Gosport Investigation

Acknowledgements
Staff interviewed by CHIs investigation team (see appendix D) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millet, Chief Executive (until 31.3.02) and Ian Piper Chief Executive of Fareham and Gosport PCT (since 1.4.02). Staff and patients who welcomed the CHI team on to the wards during observation work.

Chapter 1 - Terms of reference and process of the investigation

During the summer of 2001, concerns were raised with CHI about the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the Gosport War Memorial Hospital. These concerns also included the responsibility for clinical care and transfer arrangements with other hospitals.

On 18 September 2001, CHI's Investigations and Fast Track Clinical Governance Programme Board decided to undertake an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust is responsible at the Gosport War Memorial Hospital. CHI's decision was based on evidence of high risk activity and the likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

The investigation terms of reference were informed by a chronology of events surrounding the death of one patient provided by the trust. Discussions were also held with the trust, the Isle of Wight, Portsmouth and South East Hampshire Health Authority and the NHS South East Regional Office to ensure that the terms of reference would deliver a comprehensive report to ensure maximum learning locally and for the NHS.

The terms of reference agreed on 9 October 2001 are as follows:

The investigation will look at whether, since 1998, there had been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i). Staffing and accountability arrangements, including out of hours.

ii). The guidelines and practices in place at the trust to ensure good quality care and effective performance management.

iii). Arrangements for the prescription, administration, review and recording of drugs.

iv). Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations.
v). Arrangements to support patients and their relatives and carers towards the end of the patients' life.
vi). Supervision and training arrangements in place to enable staff to provide effective care.

In addition, CHI will examine how lessons to improve patient care have been learnt across the trust from patient complaints.

The investigation will also look at the adequacy of the trust's clinical governance arrangements to support inpatient continuing and rehabilitation care for older people.

CHI's investigation team

Alan Carpenter, chief executive, Somerset Coast Primary Care Trust
Anne Grosskurth, CHI Support Investigations Manger
Dr Tony Luxton, consultant geriatrician, Lifespan Healthcare NHS Trust
Julie Miller, CHI Lead Investigations Manager
Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
Dr Mary Parkinson, Retired GP and Lay Member (Age Concern)
Jennifer Wenborne, Independent Occupational Therapist

The team was supported by:
Liz Fradd, CHI Nurse Director, lead CHI director for the investigation
Nan Newberry, CHI Senior Analyst
Kellie-Ann Rehill, CHI Investigations Coordinator
A medical notes review group established by CHI to review anonymised medical notes (see appendix E)

The investigation process
The investigation consisted of five inter related parts:

Review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (See appendix A for a list of documents reviewed).

Analysis of views received from 36 patients, relatives and friends about care received at the Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls and a short questionnaire. (See appendix B for an analysis of views received).

A five day visit by the CHI investigation team to the Gosport War Memorial Hospital when a total of 59 staff from all groups involved in the care and treatment of older people at the hospital and relevant trust management were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards. (See appendix C for a list of all staff interviewed).

Interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (See appendix D for a list of organisations interviewed).

An independent review of anonymised clinical and nursing notes of a random sample of patients who had recently died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this specific piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendix E.

Chapter 2 – Background to the investigation

Complaints to the Trust

There have been ten complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and November 1998 raised concerns which included the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which triggered the initial police investigation, which was not pursued through the NHS Complaints Procedure.

Chapter 3 – National and Local Context

Trust Background

Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust (PHCT) between April 1994 and April 2002. The hospital is situated on the Gosport peninsula and has 113 beds. Together with outpatient services and a day hospital, there are beds for older people and maternity services. The hospital does not admit patients who are acutely ill, it has neither an A&E nor intensive care facilities. PHCT provided a range of community and hospital based services for the people of Portsmouth, Fareham, Gosport and surrounding areas. These services included mental health (adult and elderly), community paediatrics, elderly medicine, learning disabilities and psychology.

The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/02 the trust had a budget in excess of £100 million, over 20% of income was spent on its largest service, elderly medicine. All financial targets were met in 2000/01.

Move Towards the Primary Care Trust

PHCT was dissolved on 31 March 2002. Services have been transferred to local Primary Care Trusts (PCTs), including the Fareham and Gosport PCT which became operational, as a level four PCT, in April 2002. Arrangements have been made for various local PCTs to "host" clinical services on behalf of other organisations. This will not mean that the PCT will commission services of another PCT. The Fareham and Gosport PCT will manage the nursing staff, premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Medical staff involved in the care of older people, including those working at the Gosport War Memorial Hospital, are now employed by the East Hampshire PCT. Further detail of PCT hosting arrangements can be found at appendix F

Portsmouth NHS Healthcare Trust Strategic Management

The Trust Board consisted of a Chair, 5 Non-Executive Directors, the Chief Executive and the executive directors of operations, medicine, nursing and finance, together with the personnel director. The trust was organised into 6 divisions, two of which are relevant to this investigation. The Fareham and Gosport Division which managed the Gosport War Memorial Hospital and the Department of Elderly Medicine.

CHI heard that the Trust was well regarded in the local health community and had developed constructive links with the Health Authority and local PCGs. For example in the lead up to the new PCT, PHCT's Director of Operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the Trust on the Development of Intermediate Care and Clinical Governance. High regard and respect for trust staff was also commented on by the Local Medical Committee, UNISON and the RCN.

Local Services for Older People

Before April 2002, all services for older people in Portsmouth, including acute care, rehabilitation and continuing care were provided by the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. Acute services are based in the Queen Alexandra and St Mary's Hospitals, part of the Portsmouth Hospitals NHS Trust. Though an unusual arrangement, precedents for this model of care did exist, in Southampton Community Trust for example. Management of all services for older people has now transferred to the East Hampshire PCT. Until August 2001, the Royal Hospital Halsar, a Ministry of Defence military hospital on the Gosport peninsula also provided acute medical care to older civilians as well as military staff.

Service Performance Management

The principle tool for the performance management of the Fareham and Gosport division was the quarterly divisional review, which considered regular reports on clinical governance, complaints and risk. The division was led by a general manager, who reported to the chief executive. Divisional management at PHCT was well defined, with clear systems for reporting and monitoring. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level.

In patient services for older people at the Gosport War Memorial Hospital 1998-2002

The Gosport War Memorial Hospital provides continuing care, rehabilitation, day hospital and outpatient services for older people and was managed by the Fareham & Gosport Division. In November 2000 there was a change of use of beds at the hospital to provide community rehabilitation and post acute beds as a result of local developments to develop intermediate and rehabilitation services in the community.

In 1998 four wards admitted older patients at the War Memorial Hospital; Dryad, Daedalus, Sultan and Mulberry wards. This is still the case today.

Ward	1998	2002
Dryad	20? Continuing care beds. Patients admitted under the care of a consultant, with some care provided by a clinical assistant.	20 continuing care beds for frail elderly patients and slow stream rehabilitation. Patients are admitted under the care of a consultant. Day to day care is provide by a staff grade doctor.
Daedalus	Trust to complete?? Patients admitted under the care of a consultant, with some care provided by a clinical assistant.	24 rehabilitation beds; 8 general, 8 fast and 8 slow stream (since November 2000). Patients are admitted under the care of a consultant. Day to day care is provided by a staff grade doctor.
Sultan	24 GP beds with care managed by patients own GPs. Patients are not exclusively older patients, care can include rehabilitation and respite care. A ward manager (or sister) manages the ward, which was staffed by PHCT staff.	As for 1998, though since April 2002, staff now employed by a PCT.

