWMH clinical manager's meeting in November 2001 noted that patients were sometimes being transferred to Sultan ward while they awaited a bed on Daedalus ward, and this was a concern. Continuing care transfer information (produced by the continuing care forum) was highlighted as useful for wards to use when receiving patient information from the transferring ward. Clinical managers were to discuss this with their own staff (D 3.2).

6.3.2.5 Admission and Discharge Policy

1 The Trust provided a copy of the Portsmouth and SE Hampshire District Wide Admission and Discharge Policy which was formally adopted for use within PHCT (G.4.1). It states that local admission and discharge procedures may need to be amended to reflect standards within policy. It was produced by The Quality partnership Panel in July 2000 and was to be reviewed by Code A the Quality manager in conjunction with the Quality Partnership Board. It states that the standards in the policy are based on best practice and that exceptions should be rare. The patient's wishes are paramount. The policy applies to all care groups and sets the principles for planning discharge care. Any specific guidance should augment rather than replace the policy. Managers are responsible for ensuring that all staff involved in the discharge process are understand the requirements of the policy. The PHCT Admissions and Discharge policy is monitored and audited by the Quality Partnerships Group. The standards for the different stages of admission and discharge planning are given.

2 Standards for admission include:

3 Referral letter should include agreed information. This included an outline case history, treatments to date, indication of special needs of person and all available information affecting the patient's health which is likely to affect any discharge needs

4 Responsibility of other organisations to share information on social circumstances to facilitate discharge planning

5 Admission care assessment should highlight need for referral to other services

6 Anticipated length of stay should be documented and shared with carers/carers within 24 hrs of admission and then reviewed regularly

7 Standards for Inpatient Episode include:

8 Named nurse is responsible for coordinating the discharge plan

9 Each patient's care plan should include information on discharge planning

10 Patients/carers/relatives should participate in the development of a discharge plan and be kept informed at all stages and should be informed of planned date at least 48 hrs in advance
11 Patients carers relatives should be informed of what services are to be provided after discharges and involved with any subsequent home visits

12 Standards for Discharge from hospital include:
13 Discharge should only take place when the responsible clinician states patient is medically fit for discharge, in consultation with multi-disciplinary team and all support services
14 Discharge checklist should be completed prior to discharge. This included any outpatient appointments, assessment of patient/carer skills, any other referrals needed, advise to carers, aftercare arrange s made, Medication TTOs etc prescribed or issued, nursing transfer form needed/completed
15 TTOs should be prescribed at least 24hrs in advance and should be supplied for 7 days (unless course is shorter) and should check that patients/carers understand the medication and any other treatments
16 Provider spell discharge summary should be completed and sent to GP within 24hrs of discharge and a copy given to patient. This included discharge diagnosis, key investigations/findings, treatments, medication details, follow up plan, date of admission and discharge
- On transfer of care a Nursing Transfer letter should accompany the patient. This includes details of patient, diagnosis, information given to patient/carer regarding diagnosis/prognosis and understanding of condition, treatment/intervention required/summary of care/treatment in hospital/ Waterlow and/or Barthel score where appropriate (G.4.1, p13)

17 The Admissions and Discharge Policy also states that a Joint Community Care Agreement was agreed by Hampshire County Council Social Services and P&SEHH Commission in 1993 and was still in effect, but was due to be reviewed in 2000/01. It includes a Joint Policy for Hospital Discharge.

6.3.3 Do Not Resuscitate

1 PHNT has a resuscitation status policy, produced in October 1995 and revised in January 2000, which sets out the system to be used by staff for deciding and recording decisions on the resuscitation status of the patient. The policy also gives guidance on when to communicate decisions on resuscitation status to patients and relatives (2.4.6).

6.3.4 Palliative Care

6.3.5 Nutrition and Fluids

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 2.6 of Level II, that, *"The catering service provides a high standard of food to patients, staff and visitors"*. Assistance should be given to ensure users can enjoy their meals and receive the nutrition they need. Special eating utensils are available for people who need them (2.4, p24).

2 As part of a five year strategy towards a Feeding People Policy for Portsmouth Healthcare NHS Trust an audit of minimum nutritional standards was undertaken between October 1997 and March 1998. The aim was to

collect baseline data to be used to plan teaching for staff and lead to a redefinition of standards. As a result of this audit the Feeding People Working Group developed these standards, based on DoH guidelines. The audit also established a Lead Nutrition Person in each clinical area to plan teaching programmes for staff (E6.11). A re-audit was conducted in 2000 and draft action plan was formulated in November 2001 detailing the staff member responsible for the implementation and the implementation date. The audit noted that there appears to be poor documentation rather than poor practice in some areas, specifically acting on significant weight gain/loss. The re-audit concluded that, "overall the results had improved although there may be an element of complacency, as locally written protocols recommended from the 1997 audit have not been produced. Long stay areas must not get complacent just because they tend to know their clients well and their eating habits" (E6.2).

3 The Trust provided a copy of its "Policy for Prevention and Management of Malnutrition within Trust Residential and Hospital Services" (File2, 4.8). This was produced by the "Feeding People Sub Group" in Nov 2000 and was to be reviewed in Nov 2001. The purpose of the policy is to "ensure that appropriate action is taken within each service where there are patients so that individual nutrient needs are managed effectively" It provides a framework which applies to all staff who directly or indirectly are involved with feeding people and it is supported by the '*Feeding people'* minimum standards. The policy defines the core standards, key areas of responsibly, requirements and audit functions. The Service Agreement / Planning Groups are responsible for ensuring that the 'Feeding people ' standards are implemented in each clinical setting and that performance against these standards is audited. They must also ensure that resources, equipment and training are provided. The 'Feeding People Steering Group' is responsible for developing an education and training strategy, advising on changes in standards of clinical practice, training or equipment and ensuring that standards are being maintained by regular audit and monitoring. It is the responsibility of all practitioners and support staff to ensure that patients are appropriately fed. The policy states that all patients must have a nutritional risk assessment on admission, Registered nurses must plan, implement and oversee nutritional care and refer to appropriate professional as necessary. All clinical areas should have a nominated nutritional representative who attends training/updates and is a source for colleagues. Systems should be in place to ensure that staff have the required training to implement and monitor the 'Feeding People ' Standards.

4 The Feeding People Standards Include:

5 Patients to be weighed within 48 hrs of admission and at least monthly thereafter.

6 Any significant weight loss or gain to be reported to medical staff and recorded in notes

7 All patients to have nutritional assessment on admission

8 There is a designated member of staff responsible for nutrition on every unit

9 Those who need help will get help from staff at meal times

10 Appropriate action is taken in relation to a person's eating habits

11 There is a procedure for informing temporary staff of a person's nutritional needs

6.3.6 Pressure Ulcers

1 PHNT has a policy for the prevention and management of pressure ulcers, produced in February 2001. The policy adopts the Royal College of Nursing (RCN) 2000 guidelines in its entirety, with some local specific additions for PHNT. The policy also incorporates a January 2001 revised version of the local approved guideline for the assessment and management of wounds, first written in 1994 (2.4.7).

6.3.7 CPR

1 The 1999/00 CG annual report states that the trust revised its CPR policies and guidance for staff (File1 6.4.1, p4).

2 The November 2000 Divisional Review included an attached paper (dated 09/11/00) detailing "the most important clinical risk issues facing the division". These included recording of CPR status in patient's notes in Elderly Mental Health, associated with a lack of medical infrastructure in Fareham and Gosport. An action to address this is for consultants to regularly check notes written by junior staff. However, there is a time issue involved, and the view of the lead consultant is that there is insufficient medical support to these wards (1.13.3).

6.3.8 Patient Records

1 The trust provided a copy of its "Policy for Client Records and Record Keeping". It was originally produced by Code A (Risk advisor) and revised in August 2000 by Code A (Clinical Risk advisor). The Policy was approved by the Executive Group and is due to be reviewed in Dec 2001. The policy is based on the requirement of HSC 1999/053 "For the Record", Access to Health RecordsAct 1990 and other guidelines produced by the NHSE, Audit Commission and Professional Organisations. The policy outlines a set of minimum requirements for the generation, maintenance and content, confidentiality and access, audit and multiple agency records contemporaneousness of clinical records. Service Lead Groups are responsible for developing specific guidance for staff working in a service or care group within the general framework of the policy and Service managers are responsible for ensuring that staff are conversant with the requirements of the policy and for checking and auditing compliance. It is the responsibility of each practitioner to ensure his/her record-keeping complies with this policy. The policy stipulates that annual auditing of clinical records should take place and feature in the annual clinical governance plans and reports (File2, 4.13; E2.2).

2 Portsmouth Healthcare NHS Trust has developed a Records Strategy (2001) that addresses the issues of record management, specifically the retention and disposal of records. A recent risk analysis showed that there were risks attached to the management of records. Although it appears that GWMH was not assessed. They were being left in unsuitable places and in some cases staff perceptions and knowledge of what is acceptable were poor. There are no budgets allocated to document management. There is an action plan to address the problems, including having a centrally managed system with a senior manager for the service who will create a policy, work with other NHS organisations for a cohesive approach and create a secure

environment for the records to be stored. There are timescales and responsibilities specified (E2.1)

3 The trust has had a Health Records Review Group for 3 years now to look at the CNST to discuss how standards would be achieved. There is also a Health Records User Group that meets quarterly and consists of admin and support managers to discuss problems and issues at a local level. (E2.1)

4 The Health Records User Group produced a Health Records Core Standards and Procedures document for all specialties within the Portsmouth Healthcare NHS Trust in December 1998, updated May 2001. The document covers guidelines on:

- Patient access to personal information requests
- Clinical preparation
- Clinical reception
- Clinical Coding procedures
- Disposal, filing, and housekeeping of Records
- Making up health records
- Minor injuries
- Out of area treatments
- Patient registration
- Referral letters
- Missing health records
- Deceased records
- Admission process. This is in accordance with national and local requirements and explains who can admit a patient, whose responsibility that patient is and how to enter their details into the hospital records.
- Discharge process

5 In 1998 an audit of patient records was carried out (it is unclear if Gosport was involved) in three specialities, Adult mental health, Elderly mental health and Elderly medicine. The audit revealed the need for action in several areas, especially changing the habits of individual practitioners. A new record folder was in the process of being introduced and will meet standards for document storage if there is compliance. The conclusion notes that it will take years for this to be incorporated trust-wide and therefore new standards for filing records will have to be incorporated into existing systems. The Medical Records User Group is responsible for developing the new filing standards and the generic trust-wide Record Keeping policy (E2.2) also resulted from this audit (E6.10).

6 The 2000/01 CG Report states that a major patient records project was started in 2000/01. This covered the storage, access, data protection and Caldicott requirements for medical records. An audit of clinical record keeping was being undertaken in all services. An annual audit of medical records was to be implemented (File1, 6.4.2, p3; File1, 6.3.3, p3).

7 The August 2001 Divisional Review noted that, as a result of the recent enquiries, the culling of medical notes and x-rays was halted. This was beginning to cause storage problems within PHT. There was also concern within GWMH medical records department that due to the halt on microfiching, the storage space is becoming very congested and similar problems will follow there (1.13.1).

8 The August 2001 Divisional Review noted the following risk event for physiotherapy:

9 Records were lost in transit between the physiotherapy departments at GWMH and Haslar, turning up later at Haslar. Problem arose because the envelope had been addressed to a specific named therapist who was away from the department for several weeks. In future mail will be addressed to the department and not a specific therapist (1.13.1).

10 The 1999/00 CG annual report states that the Medical Director was appointed Caldicott Guardian in 1999/00. The trust also completed an assessment of its policies and procedures in respect of confidentiality in June 1999 and a progress report submitted to Regional Office (File1 6.4.1, p4).

6.3.9 Assessment and Management of Pain

1 The trust has a policy for the "Assessment and Management of Pain". This was produced by Code A in April 2001 and was due for review in April 2003. The purpose of the policy document was to identify mechanisms to ensure that all patients have early and effective management of pain or distress. The policy states that it is the "responsibility of all professionals and support staff involved directly or indirectly in care to ensure that patients/clients have their pain and distress assessed and planned effectively. All patients should be informed of the proposed ongoing care and any need for mechanical intervention. All professionals are responsible for assessment, planning, implementation of action plans, evaluation, clear documentation and liaison with multi-professional team". Service lead groups are responsible for ensuring that pain management standards are implemented in every clinical setting, ensuring that resources and equipment are available, that systems are in place to determine and access appropriate training and that qualified nurses can evidence their competencies and that standards are being maintained by regular audit and monitoring. Locally "agreed" pain assessment and documentation methods should be implemented. A clear, unambiguous prescription must be written by medical staff following diagnosis of type(s) of pain. The prescription must be appropriate given the current circumstances of the patient. If the prescription states that medication is to be administered by continuous infusion (syringe driver) the rational for this decision must be clearly documented. All prescriptions for drugs administered via a syringe driver must be written on a prescription sheet designed for this purpose (1.2, p1-2).