Admission criteria

Dryad and Daedalus wards

The current criteria for admission to both Dryad and Daedalus wards, are that the patient must be over 65 and be registered with a GP within the Gosport PCG. In addition, Dryad patients must have a Barthel score of under 4/20 and require specialist medical and nursing intervention. The Barthel score is a validated tool used to measure physical disability. Daedalus patients must require multidisciplinary rehabilitation for strokes and other conditions.

The case note review undertaken by CHI confirmed that the admission criteria for these two wards was being adhered to in recent months, appropriately admitted patients were being cared for.

Sultan ward

There is a comprehensive list of admission criteria developed in 1999, all of which must be met prior to admission. The criteria states that patients must not be medically unstable and no intravenous lines must be in situ. CHI found examples of some recent patients who had been admitted with more complex needs than stipulated in the admission criteria.

Elderly mental health
Though not part of the CHI investigation, older patients are also cared for on the Mulberry ward, a 40 bed assessment unit comprising of the Collingwood and Ark Royal wards. Patients admitted to this ward are under the care of a consultant in elderly mental health.

Terminology
CHI found considerable confusion, in written information and in interviews with staff, around the terminology describing the various levels of care for older people, for example CHI heard of "stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care". CHI was not aware of any common criteria defining these areas in use at the trust. CHI stakeholder work confirmed that this confusion extends to patients and relatives in terms of their expectations of the type of care which will be received.

Chapter 4 – Quality of Care and the Patient Experience

Introduction

The patient's experience is at the centre of all CHIs work. This chapter details CHI's findings following contact with patients and relatives which should be put into the context of the total number of 1725 finished consultant episode's (FCE's) for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Detail of the methodology used to gain an insight into the patient experience and of the issues raised with CHI are contained in Appendix B.

Patients clothing

Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by families. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes.

Transfer arrangements between local hospitals

Concern was expressed regarding the physical transfer of patients from one hospital to another. This concern was acknowledged by PHCT who sought an apology from the referring hospital who did not have the appropriate equipment available.

Nutrition and fluids

Following comments by stakeholders, CHI reviewed trust policy for nutrition and fluids. The trust conducted an audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy "Feeding People". The trust policy dated 2000 "Prevention and Management of Malnutrition" includes the designation of an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure 100% compliance. The standards state:

- all patients must have a nutritional risk assessment on admission
- Registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary.

- All staff must ensure that documented evidence supports the continuity of patient care and clinical practice.
- All clinical areas should have a nominated nutritional representative who attends training/updates and is a resource for colleagues.
- Systems should be in place to ensure that staff have the required training to implement and monitor the 'Feeding People' standards.

A second trust audit in 2000, concluded that overall the implementation of the Feeding People standards have been "very encouraging". However, there were concerns about the lack of documentation and a sense of complacency as locally written protocols had not been produced universally throughout the service.

Ward environment
All wards were built during the 1991 expansion of the hospital and are modern, welcoming and bright

Communication with patients and relatives
Daedalus ward have a communication book by each bed for patients and relatives to make comments about day to day care. This is a two way communication process which, for example, allows therapy staff to ask relatives for feedback on progress and enables relatives to ask for an appointment with the consultant.

Chapter 5 - Arrangements for the prescription, administration, review and recording of medicines

Medicine useage

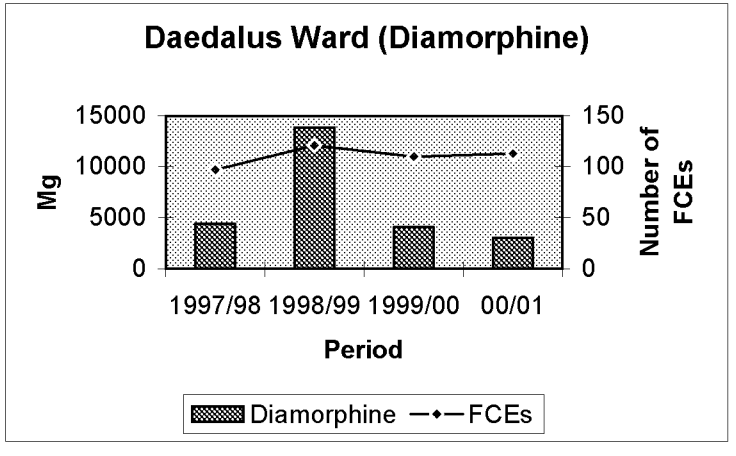
In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. Some of the medicines used in the care of older people can be delivered by a syringe driver which delivers a continuous subcutaneous infusion (under the skin). This information has been plotted against the total number of admissions for the relevant year. The data relates only to medicines issued from the pharmacy and does not include any wastage, nor can it prove the amounts of medicines actually administered. A detailed breakdown of medicines for each ward is attached at appendix H.

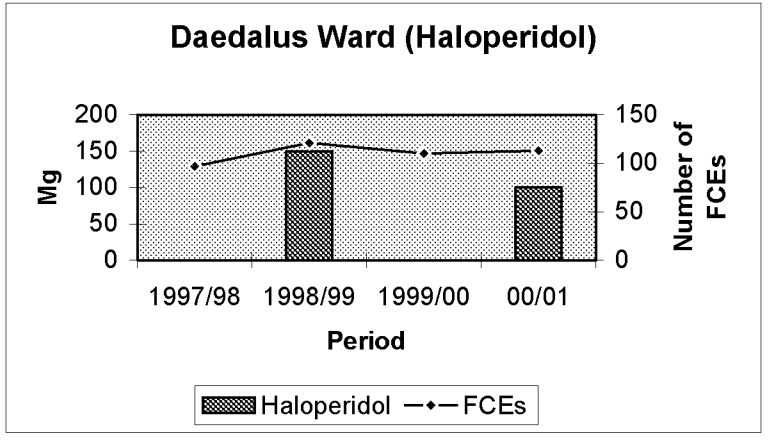
The usage of three particular medicines demonstrated below were highlighted by the experts commissioned by the police as of concern.

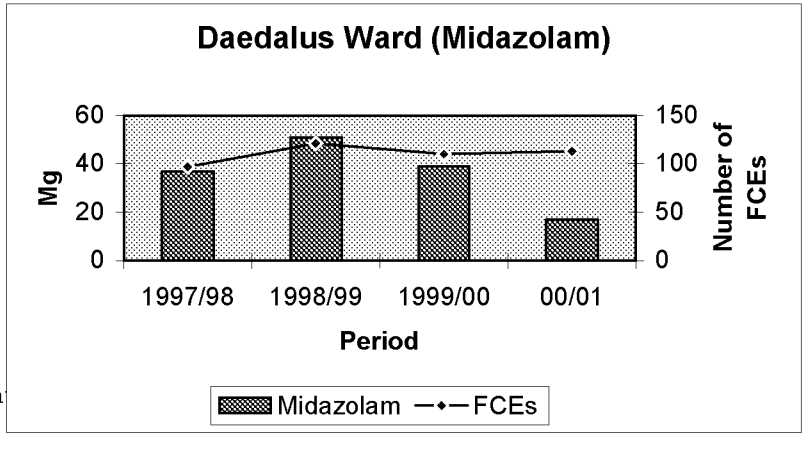
Please see graphs on separate page

Graphs to show the usage of medicine 1997/98-2000/01according to the number of FCE per ward.

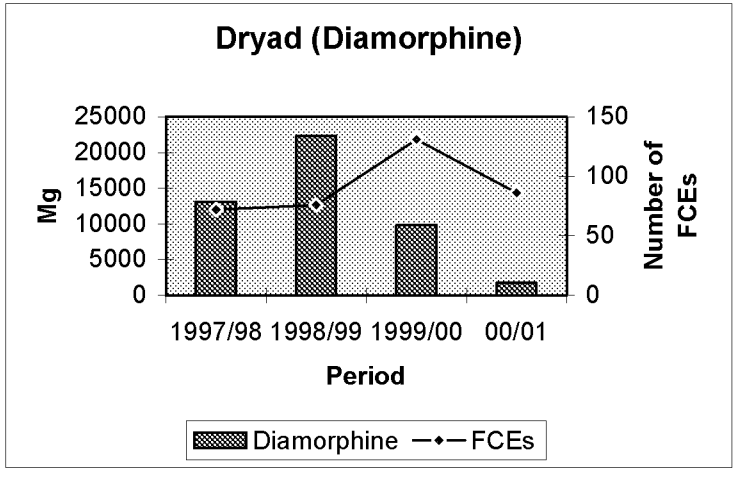
Graph 1. Daedalus

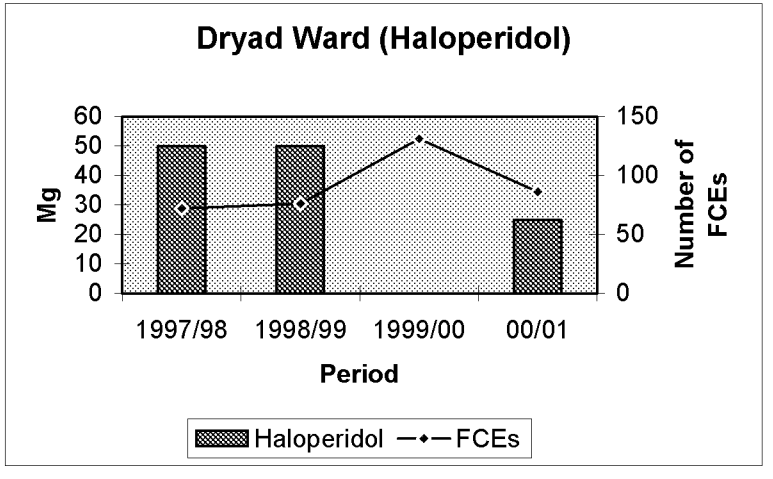


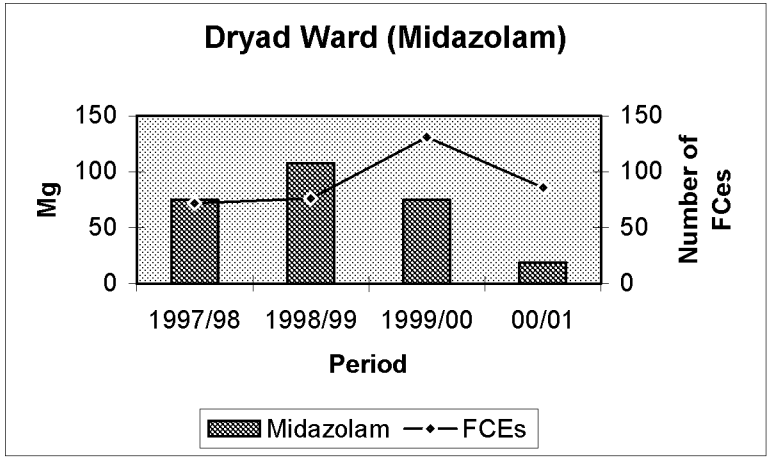




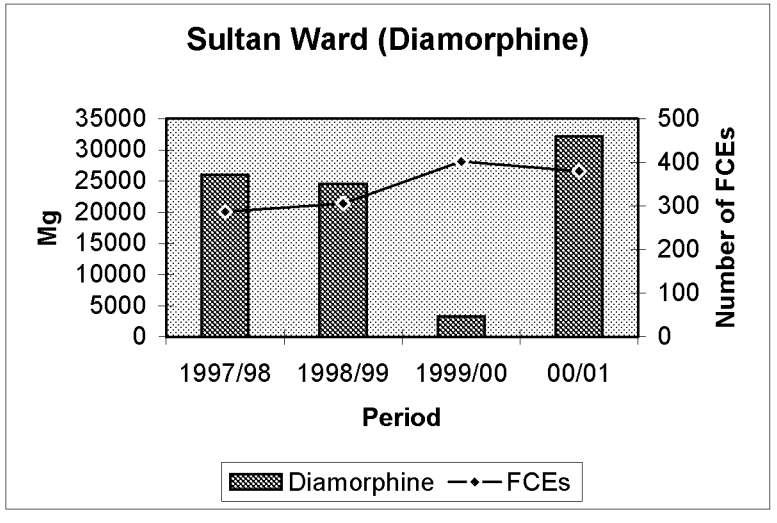
Graph 2 - Dryad

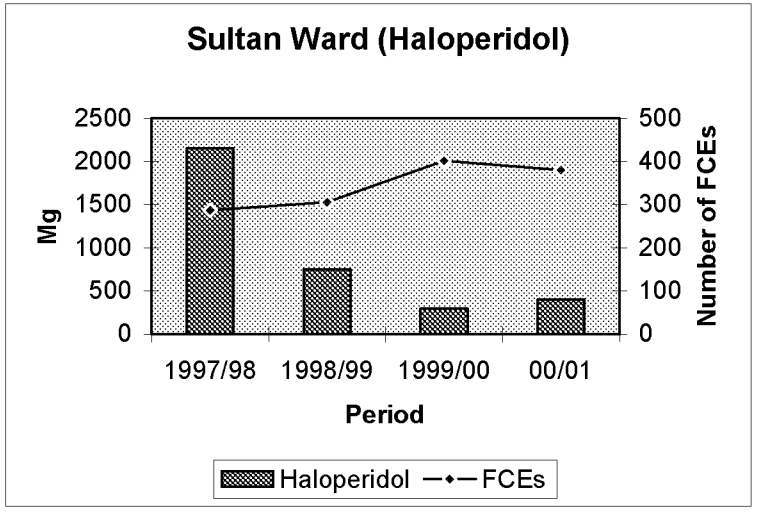


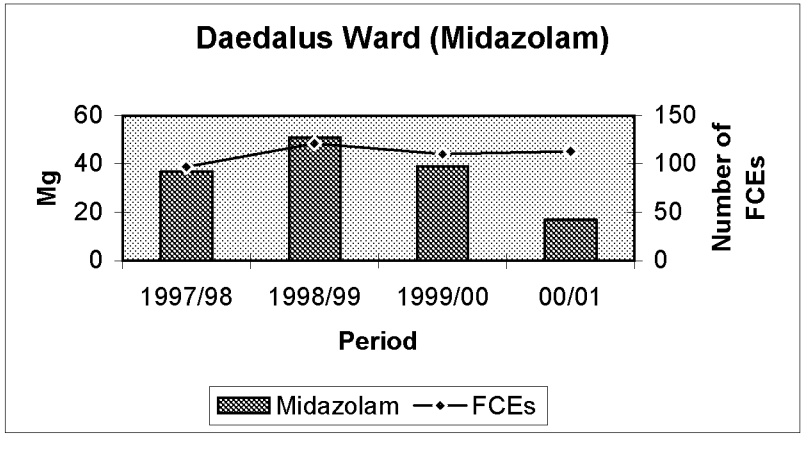




Graph 3. Sultan







Assessment and management of pain

The Trust's policy for the assessment and management of pain was introduced in April 2001 in collaboration with Portsmouth Hospitals NHS Trust and is due for review in 2003. The stated purpose of the document was to identify mechanisms to ensure that all patients have early and effective management of pain or distress. The policy places responsibility for ensuring that pain management standards are implemented in every clinical setting and sets out the following:

- The prescription must be written by medical staff following diagnosis of type(s) of pain and 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 rationale 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.

CHI has also seen evidence of a pain management cycle chart and an "analgesic ladder". The "analgesic ladder" indicates the drug doses for different levels and types of pain, how to calculate opiate doses and advice on how to evaluate the effects of analgesia and how to observe for any side effects. Nurses interviewed by CHI demonstrated a good understanding of pain assessment tools and the progression up the analgesic ladder.

Many staff interviewed referred to the "Wessex" palliative care guidelines (explained in paragraph??) which are in general use on the wards. Though the section on pain focuses on patients with cancer, there is a clear highlighted statement on the opening page of the guidelines which states that "All pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold".

Prescription writing policy

This policy was produced jointly with the Portsmouth Hospitals NHS Trust in March 1998. The policy covers the purpose, scope, responsibilities, requirements for prescription writing, medicines administered at nurses' discretion and controlled drugs. A separate policy covers the administration of IV medicines.

The policy also covers a section on verbal orders. Telephone orders for single doses of medicines can be accepted over the telephone by a registered nurse if the doctor is unable to attend the ward.

Administration of medication

Medication can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and under the skin via a syringe driver. Guidance for staff on prescribing via syringe drivers is contained within the Trust's policy for assessment and management of pain and states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