2 Other documentation to support the policy has been provided including:

- A sample of how to complete a 'syringe driver variable dose prescription' sheet with special instructions for analgesics
- A copy of a syringe driver record chart
- A 'pain management cycle' chart
- Copies of audit forms for assessing standards in pain assessment and management (initial assessment, action plan and care plans devised, clinical team meets needs of patient)
- An analgesia ladder which indicates the drug doses for different levels of pain, instructions on how to calculate the opiate dose, what to do once the patient is stable, what to remember when administering pain killers, how to evaluate the effects of analgesia and how to observe for any side effects. It also lists sources of advice (F 4.3).

6.3.10 Prescription Writing Policy

1 The trust has a "Prescription writing policy" which was produced jointly with Portsmouth Hospitals NHS Trust. The policy was approved by the Medical Directors of both Trusts and the Formulary & Medicines Group in March 1998, although the date on the copy was 2000. The policy covers the purpose, scope, responsibilities, requirements for prescription writing, inpatient prescriptions, medicines administered at nurses discretion and controlled drugs for TTO and outpatients.

2 The policy covers all prescriptions, written by doctors and nurses, but excludes some specific issues which are handled separately (Pre-printed prescriptions – individual directorates polices are in force), Intravenous Drugs (see Administration of IV Drugs Policy) Self Medication. It is the responsibility of every member of staff involved in medication process to acquaint themselves of this policy. It is the responsibility of consultants, senior nurse managers and pharmacy manager to ensure that their staff are aware of the policy and it the legal responsibility for prescribing lies with the doctor who signs the prescription (1.1).

3 The Prescription Wring policy states that prescriptions should be written legibly, in ink and should state name of patient, age, generic name of medicine, dose, route of administration, frequency of administration, quantity to be supplied. Signature of prescriber, and date. The ward, consultant name, patient id number, drug allergies and sensitivities, times of administration are also needed for inpatient prescriptions. The policy includes guidelines for documenting change to dose, discontinuing drugs and withholding medication or refusing medication.

4 The policy includes a section for "Medicines Administered at Nurses' discretion". Each directorate must specify these medicines involved in any clinical area and it is only for occasional use. Medicines that require administration on a frequent basis should be referred to a doctor for prescribing.

5 The policy also includes a section on Controlled Drugs for TTOs and Outpatients. (This may not be relevant for inpatients). The Prescription must be written in the doctor's handwriting and must include name and address of patient. Must include form, strength, total quantity, does and frequency (1.1)

6 The policy includes a section on Verbal Order. Telephone orders for single doses of drugs can be accepted by a registered nurse if the doctor is unable to attend the ward. The prescription must be times, dated and signed by the person taking the message, and endorsed "verbal order". The doctor's name should be recorded and the doctor should sign the prescription within 12 hours. Pharmacists operate under a separate protocol (1.1)

6.3.11 Control and Administration of Medicines by Nursing Staff

1 The trust has a Policy for the "Control and Administration of Medicines by Nursing Staff" (F 4.1) . This was produced by the Quality Director (Pam Grosvenor) in January 1997. It was approved by the Trust Board/OMG in Jan 1997 and was to be reviewed in Jan 1998. The policy states that "Registered Nurses are accountable for their own practice in the administration of medicines to patients including establishing their competence and are legally responsible for

2 The correct storage, handling and safe keeping of all medicines and other pharmaceuticals in clinical areas
3 Maintenance of records and registers.

4 Registered nurses also have a professional responsibility to adhere to the professional code of conduct (UKCC June 1992), the scope of professional practice (UKCC June 1992) and the standards for the administration of medicine (UKCC October 1992). Every nurse should, the policy states, have a personal copy of these documents for reference

5 Service Managers are responsible for ensuring that nurses have the necessary resources for carrying out these functions safely and ensuring that they receive the necessary guidelines and training.

6 Detailed requirements are set out in the UKCC document '*Standards for the Administration of Medicines'.* This policy notes the following in particular from this reference document:

- Must check that drug, concentration, dose, route of administration, time and patient are all correct
- 2 people must be involved in administering controlled drugs and in recording it in the Controlled Drug Register. One must be a registered nurse. This may be a competent health care support worker or doctor, but registered nurse is preferred
- HCSW may check Controlled Drugs only if they have been assessed as competent. There is a recommended Trust package for teaching and assessing competence in checking Controlled Drugs
- Medicines should not be administered without a written prescription. The 2 exceptions to this are the medicines on the Approved Lists which can be administered without a prescription by a registered nurse and where a verbal order from the doctor is recorded on the prescription sheet.
- Medication errors must be reported to the doctor in charge of the patient, clinical manager or service manager and the patient. A risk event form should be completed
- There should be local arrangements for the supply and storage of drugs and how they can be obtained in an emergency
- A Register of Signatures should be kept so that the identity of person administering drugs can be checked
- Any nurse in charge of a ward or administering medicines is responsible for security of the drugs at all times (File2, 4.10)

7 The UKCC standards will be used as the basis for an audit tool to check practice and the policy should have been reviewed in January 1998 (F 4.1).

6.3.12 Psychiatric Involvement

1 Trust provided a Policy for Psychiatric Involvement (Nov 2001). Patients deemed to have psychiatric problems are given a mental test score, completed on the ward and they will be seen by the ward consultant/staff grade or GP. They will then decide whether to refer the patient to the elderly mental health team. A referral form will be completed and faxed to the EMH offices. If it is a new patient a ward visit will be arranged and once the assessment is completed the EMH a decision will be made to either continue treatment on the ward with back-up from the EMH team or if to move the patient to an EMH bed (E4.2).

6.3.13 Falls Policy

1 Within Community hospitals, development is continuing for a Falls policy using approaches used in other trusts and research form National Falls Guidelines. The group have regular meetings to discuss the training needs of the staff, the falls screening tool and results from the staff questionnaire Members of the Community Hospital Falls Working Group are linked to the NSF Falls working group. There is a falls prevention strategy that lists the ways to prevent falls, including ensuring the ward is adequately lit and using hip protectors if there is a high score on the screening tool (E7.2)

6.3.14 Whistle Blowing Policy

1 PHNT has a whistleblowing policy, produced in June 1998. This which sets out the processes for staff to report matters of concern regarding patient care, service provision, poor resources, or unsuitable environment that have not been dealt with adequately by normal processes. The policy states that the trust is committed to openness and opportunities for all employees to contribute ideas, express concerns and question the decision of others, including those in positions of authority.

2 The policy will:

3 Provide a way for employees concerned about the care or safety of clients / patients to speak out in the event of other procedures failing or being exhausted

4 Encourage staff to challenge if they believe others are acting in an unethical way

5 Make clear that victimisation or retribution against those who use the policy will not be tolerated, and protect those who appropriately speak out in line with the policy

6 The policy can also be appropriately used where concern over staff safety, corporate governance or use of NHS resources are an issue

7 The policy will be monitored as part of staff satisfaction surveys, through identification of problems and action taken, and through discussions with trade unions via staff representatives (2.4.5).

8 The trust is committed to openness and aims to resolve staff concerns informally between the manager and the individual. If this is not possible, staff can take their concerns to any manager. PHCT requires their managers to take concerns seriously and without prejudice and to act promptly (D4.4).

6.3.15 Violence and Aggression

1 Violence and aggression directed at staff – replaces policy of the same name, written in 1998. It states what to do in a violent situation, how to report the incident and what measures are available to manage such situations. There is also advice on how to prevent this type of situation through training, risk assessments within the trust and providing information about the policy to the patients. All staff receive this leaflet when they commence employment at the trust (D4.4). There is a checklist that summarises the requirements of the policy and should be used to audit compliance with the policy as part of the annual risk assessment process (D4.4).

6.3.16 Complaints Handling Policy

1 PHNT has a policy, (Handling Patient related complaints) produced in January 1997 and updated in January 2000, detailing how staff should effectively deal with complaints. The policy was based on the March 1996 NHS Executive document *"Complaints: Guidance on the Implementation of the NHS Complaints Procedure"*, and also incorporates suggestions made by complainants in a local survey carried out in 1995. The policy sets out the trust and NHSE requirements for acknowledging complaints, and the general guidelines for investigating and formally responding to complainants. The quality manager updated the complaints policy in January 2000, with the next review date given as January 2001 (2.4.2).

6.3.17 Risk Management Policy

1 PHNT has a risk management policy, approved in October 2000, which sets out the framework for implementing the trust's risk management strategy. The policy is intended to link all national risk management standards, including controls assurance, clinical governance, corporate governance, and CNST; it covers clinical, non-clinical, organisational and financial risks. The policy identifies the trust board and chief executive as having overall responsibility for risk management across the trust. The finance director is executive lead for risk management and organisational controls assurance, the medical director the executive lead for clinical risk and clinical governance. The policy also states the responsibilities of the risk management group, health & safety committee, quality managers, risk advisers, and all other committees, managers and staff. The risk management policy sets out the requirements for identifying, assessing and prioritising risks, along with what is expected in action plans to tackle the risk (2.4.3).

6.3.18 Risk Events Policy

1 PHNT has a recording and reviewing risk events policy, produced in 1994 and updated in December 1999 and April 2001, which sets out the system to be used by staff for recording, reporting and reviewing all risk events and near misses. The stated purpose of the system is to:

- Provide data which will alert the organisation as a whole to conditions of risk,
- Promote action aimed at preventing further incidents from occurring
- Promote action aimed at minimising the actual or potential consequences of the event
- Ensure other NHS organisations and external agencies who need to know are made aware of the incident (e.g. primary care trusts, health authority, regional office, police, social services)

2 The policy defines what is meant by risk events and near misses and states the procedures to be followed for reporting risk events and serious adverse incidents, internally and externally. The policy also defines the roles and responsibilities of staff, and includes guidelines on how to carry out a critical incident review (CIR) (2.4.4).

6.3.19 Trust Performance Management Arrangements

6.3.20 Service performance management Arrangements

1 Performance within divisions at PHCT is measured quarterly by the Divisional Review process. (X.7)

6.3.21 Staff Performance management Arrangements

1 Portsmouth Healthcare NHS Trust has developed a corporate policy for staff individual performance review. They have produced documents to support the process, explaining the aims and purpose of PDPs and how to set objectives as an organisation and as an individual. The process is audited and included in the Divisional Review. The policy was first written in 1995 and updated in April 2001 (E3.1).

2 One of GWMH's key objectives for 1997/98 was to establish a system of annual appraisals for all staff. This was to be audited in January 1998. (A.1.2.13, p1)

3 Portsmouth Healthcare NHS Trust has provided staff individual performance review guidance dating from March 1995 to April 2001 as well as a related procedural statement for April 2001 (I 4).

4 The trust sent copies of the audits on Community Hospitals Contract Group and their Therapy services in 1998, 1999 and 2000. The Contract Lead Group developed an action plan including ensuring all new managers are trained for IPR and that the results from audit are shared widely. In 1999 the audit found that Bank staff were not receiving IPRs. They arranged for Sue Hutchings at Gosport to deliver the training and IPRs for nursing bank staff. Their manager who is also responsible for giving them their IPR would train Admin and clerical staff. In 2000, the number of completed IPRs had deteriorated, as had the number of review dates set for next year. The trust noted that some Bank staff have still not received appraisal and staff were not receiving a copy of their IPR for use throughout the year (E3.1).

6.3.22 Performance Indicators

1 The summary of staff/premises incidents for Q2 1999/00, as detailed in the November 1999 Divisional Review, highlighted that there were fifteen incidents for GWMH – one on Daedalus, four on Dryad, three on Sultan. Details of incident or severity by ward were not available (B.2.4 Section 4).

2 The summary of patient incidents for Q2 1999/00, as detailed in the November 1999 Divisional Review, highlighted that:

- There were twelve incidents for Daedalus – 1 "bumped / caught in / struck by"; 7 falls (found on floor); 2 falls (seen/reported); 2 falls (slip / trip-seen / reported).
- There were five incidents for Dryad –3 falls (found on floor); 1 fall (seen/reported); 1 skin (damage to).
- There were twenty incidents for Sultan –1 "bumped / caught in / struck by"; 1 equipment failure; 9 falls (found on floor); 6 falls (seen/reported); 2 falls (slip/trip - seen/reported); 1 medical collapse.

3 Of these incidents four of those on Daedalus were near misses, eight were minor risk; one on Dryad was a near miss, the other four moderate risk; and

five on Sultan were near-misses, fourteen were minor, with the other moderate risk (B.2.4 Section 4).

4 During Q2 1999/00, GWMH received 35 letters of thanks / donations (B.2.4 Section 4)

5 The summary of staff/premises incidents for Q3 1999/00, as detailed in the February 2000 Divisional Review, highlighted that:

- There was one incident for Daedalus –hazardous exposure (chemical / electrical)
- There was one incident for Dryad – scald / burn.
- There were nine incidents for Sultan - 1 assault (actual – victim), 2 assaults (verbal abuse – victim), 1 "bumped / caught in / struck by", 4 manual handling (person), and 1 scald / burn.
- All incidents were minor, with the incident on Dryad a near miss (B2.3 Section 2.4.1).

6 The summary of patient incidents for Q1 2000/01, as detailed in the February 2000 Divisional Review, highlighted that:

- There were seventeen incidents for Daedalus – 1 "bumped / caught in / struck by"; 10 falls (found on floor); 3 falls (seen / reported); 1 fall (slip / trip-seen / reported); 1 security (damaged property); 1 skin (damage to).
- There were thirteen incidents for Dryad –1 "bumped / caught in / struck by"; 7 falls (found on floor); 3 falls (seen/reported); 1 falls (slip/trip - seen/reported); 1 scald / burn.
- There were twenty-six incidents for Sultan –2 "bumped / caught in / struck by"; 13 falls (found on floor); 6 falls (seen/reported); 5 fall (slip/trip - seen/reported).
- Of these incidents eight of those on Daedalus were near misses, eight were minor, the other moderate risk; seven on Dryad were near misses, the other six moderate risk; and five on Sultan were near-misses, with the other twenty-one moderate risk (B2.3 Section 2.4.1).

7 The May 2000 Divisional Review, risk assessment reports noted a high level of falls (found on floor) in Q4 1999/00, particularly on Mulberry Ward, and an overall increase of 50% in manual handling incidents.

8 The summary of staff/premises incidents for Q1 2000/01, as detailed in the May 2000 Divisional Review, highlighted that:

- There were four incidents for Daedalus –1 "bumped/caught in/struck by"; 1 manual handling (person); 1 other injury – non-patient related; and 1 staffing (nursing).
- There were three incidents for Dryad – 1 "bumped/caught in/struck by"; 1 infection risk (clinical sharp); and 1 manual handling (person).
- There were two incidents for Sultan - both manual handling (person).
- All incidents were low risk with one each of the Dryad and Sultan incidents a near miss (B2.2 Section 2.4.1).

9 The summary of patient incidents for Q4 1999/00, as detailed in the May 2000 Divisional Review, highlighted that:

- There were sixteen incidents for Daedalus – 1 "bumped / caught in / struck by"; 1 choking; 9 falls (found on floor); 4 falls (seen / reported); and 1 infection risk (clinical sharp).
- There were ten incidents for Dryad –1 "bumped / caught in / struck by"; 7 falls (found on floor); 1 fall (seen/reported); 1 fall (slip/trip - seen/reported).

- There were ten incidents for Sultan –1 assault (actual-assailant); 5 falls (found on floor); 3 falls (seen/reported); 1 unexpected death.
- Of these incidents two of those on Daedalus were near misses, the other fourteen were minor; one on Dryad was a near miss, the other nine were low risk; and seven on Sultan were minor, with one moderate risk and the other two incidents critical incidents (B2.2 Section 2.4.1).

10 The May 2000 Divisional Review noted two critical events at GWMH.
- A 67 year-old patient on Sultan ward, GWMH was found collapsed at 12:35 9 February 2000, no pulse or signs of respiration. CPR commenced and 999 called. Attempt at resuscitation stopped at 12:52 (Section 2.4.2).
- In the second, a 98 year old aggravated patient on Sultan ward, pinched and slapped members of staff and threw objects. The patient fell back hitting their head on a table; staff were unable to carry out an examination due to the patient attempting to bite staff. Duty doctor contacted (B2.2 Section 2.4.1).

11 May 2000 Divisional Review, Key Governance indicators listed, under critical incidents:
- A failed resuscitation attempt on Sultan ward. This was followed up with the team in a "structured and facilitated reflection". Support was also sort from the resuscitation department
- An aggressive patient. An incident review was conducted and "links to Mulberry strengthened"
- Nine medication errors were reported across the community hospitals, six of these related to Fareham & Gosport (two of these were EMH patients). Of the remaining four "two were near misses, in that no inappropriate drugs were actually taken by the patient". It was stated that the risk to the patient was negligible in both instances where inappropriate drugs were taken. All errors were followed up by the manager and remedial action (where required) agreed with staff member *{not stated what if any remedial action was actually taken}*. One of the nine errors was on Daedalus ward (Section 2.4.2).

12 The August 2000 Divisional Review, risk assessment reports noted a high level of falls (found on floor) in Q1 2000/01. There were 18 falls on Sultan (5 in previous quarter) with a note that there had been a rise in turnover and six recurrent fallers.

13 On Dryad there were 20 falls compared to 7 in the previous quarter with a note that there were a several patients admitted with dementia following fractured neck of femur. "Due to dementia and despite advising and repeatedly asking them not to move unassisted, they continue to attempt to mobilise". In addition there were "at least five patients" who were recurrent fallers, with diagnoses of Parkinsons, CVA or dementia.

14 The summary of staff/premises incidents for Q1 2000/01, as detailed in the August 2000 Divisional Review, highlighted that:
- There was one incident for Daedalus –assault (actual – victim).
- There were two incidents for Dryad – 1 "bumped/caught in/struck by" and 1 infection risk (clinical sharp).
- There were three incidents for Sultan - 1 assault (actual – victim), 1 manual handling (person), and 1 security (missing property <£1000).
- All incidents were low risk with one each of the Dryad and Sultan incidents a near miss (B2.1 Section 3.4.1).

15 The summary of patient incidents for Q1 2000/01, as detailed in the August 2000 Divisional Review, highlighted that:
- There were thirteen incidents for Daedalus – 11 falls (found on floor); 1 fall (slip / trip-seen / reported).
- There were twenty-four incidents for Dryad –20 falls (found on floor); 2 falls (seen/reported); 2 falls (slip/trip - seen/reported); 1 medication error.
- There were twenty-nine incidents for Sultan –1 "bumped / caught in / struck by"; 18 falls (found on floor); 7 falls (seen/reported); 1 fall (slip/trip - seen/reported); 1 medical collapse; and 1 scald/burn.
- Of these incidents eleven of those on Daedalus were low risk (of which one was a near miss), the other two medium risk; twenty-three on Dryad were low risk, the other one medium; and twenty-seven on Sultan were low risk (of which two were near-misses), with the other two incidents medium risk (B2.1 Section 3.4.1).

16 The August 2000 Divisional Review noted one critical event (not a key governance issue). A 78 year-old patient on Mulberry ward, GWMH was found breathing rapidly. Doctors were in attendance when the patient stopped breathing and gave immediate CPR. Paramedics took the patient to Haslar Hospital where she died. This is dated as 08 May 2000 (B2.1 Section 3.4.2).

17 The August 2000 Divisional Review, Key Governance indicators listed, under critical incidents, a theft on 26/04/00 at the out patient department of a handset with tape in-situ from the clinic room. A search was undertaken and police informed. All staff were told to remove handsets and records immediately on completion of clinic (B2.1 Section 2).

18 During Q2 2000/01, GWMH received 44 letters of thanks / donations (1.13.3 Section 3.3)

19 The summary of staff/premises incidents for Q2 2000/01, as detailed in the November 2000 Divisional Review, highlighted that:
- There were seven incidents for Daedalus – 1 assault (actual-victim), 1 bullying/intimidation, 1 infection risk – disease exposure, 3 staffing (nursing), and 1 unsafe practice conditions.
- There were two incidents for Dryad – 1 fire (false alarm), and 1 staffing (nursing)
- There were six incidents for Sultan - 2 assaults (actual-victim), 1 staffing (nursing), and 3 unsafe practice conditions
- Of these incidents five of those on Daedalus were low risk, the other two medium; both on Dryad and all six on Sultan were low risk (1.13.3 Section 3.4.1)

20 The summary of patient incidents for Q2 2000/01, as detailed in the November 2000 Divisional Review, highlighted that:
- There were twenty-four incidents for Daedalus – 18 falls (found on floor), 4 falls (seen-reported), and 2 falls (slip / trip-seen / reported).
- There were eight incidents for Dryad – 5 falls (found on floor), 2 falls (seen-reported), and 1 fall (slip / trip-seen / reported).
- There were nineteen incidents for Sultan – 2 "bumped / caught in / struck by", 10 falls (found on floor), 4 falls (seen-reported), 2 falls (slip / trip-seen / reported), and 1 skin (damage to).
- Of these incidents twenty-two of those on Daedalus were low risk, the other two medium; seven on Dryad were low risk, the other one medium;

and all eighteen on Sultan were low risk with one of these being a near miss and no an actual incident (1.13.3 Section 3.4.1).

21 The November 2000 Divisional Review included an attached paper (dated 09/11/00) detailing "the most important clinical risk issues facing the division". These were:

- Recording of CPR status in patient's notes in Elderly Mental Health, associated with a lack of medical infrastructure in Fareham and Gosport. An action to address this is for consultants to regularly check notes written by junior staff. However, there is a time issue involved, and the view of the lead consultant is that there is insufficient medical support to these wards.
- Serious complaints at Gosport War Memorial. The emerging themes are nutrition and hydration, staff attitudes, and communications with carers. A meeting was arranged for the end of November between nursing and medical staff to begin to think about actions which might be taken to address the concerns raised in the complaints mentioned.
- Intermediate Care Provision. This is a new type of service and, whilst significant training and development is taking place to address perceived education need, the effect of this is untested. To address this a programme of training and development has been targeted at staff that will be working in intermediate care. The main problems associated with this are the number of staff to be put through the training and the methods of maintaining competence once training is complete. A trust-wide training and development group for community hospitals will remain part of the community hospitals clinical governance framework.
- It was acknowledged that clinical risk issues had been, up to this point, dealt with in an ad-hoc and opportunistic manner (1.13.3).

22 During Q3 2000/01, GWMH received 34 letters of thanks with donations of £153.00 (1.13.2 Section 3.1).

23 The summary of staff/premises incidents for Q3 2000/01, as detailed in the February 2001 Divisional Review, highlighted that:

- There was one incident for Daedalus –staffing (nursing).
- There was one incident for Dryad – medical collapse
- There were four incidents for Sultan - 1 security (intruder), 1 skin (damage to), and 2 staffing (nursing).
- Of these incidents the one on Daedalus was low risk; the incident on Dryad medium risk; and all four on Sultan low risk (1.13.2 Section 3.4.1).

24 The summary of patient incidents for Q3 2000/01, as detailed in the February 2001 Divisional Review, highlighted that:

- There were seventeen incidents for Daedalus – 9 falls (found on floor); 1 fall (seen-reported); 3 falls (slip / trip-seen / reported); 2 service failures (duty of care); 1 staffing (medical); and 1 staffing (nursing).
- There were eight incidents for Dryad – 1 "bumped / caught in / struck by"; 2 falls (found on floor); 2 falls (slip / trip-seen / reported); 1 medical collapse; and 2 staffing (nursing).
- There were thirty-six incidents for Sultan – 1 assault (actual-assailant); 2 "bumped / caught in / struck by"; 22 falls (found on floor); 3 falls (seen-reported); 3 falls (slip / trip-seen / reported); 1 security (missing property <£1000); and 4 staffing (nursing).
- Of these incidents sixteen of those on Daedalus were low risk, the other medium; seven on Dryad were low risk, the other one medium; and thirty-

five on Sultan were low risk with the other medium risk (1.13.2 Section 3.4.1).

25 The February 2001 Divisional Review also notes that there were two incidents of whistle blowing in the EMH department at Redclyffe House, with investigations taking place (1.13.2 Section 3.4.2) *{IH – there were no further details}.*

26 During the period covered by this review, GWMH received 37 letters of thanks with donations of £1,426.00 (1.13 Section 3.1).