Information provided by the Trust indicates that only two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five nurses had also completed a drugs competencies course. No qualified nurses from either Dryad or Deadalus ward had taken part in either course between 1998 and 2001. Some nursing and healthcare support staff spoke of receiving syringe driver information and training from a local hospice.

Review of medication

In November 1999, a PHCT review of the use of neuroleptic medicines, which includes tranquillisers such as haloperidol, within all trust elderly care continuing care wards concluded that neuroleptic medicines were not being over prescribed. The same review revealed that "the weekly medical review of medication was not necessarily recorded in the medical notes". The findings of this audit and the accompanying action plan, which included guidance on completing the prescription chart correctly, was circulated to all staff on Daedalus and Dryad wards, including part-time staff and the clinical assistant. A copy was not sent to Sultan ward. There was a re-audit in January 2000, when it was concluded that *??? (trust asked for copy)*

Structure of pharmacy

The PHCT have a service level agreement with the local acute trust, Portsmouth Hospitals NHS Trust, for pharmacy services. The contract is managed locally by a grade E pharmacist and the service provided by a second pharmacist who is the lead for older peoples services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing

workload. Pharmacy staff were confident the pharmacist would challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to use the trust intranet to provide a "Compendium of Drug therapy Guidelines, though CHI was told that the intranet was not generally available.

CHI was not aware of any trust systems which could have alerted the PHCT to any unusual or excessive patterns of prescribing, though the data to do this would have been available and was provided to CHI.

Chapter 6 – Staffing Arrangements and Responsiblity for Patient Care

Responsibility for Patient Care

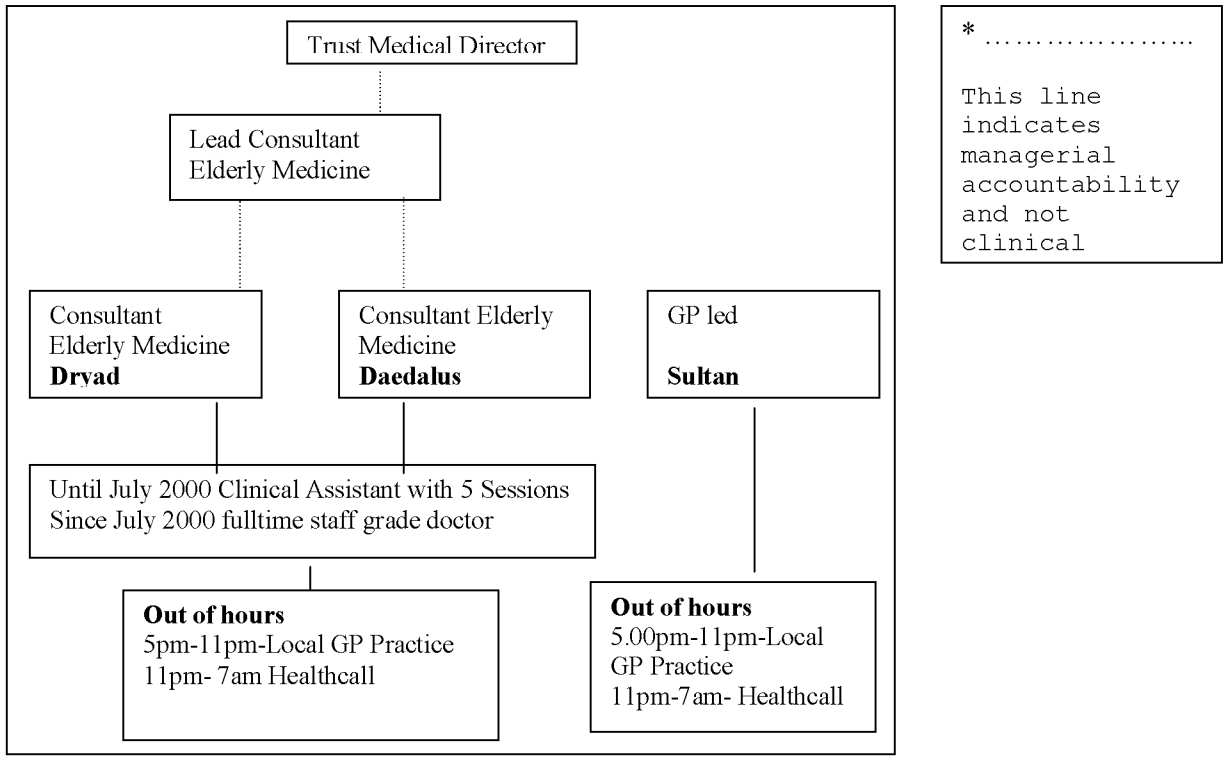
Patient care at the Gosport War Memorial for the period of the CHI investigation was provided by a consultant led team on Daedlus and Dryad wards

Medical Responsibility

For the period covered by the CHI Investigation and currently, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. All patients on both wards are admitted under the care of a consultant. Since 1999, there has been a lead consultant for Elderly Medicine who holds a two session (one session equates to half a day per week) contract for undertaking lead consultant responsibilities. These responsibilities include overall management of the department and the development of departmental objectives. The lead clinician is not responsible for the clinical practice of individual doctors. The post holder does not undertake any sessions on the War Memorial site. The job description for the post, outlines twelve functions and states that the post is a major challenge for "a very part time role".