27 The summary of staff/premises incidents for Q4 2000/01, as detailed in the May 2001 Divisional Review, highlighted that:

- There were ten incidents for Daedalus –1 bogus clinician; 1 "bumped / caught in / struck by"; 3 manual handling (person); 1 security (illegal entry); 1 security (public disorder); and 3 staffing (nursing).
- There were four incidents for Dryad – 4 staffing (nursing).
- There were eleven incidents for Sultan – 1 assault (actual – victim); 1 manual handling (object); 2 manual handling (person); 1 medicines management; 5 staffing (nursing); and 1 unsafe practice conditions.
- Of these incidents the nine on Daedalus were low risk, the other medium risk; the four incidents on Dryad low risk; and nine incidents on Sultan were low risk with one medium risk and the other high risk (1.13 Section 3.4.1).

28 The summary of patient incidents for Q4 2000/01, as detailed in the May 2001 Divisional Review, highlighted that:

- There were fourteen incidents for Daedalus – 2 "bumped / caught in / struck by"; 2 external provider; 6 falls (found on floor); 1 fall (medical collapse seen-reported); 1 fall (seen-reported); 1 fall (slip / trip - seen / reported); and 1 manual handling.
- There were five incidents for Dryad – 2 equipment (causing injury); and 3 falls (found on floor).
- There were forty-eight incidents for Sultan – 2 abscondment (actual); 1 "bumped / caught in / struck by"; 7 external provider; 25 falls (found on floor); 4 falls (seen-reported); 1 falls (slip / trip-seen / reported); 1 inappropriate admission; 1 manual handling; 3 medical collapse; 1 risk behaviour no injury; and 2 security (missing property <£1000).
- Of these incidents thirteen of those on Daedalus were low risk, the other medium; seven on Dryad were low risk, the other two incidents medium risk; and forty-five incidents on Sultan were low risk with one other medium risk and two high risk (1.13 Section 3.4.1).

29 The summary of staff/premises incidents for Q1 2001/02, as detailed in the May 2001 Divisional Review, highlighted that:

- There were eight incidents for Daedalus – 1 "bumped / caught in / struck by"; 1 fire (false alarm); 1 infection risk (clinical sharp); 1 manual handling (person); 1 sharp – non-clinical; and 3 staffing (nursing).
- There were two incidents for Dryad – 2 staffing (nursing).
- There were eleven incidents for Sultan – 1 external provider; 1 fire (false alarm); 1 harassment (sexual); 2 manual handling (person); 1 security (dangerous / illicit goods); 2 security (intruder); 3 staffing (nursing).
- Of these incidents the five on Daedalus were low risk, the other three medium risk; the two incidents on Dryad low risk; and nine incidents on Sultan were low risk with two medium risk (1.13 Section 3.4.1).

30 The summary of patient incidents for Q1 2001/02, as detailed in the May 2001 Divisional Review, highlighted that:

- There were thirty-four incidents for Daedalus – 2 "bumped / caught in / struck by"; 1 external provider; 15 found on floor; 1 fall (medical collapse seen-reported); 8 falls (seen-reported); 3 falls (slip / trip - seen / reported); 2 medical collapse; 1 security (missing property <£1000); and 1 skin (damage to).
- There were seven incidents for Dryad – 4 found on floor; 1 fall (seen – reported); 1 medicines management; and 1 sharp – non-clinical.
- There were sixty incidents for Sultan – 1 assault (verbal abuse assailant); 2 "bumped / caught in / struck by"; 8 external provider; 26 found on floor; 5 falls (seen-reported); 4 falls (slip / trip-seen / reported); 5 medical collapse; 3 medicines management; 5 security (missing property <£1000); and 1 service failure (data protection).
- Of these incidents twenty-eight of those on Daedalus were low risk, five medium risk and one high risk; six on Dryad were low risk, the other one medium risk; and fifty-five incidents on Sultan were low risk with four medium risk and one high risk (1.13 Section 3.4.1).

6.3.23 Complaints

1 The November 1999 Divisional Review, Key Governance indicators listed one complaint for the community hospitals section as at quarter two 1999:

- Mrs W – Minor injuries department. July 1999. Complaint re attitude of the nurse when the patient attended with her granddaughter (B.2.4 Section 2).

2 The February 2000 Divisional Review, Key Governance indicators listed three complaints considered in the quarterly Divisional Review for the community hospitals section:

- Mrs S – Daedalus. Complaint re care to her father. Seen by B Robinson (?) plus follow-up letter – appears resolved.
- Mrs P – Dryad. Complaint now approaching Ombudsman
- Mrs L and Mrs McL re late Mrs R – Police investigation continues (B2.3 Section 2.1).

3 The May 2000 Divisional Review, Key Governance indicators listed 3 formal complaints considered in the quarterly Divisional Review for the community hospitals section:

- Late Mrs P – Dryad. No further information regarding complainant seeking criminal investigation.
- Mrs L & Mrs K, re late Mrs Richards – Police enquiry continues. Further question asked by DCI Burt – letter of 8.2.00. Awaiting MDU confirmation prior to sending letter.
- Mrs R and Mr D re **Code A** – Initial complaint answered and apologies made (via meeting with relatives) for service failings. June 2000. Being investigated, report available, letter waiting to go. *{No further details of complaint}* (B2.2 Section 2.1).

4 Other complaints listed were:

- For physiotherapy, verbal abuse by a patient led to a complaint regarding staff attitudes. Action in response to complaint was for staff training in management of aggression, due in October 2000.
- A formal complaint by Mrs R – Sultan Ward. There were concerns regarding the care of her husband and lack of facilities at GWMH. An

investigation was completed, with a report to go to the trust central office week commencing 17th July, in response to Mrs R.
- A formal complaint by Mr T about having to wait six months for physiotherapy at Gosport. The GP referral was for a routine appointment. It was noted that there was a long wait for treatment at Gosport. Mr T offered earlier appointment elsewhere in the trust.
- There was an informal complaint regarding OT. A project group consisting of district nursing, OT, discharge co-ordinators and joint loan store representatives met to consider 'near misses' identified by District Nursing following hospital discharge. A frank and open discussion led to a much clearer understanding by all parties as to what in fact was happening, and a follow-up meeting led to recommendations being considered by the city general manager (B2.2 Section 3.1).

5 August 2000 Divisional Review, Key Governance indicators listed 4 complaints considered in the quarterly Divisional Review for the community hospitals section:
- Mrs R – Daedalus. Started Aug 1998. Police enquiry complete.
- Mrs D – Dryad. Started 06/01/00. Awaiting response from Independent Review Convenor.
- Mr W – Dryad. Start date November 1998. Result awaited from Ombudsman.
- Mrs B – Dryad Ward. June 2000. Being investigated, report available, letter waiting to go. *{IH - No further details of complaint}* (B2.1 Section 2).

6 Other complaints listed were:
- For physiotherapy, verbal abuse by a patient led to a complaint regarding staff attitudes. Action in response to complaint was for staff training in management of aggression, due in October 2000.
- A formal complaint by Mrs R – Sultan Ward. There were concerns regarding the care of her husband and lack of facilities at GWMH. An investigation was completed, with a report to go to the trust central office week commencing 17th July, in response to Mrs R.
- A formal complaint by Mr T about having to wait six months for physiotherapy at Gosport. The GP referral was for a routine appointment. It was noted that there was a long wait for treatment at Gosport. Mr T offered earlier appointment elsewhere in the trust.
- There was an informal complaint regarding OT. A project group consisting of district nursing, OT, discharge co-ordinators and joint loan store representatives met to consider 'near misses' identified by District Nursing following hospital discharge. A frank and open discussion led to a much clearer understanding by all parties as to what in fact was happening, and a follow-up meeting led to recommendations being considered by the city general manager (B2.1 Section 3.1).

7 A review of five ongoing complaints relating to three different areas in Gosport WMH, suggest some emerging themes. This will be the subject of a meeting in November to discuss and agree actions. (1.13.3 Section 1.2.1) *{IH - Handwritten note states that this was to be discussed in early December when a member of staff returned (from where?). Did this meeting happen? What were the 3 themes and 5 complaints?}*

8 Key Governance indicators listed 3 complaints considered in the quarterly Divisional Review for the community hospitals section for quarter 2 2000/01:

- Mrs R – Daedalus. Started Aug 1998. Police enquiries complete. Awaiting next stage. *{IH - Handwritten note suggests awaiting CPS review of case}*
- Mrs D – Dryad. Started 06/01/00. Note states that there is a delay with independent lay chair and clinician, now resolved.
- Mr W – Dryad. Start date November 1998. Awaiting response from Ombudsman.

9 Other formal complaints listed were:
- Mrs R – 06/00. Concerns re care of husband and lack of facilities. Response 01/08/00 – Resolved.
- Miss W – 08/00, Sultan ward. Concerns re care for mother (now deceased). Investigations completed. Response sent 14/09/00. Complainant and sister remain dissatisfied. Further information requested from PHT (see 1.2.1)
- Miss B – 06/00, Dryad ward. Re Mrs G (no other details). Response sent 22/08/00 (see 1.2.1)
- Mrs N, EVCH. Complaint re father (Mr S), an inpatient at EVCH on 1st floor of building. Mr S was agitated and confused, he had been missing for short time when his family visited. Mr S had left via an unlocked fire door and fire escape. Mr S had been taken to a HCSW shortly before leaving the building. During the next day, temporary alarms were fitted to the fire doors (discussed with fire safety officer). Estates department have been requested to fit permanent alarms as soon as possible.

10 Other informal complaints listed were:
- Mrs P regarding repeated cancellation of appointments. Apology given and situation resolved to complainants satisfaction.
- Two sets of relatives of patients on Rowan ward identified problems with communications with nursing staff. In both instances patients had been admitted under the pilot GP-bed scheme. Anxieties and concerns were expressed by relatives that patients were waiting for nursing home placements and relatives were under the impression that patient was nearing the 14 day limit of their admission. Nursing staff reviewed the quality of communications with relatives and adapted information given when patients are transferred i.e. less emphasis on the 14 day / two week expected length of stay.
- One EMH patient (ward not stated). Complaint 07/00 from Mrs P re loss of Mrs A's property. Resolved. (1.13.3 Section 3.1)

11 Key Governance indicators listed 3 complaints for Q3 2000/01 considered in the February 2001 quarterly Divisional Review for the community hospitals section:
- Mrs R – Daedalus. Started Aug 1998. Awaiting response from CPS. Action plans produced for managing result in response to meeting with staff.
- Mrs D – Dryad. Started 06/01/00. Date for independent review awaited. Staff aware.
- Mr W – Dryad. Start date November 1998. Result awaited from Ombudsman.

12 Other formal complaints listed were:
- Miss W – 08/00, Sultan ward. Investigations completed. Family remain dissatisfied. Information sought from PHT and shared with family at

meeting in December 2000. Further letter sent January 2001. No response yet.
- Miss W (Sultan); Mrs R, Mr W and Mrs B (Dryad), and Mrs R (Daedalus). Review of these complaints led to workshops focussed on nutrition and drinking, communications with relatives, and attitudes of staff. The plan for 2001/02 is to share the results of the workshop and subsequent work in community hospitals clinical network meeting (1.13.2 Sections 3.1 and 3.7).

13 Key Governance indicators listed 3 complaints considered in the quarterly Divisional Review for the community hospitals section:
- Mrs R – Daedalus. Started Aug 1998. Awaiting response from CPS.
- Mrs D – Dryad. Started 06/01/00. Independent review panel date set for 22/05/01.
- Mr W – Dryad. Start date November 1998. Ombudsman report received Apr 01; complaint not upheld.

14 Other formal complaints listed were:
- Miss W – 08/00, Sultan ward. Further letter sent January 2001. Nil response. Assume resolved.
- Miss W (Sultan); Mrs R, Mr W and Mrs B (Dryad), and Mrs R (Daedalus). Review of these complaints led to workshops focussed on nutrition and drinking, communications with relatives, and attitudes of staff. The plan for 2001/02 is to share the results of the workshop and subsequent work in community hospitals clinical network meeting (1.13 Sections 3.1 and 3.7).

15 Key Governance indicators listed 3 complaints considered in the quarterly Divisional Review for the community hospitals section:
- Mrs R – Daedalus. Started Aug 1998. Response from CPS received (no detail). Awaiting outcome of further investigations by Police / UKCC.
- Mrs D – Dryad. Started 06/01/00. Independent review panel held 22/05/01 – no further details

16 There was also mention of a critical incident (EMH) regarding medical cover on Mulberry ward. The lead consultant followed up with the GP trainer of staff grade. Issue was listed as resolved July 2001.

17 Other complaints listed were:
- (Formal Complaint) Mr P-H – 10/05/01. The complaint was regarding transfer arrangements for his mother and aspects of care. Meeting held with Mr P-H, apology sent with explanation from GP in letter re transfer. Resolved
- (Informal Complaint) Mr B – 04/01. Complaint re Mrs B fall ad fracture neck of femur. Discussions taking place with JP *{?}* and ward staff.

18 During the period covered by this review, GWMH received 36 letters of thanks with donations of £507.00 and a television (1.13.1 Section 2.2).

6.4 MEDICINES

1 Portsmouth Healthcare NHS Trust district medicines and formulary group have shared membership with the trust medicines and prescribing committee, together comprising medicines management. The district medicines and formulary group is led by the medical director and the trust

medicines and prescribing committee is led by the medical director and the clinical risk adviser (F1.1).

2 The district medicines and formulary group also has shared membership with the clinical governance panel who, in turn, are accountable to the trust board. The trust medicines and prescribing committee also has shared membership with the risk management group, which is accountable to the trust board. The risk management group and the clinical governance panel have shared minutes, undated (F1.1).

3 A medicines policy – incorporating the I.V. policy - for PHT, PHCT and the RHH has been supplied, August 2001. The policy is the district wide final draft – version 3.5 and is due for review in October 2002. It covers the following areas:

- Accountability – by staff group, individuals, managers and in terms of substances hazardous to health regulations.
- Prescribing – in terms of responsibilities, requirements of prescription writing, controlled drugs for TTOs and outpatients, pharmacists continuation of drug therapy, medication to take out, TTO prescriptions for outpatient, accident and emergency, day case surgery or day attenders and medical gases.
- Stationery and record keeping – covering permitted prescribing stationery and controlled stationery.
- Stock control and storage – including medicines procurement, medicine stock ordering by wards and departments, storage, stock control, security, controlled drugs, storage error, losses and discrepancies, obtaining medication during pharmacy hours and obtaining medication outside pharmacy hours.
- Dispensing – in terms of responsibility, provision of medication for parenteral administration, dispensing error and prescription charges.
- Distribution and delivery – within the same hospital, between hospitals and peripheral units, surgeries and clinics and in relation to chemotherapy.
- Administration and checking – covering records, controlled drugs, cytotoxic chemotherapy, radiopharmaceuticals, supply and administration of medicines by patient group directions, self – administration by patients or carers and patient's own medication.
- Disposal of unwanted drugs – covering general pharmaceutical waste, cytotoxic and radiopharmaceutical waste and controlled drugs.
- Education and training – in relation to the administration of medicines, intravenous therapy and epidural therapy, CPD, avoidance of adverse incidents and adverse medication incidents.
- Risk management – covering adverse drug reaction reporting, defective product reporting and parenteral therapy infusions.
- Clinical trials
- Individual responsibilities – for nurses, both professional and managerial, bank and agency nurses, students, midwives and student midwives, operating department practitioners and assistants, clinical support staff, doctors, dentists and pharmacists.
- Definitions and glossary
- Affiliated documents
- Directorate or specialty policies – which include medicines policies for orthopaedics and theatre practitioners (F4.2).

6.4.1 Prescribing

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 7.2 of Level II, that *"Services are appropriately audited and evaluated to ensure quality and efficiency ".* There should be regular audits of medication and prescribing patterns. The service should regularly audit the care planning process and the quality of the individual care plans to ensure that they are used to provide appropriate and responsive care. There should be clear evidence of clinical audit of record-keeping standards (2.4, p29).

2 A prescribing formulary has been provided by Portsmouth district, October 2001, although it is noted as incomplete. The formulary is for PHT, PHCT, GPs, Portsmouth and S.E Hampshire HA and the Royal Haslar Hospital (F 3.1). It contains the BNF for categories 1 to 6, 7 and 10 and the secondary care formulary for all other BNF sections. The formulary was produced as a result of a combined effort and is intended for use in both primary and secondary care sectors. Cross reference to trust prescribing guidelines for the use of certain drugs are given. There are also published compendia of adult and paediatric drug therapy guidelines which are available on the wards and from the pharmacy department. The document notes that medicines not listed will be held in pharmacy stock and a consultant's signature is required for such medicines to be ordered and supplied. The formulary list abbreviations and gives a brief outline of formulary management as follows:

- **Non-formulary usage** - Drugs that are not included in the formulary cannot be prescribed by PHT staff, as determined by the trust board in October 2001
- S**pecialist Use** Some drugs are restricted to use only by designated specialists or individual clinicians. Use outside these restrictions is not permitted
- **Dosage forms** Where dosage forms are stated, usage is restricted to these forms. Where no forms are stated, all forms are available for use (F 3.1)

3 The formulary lists all the drugs by the BNF section under which they fall. It states the category/categories under which they may be used, for example hospital use only or primary care use only. It points the reader in the direction of further useful guidelines. It also states, where necessary, trust guidelines in using specified drugs, and instances where certain drugs may only be used for certain patient groups, for example in cardiology or paediatrics (F 3.1).

4 PHCT and PHT have provided a compendium of drug therapy guidelines (for adult patients), 1998 although it is still current. The compendium is a collection of guidelines from both trusts on prescribing, administering and handling medicines (F 3.2).

5 The compendium states each guideline has been prepared by a group of experts and that all clinical guidelines have been approved by senior consultants in the relevant field. It is envisaged the compendium should be available in all clinical areas to enable consistency in the availability and use of information by junior doctors, nurses and pharmacists moving between specialties. It is stated the compendium will be updated and re-issued annually (is the 1998 compendium the most up to date one provided, if so

this clearly is not happening?). Finally, the compendium states that new information appears constantly and may need to be taken into account when following the guidelines (F 3.2).

6 The contents pages of the compendium lists each clinical guideline or policy by BNF section, it also lists general guidelines in relation to, for example, substance abuse by patients or staff, self-medication and enabling protocols for pharmacists. It also points readers in the direction of guidelines available elsewhere. The guidelines listed include Confusion in the Elderly (p38), ACE inhibitor initiation in elderly patients with heart failure (p7), Patient controlled analgesia (p47) and Subcutaneous fluid replacement (p98) (F 3.2).

7 See also Prescription Writing Policy

6.4.2 Administering

1 See Also Control and Administration of Medicines by Nursing Staff

2 A programme for updating qualified staff regarding the administration of medicines in community hospitals is provided by Portsmouth Healthcare NHS Trust, March 1997. The programme outlines that a member of staff should be able to:

- Produce a copy of UKCC guidelines
- Show evidence of understanding the guidelines
- Show evidence of knowledge of what constitutes a legal prescription
- Outline checking procedures for non-controlled and controlled medication
- Demonstrate evidence of knowledge of dose and strength of commonly used drugs
- Demonstrate evidence of knowledge of the side effects of commonly used drugs currently on the trolley
- Identify sources of drug information
- Identify process to be followed in the event of a drug error
- Complete minimum of one supervised drug round without error
- Demonstrate knowledge of the safe storage of drugs (F 5.1).

3 An assessment report is then written regarding the individuals' competencies as measured against these criteria (F 5.1).

4 PHCT have provided a guidance note for ward/clinical managers entitled 'the administration of controlled drugs – the checking role for support workers', February 1997 – still current. The note covers who should complete the programme, when the training should be carried out, who is responsible for ensuring that training is completed and for checking the HCSW is competent, who carries out the training and how frequently refresher courses should be run (F 5.2).

5 A booklet has been supplied, along with the guidance note, which is intended to provide a record of training for HCSWs who are competent to assist a qualified nurse with the administration on controlled drugs. The booklet includes questions for HCSWs to answer as part of the training (F 5.2).

6 Notes of an action-learning meeting held on 11th June 2001 at GWMH are provided. A revised self-administration programme assessment tool was considered where patients would sign an acceptance form when, and if, the patient medication assessment tool was agreed. A syringe driver prescription for pain management was also discussed and considered suitable for the

client group. The related prescription chart is to be implemented as soon as approval is finalised (D 3.2)

7 Two qualified nurses on Sultan Ward took part in a Syringe Driver training course in 1999. Five qualified nurses on the ward have taken part in a Drug Competencies course, one in 2001, and four in 2000. No qualified nurses from either Dryad or Daedalus Wards have taken part in either course between 1998 and 2001. (X.3.3)

6.4.3 Drug Review

1 In November 1999, the use of neuroleptic drugs within trust Elderly Medicine continuing care wards was reviewed. Specifically it looked at whether the prescription for these drugs was appropriate. It was revealed that on wards of the GWMH, medical reviews of medication that take place weekly are not necessarily recorded in the medical notes. The audit concluded that neuroleptic drugs were not being over-prescribed within the trust but their use is not being reviewed regularly enough within the trust. They recommended re-audit in January 2000 (E6.4).

2 In 1997 the trust developed guidelines for the management of acute confusion in the elderly. The guidelines state what process should be followed according to the severity of the confusion, this includes a guide for drug prescribing (E4.1). In October 2001, following restrictions on the use of Thioridazine and the development of a care pathway for nurses in Elderly Mental Health Consultant Geriatrician Dr Ann Dowd updated these guidelines. She requested that the guidelines be an agenda item for a service planning and development group who could pass them to the CG group to disseminate them to the staff (E4.1).

3 In February 2001, the rapid tranquillisation guidelines were drawn up by Dr A Lord to make staff aware of the recommended drug for tranquillisation, Lorazepam. The memo was circulated to all medical staff, all wards, pharmacy and Jane Williams, Kim Bezzant and Toni Scammell (E4.1).

6.4.4 Drug Recording

6.4.5 Drugs – Other

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 7.1 of Level II, that “Medication regimes for older people using primary health or inpatient services are arranged to be as simple as possible, and consistent with treatment plans and locations of care. There are safeguards for ensuing that regimes are well understood by users and their relatives or carer, and that medication is administered in a safe and reliable way”. The manual goes on to say that Staff must ensure that users understand their medication – eg the rational for use, risks, benefits, dosages, timings and duration of treatment. Mediation regimes should use as few drugs as possible and use formulations that promote as simple daily regime as possible. There should also be a regular review of medication, especially when more than 3 drugs are used. Pharmacists should be involved in the management of older users’ medication regimes (2.4, p18).

2 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 2.3 of Level II, that *"Responsibility for budgets and prescribing in all medication regimes is clear"* (2.4, p23).

3 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 2.4 of Level II, that, *" Pharmacy services, and expert advice from pharmacists, are available for both community and hospital based services".* Services should have agreed arrangement for the provision, supply and administration of stock and non-stock medicines and the supply of less familiar medicines; and the handling of patients' personal medicines on admission and discharge (2.4, p23)

6.5 COMMUNICATION AND COLLABORATION

6.5.1 Patients

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 8.1 of Level II, that "Up to date and accurate information on a range of health and social care related issues is readily available to users and carers, to cover all stages of the processes of care" (2.4, p19). Each service should have a written information leaflet of guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers. Carers and professional should be made aware of the Carers (Recognition and Services) Act 1995.

2 The Trust provided an information leaflet for relatives called 'Post-mortem' which gives practical information about post-mortem examinations (H1.1.2)

3 The 2000/01 CG Report states that a User Involvement Framework was developed to help individual services involve patients and carers in the development of clinical services. It was being piloted in a number of services (Residential Mental Services and Dept of Elderly Medicine). No trust-wide PALS service was being developed as the trust is to be dissolved in March 20002. Users and local groups have been consulted on the content of a leaflet explaining "Decision making about resuscitation". Development of the Gerentological Nursing Development programme has involved an advisory group which included representatives from patient organisations and leagues of hospital friends (File1, 6.4.2, p3; File 1, 6.5.1, p2; A4.1).

4 The trust supplied an undated document in which the user involvement development framework is discussed in full. It notes that 'user involvement has been a feature in policy documents for many years, yet much of the evidence suggests that the reality is tokenism rather than active participation. It is recognised that user involvement is essential for services to be patient-centred. The framework covers the following aspects of user involvement:
- Supporting effective user involvement
- Communication and information
- The user experience
- Advocacy
- Service developments and
- Tools and techniques for user involvement (A 4.1).