In addition, since 2000 *(check with trust)* two elderly medicine consultants provide 10 sessions in total of consultant cover on Dryad and Daedalus wards. Since September 2000, day to day medical support is provided by a staff grade physician who is supervised by both consultants. Before this, additional medical support was provided by a Clinical Assistant until July 2000. Both consultants undertake a weekly ward round with the staff grade doctor. In 1998, there had been a fortnightly ward round on Daedalus ward, CHI heard that ward rounds were less frequent than this on Dryad ward.

CHI considers that the staff grade post is a pivotal, potentially isolated post, due to the distance of the War Memorial Hospital from the hub of the department of elderly medicine based at Queen Alexandra Hospital and the difficulty in attending departmental meetings. The trust recognised this as an issue in 2001 in the document which outlines action taken following complaints and patient based incidents " A decision was taken not to employ a locum consultant to cover the wards because of the risk of professional isolation and support in Gosport".



General Practice Role and Accountability

Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation; as clinical assistants, as the clinicians admitting and caring for patients on the GP (Sultan) ward and as providers of out of hours medical support on each of the three wards.

Clinical Assistant Role

Clinical assistants are GPs who are employed and paid by trusts to provide, largely part time, medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years. PHCT employed a number of such GPs in this capacity in each

of their community hospitals. Clinical assistants work as part of a consultant led team have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

Between 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states that the clinical assistant is accountable to "named consultant physicians in geriatric medicine". Cover for annual leave and any sickness absence was the responsibility of the post holder to arrange with practice partners, with whom the trust did not have a contract for this purpose. The job description does state that the post is subject to the Terms and Conditions of Hospital Medical and Dental Staff, if identified, poor performance could have been investigated through the trust's disciplinary processes. Any concerns over the performance of any clinical assistant could have been pursued through the Trust disciplinary proceedings. CHI could find no evidence to suggest that this option was explored.

CHI is not aware of any trust systems in place to monitor or appraise the performance of the clinical assistant, this lack of monitoring is still common practice within the NHS. CHI could find no evidence of any system put in place by consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, to supervise the practice of the clinical assistant. This includes any review of prescribing. CHI could also find no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions.

Sultan Ward

Medical responsibility for patients on Sultan ward lies with the admitting GP. The trust issued admitting GPs with a contract for working on trust premises, which clearly states "you will take full clinical responsibility for the patients under your care". CHI was told that GPs visit their patients regularly and when requested by nursing staff. This is a common arrangement in community hospitals throughout the NHS. GPs have no medical accountablity framework within the trust.

GPs managing their own patients on Sultan ward could be subject to the Health Authority's voluntary process for dealing with doctors whose performance is giving cause for concern. However, this procedure can only be used in regard to their work as a GP, and not any contracted work performed in the trust as a clinical assistant. Again, this arrangement is common throughout the NHS.

Out of Hours Cover Provided by GPs

Between the hours of 9.00am and 5.00pm on weekdays, hospital doctors employed by the trust manage the care of all patients on Dryad and Deadalus wards. Out of hours medical cover, including weekends and bank holidays is provided by a local GP practice from 5.00pm to 11.00pm after which nursing staff call on either the patients' practice or Healthcall, a local deputising service for medical input between 11.00pm and 7.00am. *(check 7am-9am gap with trust)* Some staff interviewed by CHI on all wards expressed concern regarding long waits for the Healthcall service. It was suggested that waiting times for Healthcall to attend to a patient could sometimes take between 3-5 hours. However, evidence provided by Healthcall contradicts this. There is no trust system to report long waits. The Healthcall contract is managed by a local practice. *(check contract- CHI)*

In an urgent situation, out of hours, staff on all wards call 999 for assistance.

Appraisal of Hospital Medical Staff

Since, April 2000, all NHS employers have been contractually required to carry out annual appraisals, covering both clinical and non-clinical aspects of their jobs.
All doctors interviewed by CHI, including the medical director who works 5 sessions in the department of elderly medicine, have regular appraisals. Those appraising the work of other doctors have been trained to do so.

Nursing Responsibility

Ward nurses on each ward are managed by a G grade clinical manager, who reports to a senior, H grade nurse. This nurse covers the three wards caring for older people, and was managed by the general manager for the Fareham and Gosport division. The general manager reported to both the director of nursing and the operations director. An accountability structure such as this is not unusual in a community hospital. The director of nursing was ultimately accountable for the standard of nursing practice within the hospital.

Nursing supervision
The Trust has been working to adopt a model of clinical supervision for nurses for a number of years and received initial assistance from the Royal College of Nurses to develop the processes. The Trust focus had been on reflective practice, the overall aim being to ensure that staff had access to good systems of clinical support to enhance their practice. As part of the Trust's Clinical Nursing Development Programme which ran between January 1999 and December 2000, nurses were identified to lead the development of clinical supervision.

Many of the nurses interviewed valued the principles of reflective practice as a way in which to improve their own skills and care of patients. The H grade senior nurse coordinator post appointed in November 2000 was a specific trust response to an acknowledged lack of nursing leadership at the Gosport War Memorial Hospital.

Regular ward meetings are held on Sultan and Daedalus wards, with less clear arrangements on Dryad ward, which may be due to long term senior ward staff sickness.

Team working
Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. Staff interviewed by CHI spoke of teamwork, though in several instances this was uniprofessional, for example a nursing team. CHI observed a multi disciplinary team meeting on Deadalus ward which was attended by a consultant, a senior ward nurse, a physiotherapist, an occupational therapist. No junior staff were present. Access to social work input was described by hospital staff as good, though not always available.

Arrangements for multi-disciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multi-disciplinary goal setting for patients though were hopeful of more progress.

Allied Health Professional Structures
Allied Health Professionals (AHP's) are a group of staff which include occupational therapists, dieticians, speech and language therapists and physiotherapists. The occupational therapy structure is in transition from a

traditional site based service to staff providing defined clinical specialty (e.g. stroke rehabilitation) in the locality. All referrals are received centrally. Staff explained that this system enables the use of specialist clinical skills and ensures continuity of care of patients, as one occupational therapist follows the patient throughout hospital admission(s) and at home. Occupational therapists talking to CHI described a good supervision structure, with supervision contracts and performance development plans in place.

Physiotherapy

Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right through to home treatment. Physiotherapists illustrated good levels of training and supervision and involvement in multi-disciplinary team meetings on Daedalus ward.