5 The document also outlines the monitoring and reporting arrangements for the framework (A 4.1).

6 The February 2001 Divisional Review noted that the outpatient forum was working on a survey, and they were aiming to achieve uniformity, support for each other and share good practice. The focus for 2001/02 is to make booking systems more patient centred and accessible (1.13.2 Section 3.7).

6.5.1.1 Patient Surveys

1 A GWMH Patient Survey form was provided. This asked for patient opinions on what they liked least, what they liked most, and how their stay could have been improved. A Patient Survey action plan was also provided, which showed actions planned to deal with concerns raised in Patient Surveys held in July and October 2001. (G.2.1, pp4-6)

2 Details of patient surveys, as part of the patient involvement strategy at PHCT, have been supplied, November 2001. Results may be contradictory, but are ass follows: (A 4.3):

.1 Daedalus ward

Liked Best	Liked Least	How could your stay in hospital be improved?
Friendly staff Food Service of nurses Able to go out with relatives Good care and attention Cup of tea in morning Physiotherapy Visiting times Nice furnishings Good chairs, suitable for patients Freedom Being able to keep dignity Help given on difficult days Staff seeing me as an individual	All tablets together Going to sleep and waking confused Menu could be more varied Breakfast in bed, propped up by pillows Sitting on commode for too long Waiting too long in one position Food Way I have been treated by some nurses Length of stay boring Conversation between nurses about their private lives	Chairs for the toilets, so patients could sit down and wash themselves Consistent number of nurses at all times Food improved More help getting dressed More cups of tea More stimulation

.1 Dryad ward

Liked best	Liked least	How could your stay in hospital be improved?
Nursing care Seeing staff work as a team Being looked after well Being given a choice	Seeing staff run around No staff Noise from swing doors banging	Keeping noise down Special dietary needs for no solids! Getting enough nourishment?

Courtesy and consideration of staff		

.1 Sultan ward

Liked best	Liked least	How could your stay in hospital be improved?
Staff helpful Kindness Felt safe Regular cups of tea Hygiene care Ward clean Buzzer call at night very good Food Staff always there to help you, day or night Happy conversation Atmosphere very comfortable and pleasant Small ward areas – ample space between beds The garden	Putting on staff when they can do it for themselves Lack of physiotherapy Food Too hot in ward Strong tea Early morning start Having to use bed pans Shouting by staff Air mattress Smelly pillows Poor hygiene with cutlery Not always getting the food requested Restriction to smoking Not enough tea	Increase staff levels Slight improvement of meals Possibility of more privacy More plugs for wash hand basins More time to chat to nurses TV by each bed

1 The Gosport and Fareham PCT proposal states that 'many of the services currently provided by Portsmouth Healthcare NHS Trust have well established and active user and care involvement groups, to assess client satisfaction and to assist in service reviews' (A 5.2, p8).

6.5.1.2 Information Leaflets

1 PHCT produce a leaflet providing information on catering services within the trust, which includes a form for patients to use to give feedback – suggestions for improvement, compliments, and criticisms - on catering services that they have experienced. Patients can choose to receive a written reply to their comments. (G.1.1)

2 A selection of information leaflets were supplied to CHI. These were:

- 'Catering Services', which outlines PCHT's provision of meals for patients
- 'Gosport War Memorial Hospital: from 1923 to 1995', a leaflet outlining the history of the hospital.
- 'Gosport War Memorial Hospital: its past, its present and its future as the hospital for Gosport community', notes to accompany and commemorate the completion of GWMH 03/10/1995

- Welcome leaflet for Sultan Ward, detailing Ward layout, staff, meal provision and other services available on the Ward
- 'MRSA: the facts', information on methicillen resistant staphylococcus aureus (MRSA) for patients
- 'Consent – what you have a right to expect' – DoH guide to consent procedures for relatives and carers
- Information leaflet on the Disability Information Centre
- Information leaflet on Gosport Shopmobility
- Information leaflet on Gosport Gardens Scheme – scheme to help with gardening for those who are disabled or elderly
- Flyer for the Disability Information Centre
- 'Avoiding slips, trips and broken hips' – DTI/HEA Information leaflet for older people with advice on how to avoid falls at home
- 'Step up to safety' – DTI/Our Healthier Nation leaflet providing advice for older people on how to use stairs safely
- 'Fight the Flu' – Help the Aged leaflet providing advice on influenza
- 'Falls: how to avoid them and how to cope' – RoSPA/Age Concern guide for older people and carers

3 No information was supplied as evidence of dissemination of these leaflets amongst GWMH or PHCT patients. (G.1.1)

6.5.2 Relatives and Carers

1 A leaflet (undated) entitled "Because We care" was produced by Portsmouth HealthCare NHS Trust for the Community Health Services at GWMH and at Redclyffe House. It gives practical information on what to do following a death, and some guidelines on grief bereavement. Details of local Registrar, funeral directors and voluntary organisations given (H3.1).

2 The need to improve communication with relatives was discussed at a GWMH clinical manager's meeting in November 2001. It was felt that communication had improved and that contact of relatives was now clear in the documentation (D 3.2).

6.5.3 Primary Care

6.5.4 Acute Sector

6.5.5 With Social Services

1 A survey of community hospitals staff was carried out in 1998. 32% of respondents said they found it easy to communicate with Social Services, 19% that they did not find communication easy and 49% said it was not applicable to their job (C1.1).

6.5.6 With Health Authority

1 November 1999 Divisional Review, noted the general manager had written to the health authority, advising them of the continued financial pressure and demand for heavily dependent patients in respite care. At the time of the report, no response had been received (B.2.4 Section 1).

6.5.7 With Haslar Hospital

6.5.8 Within Trust

1 The 1998 community hospitals survey found that 81% of respondents receive and read a copy of the trust newsletter every week. 69% of respondents said they receive and read a copy of the trust newspaper every quarter. No respondents said they had never received or read a copy of either publication (C1.1).

2 When surveyed about their attendance at 'Information Exchange' (team briefings), 47% said they had attended one month ago, 21% said longer than three months ago and only 6% said they had no opportunity to attend (C1.1).

3 The survey respondents consisted of 66% nursing staff, 19% admin and clerical staff, 4% other, 3.5% ancillary, 3.5% medical and dental, 3.5% management and no PAMs answered the survey (C1.1).

6.6 END OF LIFE

6.6.1 Arrangements for Patients

1 The Trust provided programme of a study day for Health Care Support Workers entitled "Talking with Dying Patients". The aim of the workshops was to enable staff to develop confidence in talking with patients who are dying. (H1.2)

2 The trust has provided the community hospitals guidelines for certification of death which was last reviewed in 1999 (E5.2).

3 The trust has provided the Queen Alexandra Hospital Dept. of Elderly Medicine patients' affairs procedure, dealing with post mortem and certifying death (E5.1).

6.6.2 Arrangements for relative/cares

1 Portsmouth Healthcare NHS Trust guidance on organ donation has been provided, undated, outlining the process to go through following the death of a patient who indicated they wanted to donate organs for transplant (D 2.3).

6.6.3 Arrangements to Support Staff

1 Portsmouth Healthcare NHS Trust used an Employee Assistance Programme (EAP) that was provided by Employee Advisory Resource Limited (EAR) from 1st February 1996 to 2000. EAR's employee assistance programme was a "comprehensive 24 hour counselling and information service available to employees, their families and significant others". The EAP was defined as a *professional confidential resource that provides a work-based intervention and/or resolution of both work and personal problems that may adversely affect performance. These problems may include, but are not limited to, health, legal, martial, relationships, family, financial, substance abuse or emotional concerns*". Feedback to EAR from members of the scheme indicated that the service provided had been helpful (H2.3.1, H2.3.2).

2 EAR provided Usage reports to the trust. These show that, for the period Feb 1996 – January 2001, about 10.75% of staff used the facility each year. Of these contacts, approximately 16-18% were for staff from Fareham and Gosport Davison. The most common work related reason for using the EAP were emotional health, policies, relationships and performance.

3 In May 2000 the EAP was provided by Coutts Corecare. The Trust provided the Annual Report for EAP (May 2000 – April 2001). Annual Usage was 9.8%. The majority of workplace difficulties related to Workplace Emotions (36%), Interpersonal Conduct (20%), Harassment (13%) and Aggression (11%) (H2.2.1).

4 In addition to the Employee Assistance Programme, Corecare assisted PHCT with a Post Trauma debriefing and Critical Incident Training Day (dates not given) (H2.2.1). The trust also enclosed a document entitled "Guidelines for Managing the Psychological Effects of Trauma in the workplace" which was produced by Corecare (Feb 2000). This describes "What to expect following trauma, What to do following trauma and Defusing and Debriefing situations". The document provides guidelines only but states that "*each traumatic incident is unique and it is important that organisations have disaster management procedures and responsibilities in place before incidents occur*" (H2.2.5).

6.6.4 Cultural, Spiritual needs

1 A Chaplaincy service is available at Gosport War Memorial hospital. A Church of England Chaplain and a Free Church pastor are available for staff, relatives and patients on request. They each visit the wards during the week and lead chapel services on Sundays. A Chaplaincy assistant also visits wards. The C of E Chaplain also arranges support from leaders of other faiths on request (H3, Z3.1).

6.7 SUPERVISION AND TRAINING

1 A policy statement regarding training and education has been provided, undated, for Portsmouth Healthcare NHS Trust. The statement details the purpose, scope, principles and requirements of the policy as well as audit standards that support the policy. There is also guidance on funding and a procedural statement for management training and development. The policy is due for review in April 2002 (I 5).

2 Portsmouth Healthcare NHS Trust have provided a 'training on demand' (TOD) leaflet which includes an index of titles, March 2001. The leaflet states the TOD series is intended to provide managers and others with a means of delivering training sessions in a range of topic areas to their own staff at an appropriate time and place. Topics covered include record keeping for healthcare professionals, working with the data protection act, fire safety and working in partnership among others. A brief outline of each of the 16 courses offered is given, detailing the aims of the course and its target audience. Group size may be between 4 and 10 participants for all packs and details are given of how to obtain a TOD pack. TOD packs are available to team co-ordinators, clinical managers, ward managers, administration managers and others who have responsibility for groups of staff (I 3.2).

3 A programme of training events for Portsmouth Healthcare NHS Trust 2000-2001 is also supplied. Events and courses offered include a national certificate of healthcare supervision, dealing with complaints, loss, death and bereavement, nursing management of diabetes and training in relation to the mental health act (I 3.1).

4 A 'Diversity matters' leaflet has been provided by Portsmouth Healthcare NHS Trust, undated. It outlines trust policies that underpin *diversity matters,* and its definition and scope. Guidance is given on how to raise concerns, and information regarding further help and advice is also given, including legislation and other trust leaflets (I 3.4).

5 A 'valuing diversity' training paper from Portsmouth Healthcare NHS Trust, undated, has been supplied. The aim is to enable participants to review their current knowledge and understanding with regards to the treatment of diversity at work, and to create a plan to implement appropriate change. The paper outlines the objectives of the workshop and the programme details (I 3.4).

6 A catalogue of interactive e-learning training programmes at St. James' has been supplied, November 2001. Courses covered include, report writing, constructive criticism, body pressure management and body temperature management (I 3.3).

6.7.1 Medical Supervision and Training

1 Portsmouth Healthcare NHS Trust have supplied supervision arrangement consultant timetables, from April 1998 to July 2001. The document relates to the supervision of junior medical staff and notes that consultant ward rounds at GWMH are an opportunity for supervision between the consultant and the clinical assistant. The timetables list each day of a Monday-Friday week and the name of the consultant supervising as well as who and where they will be supervising (D 3.3; D1.5).

2 The Department of Medicine for Elderly people has provided a timetable for their Wednesday lunchtime learning meetings from Jan 1997 to Sept 2001 and their Friday lunchtime Journal Club from July 1999 to August 2001. The documents lists dates, the name of the doctor and the sponsor involved, contact telephone numbers and the venue, but not the topics covered or the staff groups who attended (I1.1, I1.2).

3 Portsmouth Healthcare NHS Trust Department of Medicine for Elderly people, QAH, has sent memoranda for clinical assistant teaching sessions in elderly medicine. Invitees comprise clinical assistants, staff grades and consultants. The courses cover the following topics and invitations require response via a slip:

- Osteoporosis and falls – 14th November 2001
- The NSF for older people – 18th September 2001
- Heart failure in Portsmouth – CHD NSF - 27th March 2001
- Pain management - joint meeting with the pain clinic, addressing chronic pain, low back pain and neuropathic pain – 1st February 2000
- Update on strokes – 22nd June 1999
- NSAIDs (?) and the upper GI tract – 13th January 1999
- Fractured neck of femur – Rehabilitation and care pathways – 10th November 1998
- Getting the best out of the cardiac echo – 8th July 1998

- Valvular lesions and indications for treatment – 14th January 1998
- Hyponatraemia – 10th July 1997
- Assessment of a dizzy patient – 14th May 1997
- Incontinence – 13th November 1996 (I1.3)

4 The trust has also supplied examples of topics covered in 'Study Days' including:
- Parkinson's Disease – Ways without drugs
- Management of depression and dementia in the elderly (I1.3).

5 Trust provided information used to support training of Junior Medical Staff on death and associated subjects. This included:
6 Reasons for referring death to coroner (eg death was suspicious, may have been due to neglect, cause of death unknown)
7 Portsmouth Hospitals NHS Trust Post Mortem Consent Form (10/01/00)
8 Completion of Medical Certificate of Cause of Death (Office for National Statistics July 1997)

9 The review of the 200/01 CG Action Plan (March 2001) states that the trust is accredited for junior doctor's hours of work. The trust was not aware of any clinical areas where there are areas of concern about accreditation or that any specialties were on notice form the Royal Colleges (File1, 6.3.3, p3).

6.7.2 Nursing Supervision and Training

1 Training records for qualified nurses on Daedalus, Dryad and Sultan wards (and HCSWs on Sultan ward) during 1998-2001 were provided. The spreadsheets are very comprehensive and include a list of all nurses and different training courses etc. Attendance at specific events relevant to the Terms of Reference for the investigation has been included in appropriate section in this report. (X.3.3.1)

2 Trust provided CHI with a document outlining a proposal for an integrated Work based Learning and Practice Development project between the RCN's Gerontological Nursing programme, Portsmouth Healthcare NHS Trust, PCTs and Portsmouth University (2001). This included background information, the rationale fro the project, expected advantages and costs. It also included a Project plan for developing methods within Community Hospitals. A steering group and advisory group have been established, Critical companions have been recruited and links with university and promoting project are underway. A series of workshops have been arranged for October 2001 – April 2002. These cover Maximising the potential of the older person, Person centred assessment, Empowerment of older people (including carers), Medication and the older person, Working with older people with cognitive impairment and Discharge planning of older people with complex needs. (1.15 and H3.2).

Clinical Nursing Development programme Jan – March 1999 (1.14)

3 CHI received a copy of the agendas for 10 Study Days that formed part of the Clinical Nursing Development programme run by Portsmouth Healthcare NHS Trust in Jan – March 1999. No attendance information was provided, nor was it clear which staff grades were eligible to attend. The course included sessions given by clinical and managerial staff from PHCT and the University of Portsmouth. Topics included:

4 Exploring nursing practice
5 Policy changes and nursing practice
6 Evaluating quality in clinical practice
7 Clinical leadership
8 Enquiry based learning
9 Role of Non Executive Directors
10 Facilitating others to improve nursing practice
11 Clinical Supervision
12 Clinical audit
13 Clinical governance
14 Primary Care Groups
15 Health Improvement Programmes
16 Money, Activity and Quality
17 Recruitment and Retention
18 Information Strategy
19 Building and using a portfolio
20 Working with conflict and managing change
21 Presentation skills
22 Facilitation skills.

23 A progress report on training and development for nursing staff in PHCT community hospitals relating to intermediate care has been supplied, 12th February 2001. The service manager/senior nurse, training and development projects lead and Havant and Petersfield community hospitals produced the report. In anticipation to some changes to bed use as a result of immediate care, three related trust-wide projects have been ongoing since summer 2000. The aim was to identify and implement training and development for nursing staff to increase their skills base to help meet the needs of a changing patient group (I2.3).

24 The three projects are:

- The **ALERT** course – The acute life-threatening event, recognition and treatment course. A multi-professional one-day training course which aimed to train staff in helping to avoid unnecessary physical deterioration and deaths through the use of simple, preventative therapies. Training was provided by staff trained by the post-graduate school of medicine at the University of Portsmouth. For community hospitals, one training team was based in Gosport and Fareham and the other in Havant and Petersfield. Training was co-ordinated in these localities for February and March 2001 and was targeted at community hospitals nursing staff and GPs who work in the hospital. The plan is to extend the training to a rolling programme and include, for example, physiotherapists and occupational therapists (I2.3). An ALERT course outline has been provided, October 2000, produced by the University of Portsmouth. The course covers, assessing the critically ill patient, the blue and breathless patient, the hypotensive patient, the patient with a disorded conscious level, the oliguric patient, the patient in pain, organisational and communication skills and a brief introduction to the ethics of acute care. The latter module covers the principles of ethics, informed consent, DNR orders and withholding and withdrawal of treatment (I 2.2).

- The **AED** course – Review of medical emergency response and the use of automated external defibrillators (AED) in community hospitals (I 2.3).

- "Acute skills" and rehabilitation updates. A baseline of skills and competencies have been identified which will require nursing staff to meet the challenges relating to possible changes in bed use, for example from continuing care beds to more acute rehabilitation. This will include IV training and updates, internal ECG training and cannulation skills. Rehabilitation workshops have been provided (I 2.3).

25 The progress report notes that training and development opportunities related to these projects have been extended to staff at Gorseway Nursing Home and that Rembrandt staff were included in the AED project. It was identified that staff on the Unit were recruited having the baseline competencies identified by the T&D project group. It also notes there are a team of ALERT trainers in the department of elderly medicine included in the community hospitals project. Much of the equipment needed to support the increased response has been provided as part of the intermediate care bids (I 2.3.).

26 A post-registration education prospectus has been provided from the University of Southampton School of Nursing and Midwifery, 2001/2002. It covers diplomas, degrees and professional awards in topics ranging from basic moving and handling, medical nursing, chronic disease management, nursing elderly people to care and rehabilitation of disabled people and continuing care of the dying patient and family (I 2.1).

27 Information on the development of clinical supervision for nurses at Gosport and Fareham has been supplied. The document, undated, provides a brief overview of activities that have taken place involving nursing staff at Gosport and Fareham. Portsmouth Healthcare NHS Trust, according to the document, has been working to introduce systems for clinical supervision to all nurses across the trust for the past 5-6 years. The approach adopted has been initial introductory workshops, skills based workshops and helping to 'lead' in identifying the best ways of introducing clinical supervision. The document notes that several nurses have participated in the activities but that many have been prevented from doing so due to practical problems which will need addressing (D 3.1).

28 GWMH have provided information on nursing supervision arrangements, April to November 2001. Supervision arrangements are variable for each area, except for students and overseas nurses, and the arrangements are detailed by ward, for clinical managers and for H Grade (D 3.2).

29 Details of supervision sessions from Portsmouth Healthcare NHS Trust, September and October 2001, have also been provided listing each component involved and the resultant actions. Components covered involve complaints about attitudes, ward level organisation, off duty arrangements and concerns about staff training (D 3.2).

30 The lack of HCSW training was discussed at a GWMH clinical manager's meeting in November 2001. This was being addressed (D 3.2).

31 Two qualified nurses on Sultan ward have had pain management training (in 1999). No qualified nurses on Daedalus or Dryad Wards have had this training. (X.3.3)

32 Two qualified nurses on Sultan Ward took part in a Syringe Driver training course in 1999. Five qualified nurses on the ward have taken part in a Drug Competencies course, one in 2001, and four in 2000. No qualified nurses

from either Dryad or Daedalus Wards have taken part in either course between 1998 and 2001. (X.3.3)

33 An older person's nursing development programme was launched in 2000-01, jointly by PHCT and the Royal College of Nursing. The course is intended for trained nurses working with older people, and the aim of the course is to promote training in leadership, management and clinical issues. (A.1.2.1, p4)

34 [no evidence as to whether this is the same as:]

35 The Gerontological Nurse Development Programme is a tailor-made training and development programme for senior qualified nursing staff. It is to be progressed jointly by 'H&P' **[assume 'H&P community hospitals', which is to become part of E. Hampshire PCT at 01/04/01]**, and Fareham and Gosport PCT (when it is established). The spreadsheet showing uptake of training courses by qualified nurses shows that, of staff on Daedalus, Dryad and Sultan wards, one qualified nurse (Daedalus, 2001) took part in a 'gerontological programme'. (A.1.2.1, p15, X.3.3.3)

36 Nurses were to be identified for clinical leadership training at community hospitals and GP bed settings in PHCT in 2000/01. (A.1.2.4, p17)

37 Progress in training and development for qualified nursing staff in elderly medicine is listed as an area of significant achievement for PHCT in 2000-01. (A.1.2.1, p15) In 1999-2000, a clinical nurse development programme was consolidated at the trust, which aims to use research findings to identify areas of practice contributing to effective care and to use these as the basis for a programme of nurse development. (A.1.2.4, p4)

38 ENB Courses in diabetes, incontinence, care of the elderly, care of the dying, and palliative care are available at the hospital. No qualified nurses on Daedalus or Dryad wards took part in these from 1998-2001. Of qualified nurses on Sultan ward, one took part in the diabetes course (1999), one took part in palliative care (1999), one took part in the incontinence course (1999), and one took part in the care of the elderly course (1998). (X.3.3.3)

39 Daedalus ward at GWMH was identified, in the November 2000 Divisional Review, as one of three priority areas for training and development to meet intermediate care provision in community hospitals. The three wards Daedalus, Cedar ward at PCH and Shannon ward at SCH) were identified as having being areas where change of bed use is greatest i.e. from continuing care to more acute rehabilitation (1.13.3 Section 3.6).

40 The February 2001 Divisional Review noted that the training and development programme was progressing. The training and development group have identified a baseline of skills required to enable nursing staff to meet the needs of patients under the various intermediate care schemes. ALERT training teams are now based in F&G, H&P and elderly services, and these will be co-ordinating training for their respective areas. Over 100 qualified nursing staff have been trained on the use of automated external defibrillators (AED), and AED is now available for use on a number of wards, including Daedalus and Dryad at GWMH (1.13.2 Section 3.6).

6.7.3 AHP Supervision and Training

6.7.4 Other Staff Supervision and Training

1 Trust provided programme of a study day for Health Care Support Workers entitled "Talking with Dying Patients". The aim of the workshops was to enable staff to develop confidence in talking with patients who are dying. Twelve workshops were held between 1994 – 1998 and one hundred and twenty five staff attended. The workshop covered topics such as 'Why is dying a difficult subject to talk about, Fear of Dying, Facing Death, Breaking Bad News, Developing Communication Skills, Emotional Responses to Dying' (H1.2).

2 The Trust provided programme of a workshop for any health staff in the Community entitled "Loss, Death and Bereavement". The aim of the workshops was to enable staff to gain more confidence in dealing with issues of loss, death and bereavement. Seventy-nine workshops were held since 1994 (no end date given) and eight hundred and ninety nine staff attended. The workshop covered topics such as 'Facing loss, Other people's experience of loss., Facing death, Bereavement' (H1.3).

3 No qualified nurses from Sultan, Dryad or Daedalus wards took part in 'Loss, death and bereavement' training from 1998-2001. (X.3.3)

4 In 1999, the Community Hospitals attained the Investors In People award. The majority of the trust's services had achieved IIP and the rest were working towards it (File1, 4.2)

5 PHCT provide receptionist training and telephone behaviour training as part of their programme of training events 2001-2002. (G.3.1)

6 PHCT's Training on Demand – Working in Partnership document has been provided. This is a guide for trainers in how to provide the Working in Partnership training session. The session is aimed at all staff who provide direct care to elderly patients. The session aims to increase awareness of partnership working and enhance the quality of such working. The session is to enable participants to state the qualities/skills necessary to facilitate effective partnerships, to prepare a Charter for effective partnerships, and to identify and be able to deal with issues preventing them from implementing this Charter. The course is designed to focus on the underpinning principles of partnership working, and therefore does not have great emphasis on day-to-day working. (G.3.2, p2). GP Bed and Community Hospital wards in PHCT use 'Training on demand' packs. (A.1.2.4, p17).