Speech and Language Therapists

Speech and language therapists also reported participation in multi-disciplinary team meetings on Daedalus ward.

Dietetics

The staffing structure consist of one full time dietician based at St James Hospital. Each ward has a nurse with lead nutrition responsibilities to offer advice to colleagues on request.

Workforce and service planning

In preparation for the change of use of beds in Dryad and Daedalus wards in November 2000, from continuing care to intermediate care, the Trust undertook an undated resource requirement analysis and identified three risk issues;

(i) consultant cover
(ii) medical risk with change in client group and the likelihood of more patients requiring specialist intervention. The trust believed that the introduction of automated defibrillators would go some way to resolve this. The paper also spoke of "the need for clear protocols….within which medical cover can be obtained out of hours".
(iii) the trust identified a course for qualified nursing staff, ALERT, a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration.

Concerns were raised formally with the trust in early 2000 around the increased workload and complexity of patients, which were acknowledged by the Medical Director, though CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix.

Access to specialist advice

Older patients are admitted to Gosport War Memorial Hospital with a wide variety of physical and mental health conditions such as strokes, cancers and dementia. Staff demonstrated to CHI good examples of systems in place to access expert opinion and support. There are supportive links with palliative care consultants, consultant psychiatrists and oncologists. The lead consultant for elderly mental health reported close links with the three wards, with patients either given support on the ward or transfer to an elderly mental health bed. There are plans for a nursing rotation programme between the elderly medicine and elderly mental health wards.

A joint palliative care booklet, published jointly in 1998 with PHCT, the Portsmouth Hospitals NHS Trust and a local hospice which staff are aware of and use. The booklet includes a number of guidelines on clinical management, including symptom management, psychological and spiritual care and bereavement.

Staff welfare

The trust developed, since its creation in 1994, an approach of being a caring employer, demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy which has won national recognition. The hospital was awarded Investors in People status in 1998. Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship.

Trust managers told CHI of their encouragement of staff to use the trust's counselling service and of organised support sessions for staff.

Chapter 7 – Lessons Learnt from Complaints

A total of 129 complaints were made regarding the division of elderly medicine since 1.4.97. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra Hospitals. In addition, CHI was told that over four hundred letters of thanks had been received by the three wards at the Gosport War Memorial Hospital during the same period.

Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. One recent complaint concerned admission arrangements in Sultan ward. Three complaints in the last five months of 1998 expressed concern regarding levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients was considered by the police expert witnesses. (findings summarised on page ??)

External review of complaints

One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical advisor found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 was referred to an Independent Review Panel (IRP), which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Though the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

Complaint Handling

The trust has a policy for handling patient related complaints produced in 1997, based on national guidance "Complaints: Guidance on the Implementation of the NHS Complaints Procedure" published in 1996. *(evidence of a review?)* A leaflet for patients detailing the various stages of the complaints procedure was produced, this includes the right to request an Independent Review if matters are not resolved to their satisfaction together with the address of

the Health Service Commissioner. This leaflet was not freely available on the wards.

CHI found that letters to complainants in response to their complaints did not always include an explanation of the IRP process, though this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. Audit standards for complaints handling are good with at least 80% of complainants satisfied with complaint handling and 100% of complainants resolved within national performance targets. *(CHI check date)* All written complaints were responded to by the Chief Executive. Staff interviewed by CHI valued the Chief Executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services.

Once the police became involved in the initial complaint in 1998, the trust ceased internal investigation processes. CHI found no evidence in either public or private board agendas that the trust board were formally made aware of police involvement. The doctor involved in the care of this patient wrote to the trust's quality manager expressing concern that she discovered by chance three months later that a complaint had been made. Neither that doctor nor portering staff involved in the transfer of the patient were asked for statements during the initial trust investigation.

Trust Learning Regarding Prescribing

Action was however taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter??). In addition, CHI learnt that external clinical advice sought by PHCT in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mgs to 200mgs a day was poor practice and "could indeed lead to a serious problem". The comment was made that the patient had been given doses ranging from 20mg to 40mg per day.

PHCT correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mgs a day. CHI understands this to be the "Wessex guidelines". Further correspondence in October 1999, indicated that a doctor working on the wards asked for a trust position policy on the prescribing of opiates in community hospitals. This was

not addressed until April 2001, when the joint PHCT and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain was introduced.

Other Trust Lessons

Lessons around issues other than prescribing have been learnt by the trust, though the workshop to draw together this learning was not held until early 2001 when the themes discussed were; communication with relatives, staff attitudes and fluids and nutrition. Action taken by the trust since the series of complaints in 1998 are as follows:

- An increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999.
- The appointment of a staff grade doctor in September 2000 to increase medical cover following the resignation of the clinical assistant.
- Piloting of pain management charts and prescribing guidance approved in May 2001. Nursing documentation is currently under review, with nurse input.
- One additional consultant session in ?? following a district wide initiative with local PCGs around intermediate care.
- Nursing documentation now clearly identifies prime family contacts and next-of-kin information to ensure appropriate communication with relatives.
  All conversations with families are now documented in the medical record. CHIs review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff.

Monitoring and Trend Identification

A key action identified in the 2000/01 Clinical Governance Action Plan was a strengthening of trust systems to ensure that actions following complaints have occurred. The Trust's Quality Manager played a key role in this. Until the dissplution of PHCT, actions were monitored through the divisional review process and the Clinical Governance Panel and Trust Board. A Trust database was introduced in 1999 to record and track trends in recent complaints. An investigations officer was also appointed in order to improve fact finding behind complaints. This has improved the quality of complaint responses.

The PHCT offered specific training in complaints handling, customer care and loss, death and bereavement, which many,

though not all, staff interviewed by CHI were aware of and had attended.

Chapter 8 - Communication

This chapter considers how the trust communicated with and established relationships with its patients and relatives, its staff and the wider NHS.

Patients, Relatives and Carers

The trust has an undated "User Involvement in Service Development Framework", which sets out the principles behind effective user involvement within the national policy framework. It is unclear from the framework who was responsible for taking the work forward and within what timeframe. Given the dissolution of the Trust, a decision was taken not to establish a trust wide Patient Advocacy and Liaison Service (PALS), a requirement of the NHS National Plan. However, work was started by the trust to look at a possible future PALS structure for the PCT.

The trust uses patient surveys as part of its patient involvement framework. This was also one of the action points arising from a complaints workshop in February 2001. Surveys are given to patients on discharge, the response rate was not collected. Issues raised by patients in completed surveys are addressed by action plans discussed at clinical managers meetings. Ward specific action plans are distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, thermometers were purchased by the ward to address the problem. CHI could find no evidence to suggest that the findings from patient surveys are shared across the trust.

Communication Towards the End of Life

Staff spoke of the "Wessex" palliative care guidelines in use on the wards which talks about breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure at Portsmouth Hospitals NHS Trust hospital, Queen Alexandra and St Mary's Hospitals to discharge patients too quickly to the Gosport War Memorial Hospital. Staff were aware of more medically unstable patients being transferred in recent years.

Staff Communication

Most staff interviewed by CHI spoke of good internal communications, and were well informed about the transfer of services to PCTs. The trust used newsletters to inform staff of key developments. An intranet is being developed by the Fareham and Gosport PCT to facilitate communication with staff.

Chapter 9 – Clinical Governance

Introduction

Clinical governance is about making sure that health services have systems in place to provide patients with high standards of care. The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems support the delivery of continuing and rehabilitative inpatient care for older people at the Gosport War Memorial Hospital. This chapter sets out the framework and structure adopted by the trust between 1998 and 2002 to deliver the clinical governance agenda and details those areas most relevant to the terms of reference for this investigation; risk management including medicines management and the systems in place to enable staff to raise concerns.

Summary

The trust reacted swiftly to the principles of clinical governance outlined by the Department of Health in NHS a First Class Service by devising an appropriate framework. In September 1998 a paper outlining how the trust planned to develop a system for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff interviewed by CHI were aware of the principles of clinical governance and were able to demonstrate how it related to them in their individual roles. Understanding of some specific aspects, particularly risk management and audit was patchy.

Clinical Governance Structures

The Medical Director took lead responsibility for clinical governance and chaired the Clinical Governance Panel, a sub committee of the Trust Board. The Clinical Governance Panel was supported by a Clinical Governance Reference Group, whose membership included representatives from each clinical service, professional group, non-executive directors and the chair of the Community Health Council. Each clinical service also had its own Clinical Governance Committee. This structure had been designed to enable each service to take

clinical governance forward into whichever PCT it found itself in after April 2002. The trust used the divisional review process to monitor clinical governance developments.

District Audit carried out an audit of the trust's clinical governance arrangements in 1998/99. The report, dated December 1999, states that the Trust had fully complied with requirements to establish a framework for clinical governance. The report also referred to the Trust's document "Improving Quality – steps towards a First Class Service" which was described as "of a high standard and reflected a sound understanding of clinical governance and quality assurance".

Whilst commenting favourably on the framework, the District Audit Review also noted the following:

- The process for gathering user views should be more focussed and the process strengthened.

- The clinical governance loop needed to be closed in some areas to ensure that strategy, policy and procedure resulted in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and re-audited; lessons learnt from complaints and incidents not always used to change practice and that R&D did not always lead to change in practice.

- More work needed to be done with clinical staff on openness and the support of staff alerting senior management of poor performance.

Following the review, the trust drew up a trust-wide action plan in December 1999 which focussed on widening the involvement and feedback from nursing, clinical and support staff regarding Trust protocols and procedures, and on making greater use of R&D, clinical audit, complaints, incidents and user views to lead to changes in practice. *Outcome of this to be inserted ask trust?*

In addition, each service has its own Clinical Governance Committee led by a designated clinician, including wide clinical and professional representation. Baseline assessments have been carried out in each specialty and responsive action plans produced. The quarterly Divisional Review system was modified to include reporting on clinical governance in February 2000. The Medical Director and

Clinical Governance Manager attended Divisional Review meetings and reported key issues back to the Clinical Governance Panel.

Risk management

A Risk Management group was established by the Trust in ?? to develop and oversee the implementation of the trust's Risk Management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The Group has links with other Trust groups such as the Clinical and Service Audit Group, the Board and the Clinical Nursing Governance Committee. Originally the Finance Director had joint responsibility for strategic risk with the Quality Manager. This was changed in the 2000/03 strategy to include the Medical Director, who is the designated lead for clinical risk. The Trust achieved the Clinical Negligence Scheme for Trusts (CNST) level 1 in 1999, a decision was taken by the Trust, due to pending dissolution in 2002, not to pursue the level 2 standard.

The Trust had an operational policy for "Recording and Reviewing Risk Events" introduced in 1994. New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non-clinical risk. The same trust policy is used to report clinical, non-clinical and accidents. All events are recorded in the Trust's Risk Event Database (CAREKEY). The procedure states that this reporting system should also be used for near misses and medication errors.

Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, though CHI was less confident that medical staff regularly identified and reported risks. CHI was told that risk forms were regularly completed by wards in the event of staff shortages. This is not one of the trust's Risk Event Definitions.

The Clinical Governance Development Plan for 2001/02 states that the focus for risk management in 2000/01 was the safe transfer of services to successor organisations, with the active involvement of PCTs and PCGs in the Trust's Risk Management Group. Meetings have been held with each successor organisation to agree future arrangements for such areas as; risk event reporting, health and safety, infection control and medicines management.

Raising concerns

The Trust has a Whistleblowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999.

The policy sets out the process staff should follow if they wish to raise a concern about the care or safety of a patient in the event of other procedures having failed or being exhausted. NHS guidance requires systems to enable concerns to be raised outside of the usual management chain. The trust policy informs staff that they can use the Whistleblowing process when staff have concerns "that cannot be resolved be resolved by the appropriate procedure".

Most staff interviewed were clear about how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. There was less certainty around the existence of the Trust's Whistleblowing Policy.

Clinical Audit

CHI heard of no demonstrable examples during interviews with staff of positive changes in patient care as a result of clinical audit outcomes. Despite a great deal of work on revising and creating policies to support good prescribing, there has been no planned audit of outcome.

Need to include outcome of trust recent prescribing audit here when received.

APPENDIX C

Portsmouth Healthcare Trust staff and non-executive directors interviewed by CHI

CHI is grateful to Caroline Harrington for scheduling interviews.

- Baldacchino, Linda, Health Care Social Worker
- Banks, Dr Vicki, Lead Consultant
- Barker, Debbie, Staff Nurse
- Barker, Marilyn, Enrolled Nurse
- Barrett, Lynn, Staff Nurse
- Beed, Phillip, Clinical Manager
- Brind, Shelly, Occupational Therapist
- Cameron, Fiona, General Manager
- Carroll, Patrick, Occupational Therapist
- Clasby, Jerry, Senior Nurse
- Crane, Rosemary, Senior Dietician
- Day, Ginny, Senior Staff Nurse
- Douglas, Tina, Staff Nurse
- Dunleavy, Jo, Staff Nurse
- Dunleavy, Shirley, Physiotherapist
- Goode, Pauline, Health Care Social Worker
- Hair, James, Chaplain
- Hallman, Shirley, Staff Nurse (until..... trust please fill in)
- Hamblin, Gill, Senior Staff Nurse
- Haste, Anne, Clinical Manager
- Hooper, Bill, Project Director
- Humphrey, Lesley, Quality Manager
- Jarrett, Dr David, Lead Consultant
- Joice, Chris, Staff Nurse (until..... trust please fill in)
- Jones, Julie, Corporate Risk Advisor
- Jones, Teresa, Ward Clerk
- King, Peter, Personnel Director
- King, Steve, Clinical Risk Advisor
- Landy, Sharone, Senior Staff Nurse
- Langdale, Helen, Health Care Social Worker
- Law, Diane, Patient Affairs Manager
- Lawrence, Vanessa, Ward Pharmacist
- Lee, David, Complaints Convenor & Non Executive Director
- Lock, Joan, Sister (retired 1999)
- Loney, Mick, Porter
- Lord, Dr Althea, Lead Consultant
- Mann, Katie, Senior Staff Nurse