7 A programme of training events 2001-2002 has been provided by PHCT, which includes:
- Receptionist Training Programme
- Telephone Behaviour (G.3.1)

8 PHCT has developed various courses with the local university **[Portsmouth?]** in response to staff development needs. These are:
9 Clinical Governance PGC
10 Research and Development PGC
11 Clinical Leadership Programme
12 Gerontological Nursing Programme
13 Gerontological MSc
14 Professional Doctorate

15 Stroke Nurse Consultant Post (X.3.3.2)

6.7.5 Induction

1 PHCT have an induction training policy to ensure a minimum standard of induction training for all new staff. There is an induction checklist to be completed by the manager and the employee. There is a local induction seminar covering information on the structure of the NHS, PHCT and structures and features of the division. If the new employee is required to attend mandatory courses, food hygiene, lifting and handling, first aid and dealing with aggressive behaviour it is the responsibility of their manager to ensure the relevant courses are attended (D4.3).

2 The trust has sent the agendas for the Fareham and Gosport induction programme. The May 1999, February 2000 and August 2000 all have a similar agenda for a half-day, providing induction on salaries and wages, pensions, occupational health, safety and welfare as well as an introduction to the trust by a general manager. The most recent induction agenda, from 9th November 2001 is a full-day induction incorporating the above subjects with basic life support training, fire regulations, health at work, control of infection and an introduction to food hygiene (D4.1).

3 The trust has provided their ward induction packs for Daedalus and Sultan Wards. They include basic information about the hospital and also explain the basic procedures within the ward, for example using the telephones and preparing a ward area (D4.2).

4 The Department of Medicine for elderly people have produced a booklet called, 'Essential information for medical staff'. This includes

- The timetables for all medical staff
- Agendas for their lunchtime meetings
- Details of all types of care they provide, e.g. rehabilitation
- Guidelines for handover and hand back
- Guidelines for accepting admissions to the acute wards
- On-call responsibilities
- List of key staff
- Drugs and Therapeutics information
- Guidelines for the management of the Day Hospitals
- Discharge summary standards
- Overview of the stroke service
- Guidelines on infection control
- Whistle blowing
- Violence and aggression (D4.4)

5 There is a welcome pack for medical staff that includes data protection guidelines, diversity matters, violence and aggression, stress guidelines, hospital chaplaincy, library information (NB: This may be directed to just QAH and SMH) (D4.5).

6 PHCT have a staff handbook that details all the services available to staff, the conditions of employment, arrangements for health and safety and arrangements for training and development of staff. The handbook also informs staff of communication networks within the trust (D4.6).

6.7.6 Mandatory Training

6.7.7 General

1 The 2000/01 CG Annual report states that an audit of the number of professional staff who have received an annual appraisal and personal development plan was being undertaken at March 2001. (File1, 6.4.2, p3).

2 The 2000/01 CG Annual report states that a Training and Education Strategy Group was established. It would assess and quantify the educational needs in respect of running clinical services. The trust's personnel director is a member of the Local Education Committee (File1, 6.4.2, p3; File1, 6.3.3, p3)

3 According to the review of the CG Action Plan 2000/01 (March 2001) the trust has processes in place to support and ensure clinical supervision – however these were better developed in some professions than others. A review of the extent of clinical supervision was to be undertaken in 2001/02. The trust has systems in place for managing poor performance. Competencies have been defined in some areas but the work needs to be extended and prioritised according to clinical risk. Further work was needed to produce guidance for assessors. A key action for the trust was to develop, by Dec 2000, an education plan that defines training needs and priorities against clinical risk features. In March 2001 no formal plan had been produced but each service had been prioritising clinical risk issues. Training needs which had been identified included CPR, Infection Control, Medical collapse, Assessment of risk and restraint techniques (Fiel1, 6.3.3, p2).

4 The review of the 200/01 CG Action Plan (March 2001) states that most staff receive appraisals and have personal development plans. This process was to be completed "in the next few months" and after that all staff would have an annual appraisal (File1, 6.3.3, p3).

6.8 HOW LESSONS HAVE BEEN LEARNED

6.8.1 Complaints

6.8.2 Trust Management of Complaints

1 The HAS Standards for Health and Social Care Services for Older People (2000) states, in Standard 7.4 of Level II, that, *"There is a clear and responsive complaints procedure "* . Users and carers should be aware of the procedure. There should be evidence that the procedure is implemented, Complaints should be dealt with effectively and in a reasonable timescale. The procedure should be used to improve the quality of care and to reduce risks. Complaints and claims should be monitored, to identify trends and inform the process of implementation of f required actions (2.4, p30).

2 The trust has a policy for handling patient related complaints produced in January 1997. The policy is based on the NHS Executive document 'Complaints: Guidance on the Implementation of the NHS Complaints Procedure' (published in 1996), and mirrors the NHS Executive's 1996 complaints handling procedure, having two parts. These are local resolution, and independent review. A number of steps are to be taken at the local level; once these have been taken a complaint can progress to independent

review if the complainant remains unsatisfied. The trust's policy incorporates complainants' suggestions made in a 1995 review of the process. (1.4, pp1-2)

3 A database was introduced in 1999 to assist keep record of and track trends in patient complaints. An investigations officer was also appointed, resulting in improved fact finding behind complaints. (A.1.2.4, p5)

4 The trust's aim is to have a system which:
5 Is accessible to users (well publicised, user friendly)
6 Ensures that complaints are dealt with at the point at which they arise wherever possible
7 Is fair to all (including staff) and impartial
8 Provides a thorough, effective mechanism for dealing with grievances
9 Is quick and efficient
10 Ensures that lessons are learned from complaints and that action takes place to rectify any deficiencies (1.4, p1)

11 All complaints received are to be reported as soon as possible to the Complaints Adviser, who registers and records them on the trust's database. A summary of complaints is produced within 20 days of the end of each quarter. This summary is considered part of the Divisional Review process. Action planned as a result of complaints, and confirmation of actions that have taken place, should be described in Divisional Review Report (1.4, p6)

12 Audit standards for complaints handling:
- 100% acknowledged within two working days
- 100% resolved within 20 working days
- At least 80% complainants satisfied with complaint handling
- Divisions receive reports on all complaints within one month of end of quarter
- 100% dealt with at appropriate level
- Action taken in all cases where appropriate to do so (1.4, p6)

13 Non-compliance with the trust's complaints policy is subject to disciplinary action, except in exceptional circumstances (1.4, p6)

14 The trust has supplied a leaflet ('Your Views Matter' (1.4.01)), which explains the procedure for complaint to patients. Patients are advised to make complaints within six months of the event, or of their realising that they have a subject for complaint if that is within twelve months of the event. Patients are encouraged to make direct verbal comments to staff if it is possible. If it is not, they are advised either to speak to the head of the relevant department, or to write to the trust's Chief Executive, whose address is given. The Health Authority Complaints Team's telephone number is also given as a contact point for further guidance. (1.4.01)

15 The trust advises patients that acknowledgement will be sent within two days of receipt of a formal written complaint, and that a full written response to the complaint will normally be sent within twenty working days. (1.4.01)

16 The trust's guidance leaflet for patients on how to make a complaint advises that complainants may seek Independent Review if matters are not resolved to their satisfaction. Any such request will be considered by a non-executive director, and if deemed appropriate by them, the complaint will be considered by a specially convened panel. If the Independent Review does not satisfactorily resolve the matter, patients are advised that they may contact the Health Ombudsman, whose address is given. (1.4.01)

17 The August 2001 Divisional Review noted that investigations into elderly mental health resulting from allegations made by a staff member at Redclyffe house were nearing completion. The report stated that it was likely that a project group involving staff reps would be set up to agree an action plan and monitor progress (1.13.1). *{IH - Do we have details? Is it relevant to the investigation?}*

18 The August 2001 Divisional Review noted that a number of investigations into allegations made by a member of staff.

6.8.2.1 Numbers / Types of Complaints

1 The 1999/00 CG Annual report included a Complaints report for quarter ending March 2000. 92 complaints were received in 1999/00. 73% were acknowledged within 2 working days and a response was made within 20 working days for 26%. There were 4 requests for Independent Review in 1999/00 (all in Q3). One was sent back for local resolution and an action plan was developed as a result. This included a review of staff training needs especially in communication skills, development of protocols for administering client's own non-psychiatric medicines and better involvement/information for clients on care planned. File1 6.4.1 Attachment C).

2 The majority of complaints related to "staff attitude" (24) and "clinical treatment" (35) and "Admission/discharge/transfer" (11). The highest number of complaints were about the Elderly Medicine service (26) and Adult Mental health (18). Actions and changes that resulted from these complaints included:

3 A number of clients had their treatment needs and care plans reviewed/revised

4 Staff reminded to give MRSA info leaflets to relatives/clients (File1 6.4.1 Attachment C).

5 The 2000/01 CG Annual report included information on complaints. The quarterly Divisional Review includes a review of any action plans that have been drawn up following complaints (File1, 6.4.2, p3).

6.8.3 Ward Management of Complaints

6.8.4 Trust Lessons learned

1 The 1999/00 CG Annual Report states that "there was need, where complaints had led to recommendations about changing practice, to ensure that review occurs to ascertain whether practice ahs improved" (File1, 6.4.1, p3).

2 The November 2000 Divisional Review included an attached paper (dated 09/11/00) detailing "the most important clinical risk issues facing the division". The included serious complaints at Gosport War Memorial. The emerging themes are nutrition and hydration, staff attitudes, and communications with carers. A meeting was arranged for the end of November between nursing and medical staff to begin to think about actions which might be taken to address the concerns raised in the complaints mentioned (1.13.3). *{IH - What was the outcome of this?}*

3 The February 2001 Divisional Review includes a quality report, which noted that a review of management of a recent police investigation revealed areas for development for the organisation. Actions included a plan to deal with the results of the CPS review and a procedure to be developed to ensure lines of communication and staff and family support are co-ordinated, should there be any future investigation of this nature (1.13.2 Section 3.7).

4 The May 2001 Divisional Review provided feedback from the analysis of complaints workshop held on 27 February 2001. From five complaints received between 1998 and 2000, three themes emerged – communication with relatives, attitudes of staff, and eating and drinking. Those present at the workshop agreed that communication was probably the most significant, as it impacted on the other two themes. It was recognised that the complaints were quite old, but still current and that a number of changes had already taken place. It was agreed that there was a need to deal with the perceptions held by the complainants, whether staff agreed with the complaints or not. It was also highlighted that during a period at the end of 1998 and early 1999, the wards were under some pressure.

5 The workshop considered a number of issues:
- Things done since 1998
- The issues for staff / barriers to good communication with relatives
- What good communication with relatives would look like, and
- Ideas for achievement

Actions from the workshop included further workshops for staff, a review of bleep-holder problems / issues, the establishment of a working group, and a survey of patients / relatives views (1.13 Section 7.1.2).

6.8.5 Ward Lessons learned

1 Following a complaint Ward staff on Sultan Ward "will be reflecting on how they can improve communication with relatives, particularly in clarifying expectations of the care planned". The Trust was also developing new policy and protocol for the management of pain relief, with contribution of staff from GWMH (Z 1.2).

2 An action plan of issues was to be discussed with all ward staff and medical staff on Dryad Ward at GWMH following a complaint. These would involve Admission protocols (To include relative support review), Pain Control, Review of fluids protocols and Medical cover requirements over weekends and bank Holidays). From 16/2/1999 the consultant's ward round was to be weekly not fortnightly (Z1.1).

3 The review of the 2000/01 CG Action Plan (March 2001) states that there are systems in place to ensure that action and weaknesses are identified following complaints but it was recognised that follow up systems need strengthening to ensure that actions have occurred . A key action for the trust was to implement a system by Sept 2000 to ensure that the follow up action following complaints was reviewed as part of Divisional performance review process. This has been implemented (File1, 6.3.3, p3).

4 Following five patient complaints in 1998/1999, a workshop was held in February 2001 and emerging themes were discussed. One of the agreed action plans was to introduce a patient survey. This is given to patients on discharge and is run on a quarterly basis. Results are collected and discussed among all clinical managers and written up as an action plan.

Each ward is also given a copy of the individual results from their area in order that any necessary action can be implemented (A 4.3).

6.9 PATIENT SURVEYS

1 Patient surveys were carried out at GWMH in July and October 2001. The patient survey form allows patients to state what they liked best, what they liked least, and what could be improved about their stay in hospital. (G.2.1)

2 An action plan was drawn up in response to concerns raised in the July 2001 and October 2001 patient surveys. Actions were planned in the following areas:

- Staff levels
- Beverage rounds
- "Smelly pillows"
- Ward temperatures
- The catering service
- Staff attitude

3 These actions were all assigned lead staff, and were either set deadlines between November 2001 and May 2002, or identified as being ongoing. (G.2.1, 4-6)