- Melrose, Barbara, Complaints
- Millett, Max, Chief Executive
- Monk, Anne, Chairman
- Nelson, Sue, (until..... trust please fill in)
- Neville, J, Staff Nurse (until..... trust please fill in)
- O'Dell, Jo, Practice Development Facilitator
- Parvin, Jane, Senior Personnel Manager
- Peach, Jan, Service Manager
- Peagram, Lin, Physio Assistant
- Pease, Yong, Staff Nurse
- Phillips, Catherine, Speech & Language Therapist
- Piper, Ian, Operational Director
- Qureshi, Dr, Consultant
- Ravindrance, Dr, Consultant
- Reid, Ian, Medical Director
- Robinson, Barbara, Deputy General Manager
- Scammel, Toni, Senior Nurse Coordinator
- Taylor, Jo, Senior Nurse
- Thomas, Eileen, Nursing Director
- Thorpe, Maria, Health Care Social Worker
- Tubbitt, Anita, Senior Staff Nurse
- Walker, Fiona, Senior Staff Nurse
- Wells, Penny, District Nurse
- Wigfall, Margaret, Enrolled Nurse
- Wilkins, Pat, Senior Staff Nurse
- Williams, Jane, Nurse Consultant
- Wilson, Angela, Senior Staff Nurse
- Wood, Andy, Finance Director
- Woods, Linda, Staff Nurse
- Yikona, Dr, Staff Grade Physician

APPENDIX E

Medical case note review

Terms of Reference for the Medical Notes Review Group to Support the CHI Investigation at Gosport War Memorial Hospital

Purpose

The Group has been established to review the clinical notes of a random selection of recently deceased older patients at the Gosport War Memorial Hospital in order to inform the CHI investigation. With reference to CHIs investigation terms of reference and the expert witness reports prepared for the police by Dr Munday and Professor Ford, this review will address the following:

(i) The prescription, administration, review and recording of drugs.
(ii) The use and application of the Trust's policies on the Assessment & Management of Pain, Prescription Writing and Administration of IV Drugs.
(iii) The quality of nursing care towards the end of life.
(iv) The recorded cause of death.

Method

The Group will review 15 anonymised clinical notes supplied by the Trust, followed by a one day meeting at CHI in order to produce a written report to inform the CHI investigation. The Group will reach its conclusions by March 31st 2002 at the latest.

Membership

Dr Tony Luxton, Geriatrician – Lifespan NHS Trust (CHI doctor team member & chair of Group)
Maureen Morgan, Independent Management Consultant (CHI nurse member)
Professor Gary Ford, Professor of Pharmacology of Old Age, University of Newcastle and Freeman Hospital
Dr Keith Munday, Consultant Geriatrician, Frimley Park Hospital
Annette Goulden, Deputy Directior Of Nursing, Trent Regional Office and formerly Department of Health Nursing Officer for elderly care

Dr Luxton and Maureen Morgan have been seconded to CHI for their work with CHI on this investigation, similar arrangements will apply to Professor Ford, Dr Munday Annette Goulden with regard to expenses, confidentiality etc. The Group will be supported by Julie Miller CHI Investigation

Manager, who will produce a report based on the Group's work.

Findings of Group

The findings of the Group will be shared with:

(i) the CHI Gosport investigation team
(ii) CHI's Nurse Director and Medical Director and other CHI staff as appropriate
(iii) The Trust
(iv) Relatives of the deceased (facilitated by the Trust) if requested, on an individual basis

The Group's findings will not be published in full in the investigation report, though a summary will be included. The final report of the Group will be subject to the usual rules of disclosure applying to CHI investigation reports.

APPENDIX F

An explanation of the dissolution of services into the new Primary Care Trusts.

Arrangements for hosting clinical services

	Portsmouth City PCT	East Hampshire PCT	Fareham & Gosport PCT	West Hampshire NHS TRust
Elderly medicine		●		
Elderly mental health		●		
Community paediatrics	●			
Adult mental health services	● For Portsmouth City Patients			● For Hampshire Patients
Learning disability services			●	
Subsatnce misuse	●			
Clinical pyschology	●			●
Primary care counselling	●			
Specialist family planning	●			
Palliative care		●		

(**Local Health, Local Decisions, Consultant Document September 2001,** South East Regional Office of the NHS Executive: Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

APPENDIX G

Table illustrating the Throughput in the Gosport War Memorial Hospital wards Daedalus, Dryad and Sultan.

Table . Throughput data 1997/98 – 2000/01

Financial Year	Ward	FCEs
1997/98	Daedalus	97
1997/98	Dryad	72
1997/98	Sultan	287
	GWMH	**456**
1998/99	Daedalus	121
1998/99	Dryad	76
1998/99	Sultan	306
	GWMH	**503**
1999/00	Daedalus	110
1999/00	Dryad	131
1999/00	Sultan	402
	GWMH	**643**
2000/01	Daedalus	113
2000/01	Dryad	86
2000/01	Sultan	380
	GWMH	**579**

*** Daedalus and Daedalus Stroke have been added together.**

APPENDIX H

Breakdown of Medication in Daedalus, Dryad and Sultan wards at the Gosport War Memorial Hospital.

Summary of Medicine Useage 1997/98-2000/01 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine Injection	Daedauls	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total	**5mg**	**5**	**6**	**10**	**0**	**19**
Diamorphine Syringe	Sultan	5mg	1	0	10	0	0
	Total	**5mg**	**1**	**0**	**10**	**0**	**0**
Diamorphine Injection	Daedalus	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	87	38	24	35
	Total	**10mg**	**5**	**128**	**127**	**107**	**74**
Diamorphine Syringe	Dryad	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total	**10mg**	**1**	**0**	**37**	**0**	**0**
Diamorphine Injection	Daedalus	30mg	5	16	27	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	43	14	31
	Total	30mg	5	117	121	69	42
Diamorphine Syringe	Dryad	30mg	1	0	5	0	0
	Total	**30mg**	**1**	**0**	**5**	**0**	**0**

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine Injection	Daedalus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total	100mg	5	34	51	3	0
Diamorphine Injection	Daedalus	500mg	5	0	1	0	0
	Dryad	500mg	5	0	2	0	4
	Sultan	500mg	5	1	1	0	4
	Total	**500mg**	**5**	**1**	**4**	**0**	**0**
Haloperidol Injection	Daedalus	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
	Sultan	5mg/5ml	10	43	15	6	0
	Total	**5mg/5ml**	**10**	**44**	**19**	**6**	**0**
Drug	**Ward**	**Dose**	**Pack**	**97/98**	**98/99**	**99/00**	**00/01**
Haloperidol Injection	Daedalus	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
	Sultan	5mg/5ml	5	0	0	0	16
	Total	**5mg/5ml**	**5**	**0**	**0**	**0**	**21**
Midazolam	Daedalus	10mg/2ml	10	37	51	39	17
	Dryad	10mg/2ml	10	75	108	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total	**10mg/2ml**	**10**	**133**	**168**	**116**	**47**

(Summary of Medicine Useage 1997/98-2000/01 (Mar 2002), Portsmouth Hospitals Trust , Pharmacy Service)