

1 Gosport Investigation

2

3 *Acknowledgements*

4 CHI wishes to thank the following people for their help and
5 co-operation with the production of this report:

6 The patients and relatives who contributed either in person,
7 over the phone or in writing. CHI recognises how difficult
8 some of these contacts were for the relatives of those who
9 have died and is deeply grateful to them.

10 CHIs investigation team (see Chapter ?? paragraph ??) and
11 the clinical notes review group (see appendix E).

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

20 Detective Superintendent John James, Hampshire Constabulary
21 The agencies listed in appendix D who gave their views and
22 submitted relevant documents to the investigation.

23

24 **Executive Summary**

25

26 *Introductory Background*

27 CHI has undertaken this investigation as a consequence of
28 concerns expressed by the police and others around the care
29 and treatment of frail older people provided by the
30 Portsmouth Healthcare NHS Trust at the Gosport War Memorial
31 Hospital. This follows a number of police investigations
32 between 1998 and 2001 into the potential unlawful killing of
33 a patient in 1998. As part of their investigations, the
34 police commissioned expert medical opinion, which was made
35 available to CHI, relating to a total of five patient deaths
36 in 1998. In February 2002, the police decided not to
37 proceed with further investigations.

38

39 The police were sufficiently concerned about the care of
40 older people at the War Memorial Hospital, based on
41 information gathered during their investigations, to share
42 their concerns with CHI in August 2001.

43

44 *Key Findings*

45 In reaching the conclusions in this report, CHI has
46 addressed whether, since 1998, there had been a failure of
47 trust systems to ensure good quality patient care.

48

1
2 CHI believes that the use of diamorphine and the combination
3 of medicines with a sedative effect administered to patients
4 in 1998 was excessive and outside of accepted practice.
5 There had been no trust policies in place to ensure the
6 correct use of an "analgesic ladder", patients had been
7 administered strong opiate analgesia on admission. There
8 had been a practice of anticipatory prescribing of high dose
9 ranges of medicines , with discretion given to nursing staff
10 to administer as required.

11
12 The Portsmouth Healthcare NHS Trust (PHCT) failed to act on
13 the triggers provided four years ago, in 1998, by a police
14 investigation, a pattern of patient complaints and the
15 trust's own pharmacy data to undertake an immediate review
16 of prescribing practice on the wards caring for older
17 people.

18
19 The PHCT has since, 2001 a policy in place relating to the
20 assessment of pain. This includes guidance on appropriate
21 prescribing. Following a review of the case notes of
22 patients in late 2001 and early 2002, CHI believes that
23 appropriate prescribing is now being undertaken and
24 anticipatory prescribing is no longer happening. The trusts
25 own review ?????

26
27 CHI found no trust system for reviewing the performance of
28 clinical assistants and unsatisfactory supervision
29 arrangements. CHI understands that appraisal systems for
30 GPs acting as clinical assistants are still in their infancy
31 within the NHS but considers that the concerns around
32 prescribing on these wards were significant enough to have
33 initiated such a review of practice.

34
35 There was confusion at both ward and senior management
36 level, echoed nationally, around the terminology and
37 expectations of the range of care offered to older people.

38
39 CHI found a well structured and motivated senior managerial
40 team which demonstrated a strong emphasis on staff welfare
41 and development. Good, patient quality based local
42 performance review mechanisms were in place throughout the
43 trust. The principles of clinical governance and reflective
44 nursing practice had been developed to deliver improved
45 patient care.

1 Chapter 1 - Terms of reference and process of the
2 investigation

3
4 During the summer of 2001, concerns were raised with CHI
5 about the use of some medicines, particularly analgesia and
6 levels of sedation, and the culture in which care was
7 provided for older people at the Gosport War Memorial
8 Hospital. These concerns also included the responsibility
9 for clinical care and transfer arrangements with other
10 hospitals.

11
12 On 18 September 2001, CHI's Investigations and Fast Track
13 Clinical Governance Programme Board decided to undertake an
14 investigation into the management, provision and quality of
15 healthcare for which Portsmouth Healthcare NHS Trust is
16 responsible at the Gosport War Memorial Hospital. CHI's
17 decision was based on evidence of high risk activity and the
18 likelihood that the possible findings of a CHI investigation
19 would result in lessons for the whole of the NHS.

20
21 *Terms of reference*

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

30
31 The terms of reference agreed on 9 October 2001 are as
32 follows:

33
34 The investigation will look at whether, since 1998, there
35 had been a failure of trust systems to ensure good quality
36 patient care. The investigation will focus on the following
37 elements within services for older people (inpatient,
38 continuing and rehabilitative care) at Gosport War Memorial
39 Hospital.

- 40
41 i). Staffing and accountability arrangements, including
42 out of hours.
43 ii). The guidelines and practices in place at the trust
44 to ensure good quality care and effective
45 performance management.
46 iii). Arrangements for the prescription, administration,
47 review and recording of drugs.

- 1 iv). Communication and collaboration between the trust
2 and patients, their relatives and carers and with
3 partner organisations.
4 v). Arrangements to support patients and their
5 relatives and carers towards the end of the
6 patients' life.
7 vi). Supervision and training arrangements in place to
8 enable staff to provide effective care.
9

10 In addition, CHI will examine how lessons to improve patient
11 care have been learnt across the trust from patient
12 complaints.
13

14 The investigation will also look at the adequacy of the
15 trust's clinical governance arrangements to support
16 inpatient continuing and rehabilitation care for older
17 people.
18

19 *CHI's investigation team*
20

21 Alan Carpenter, chief executive, Somerset Coast Primary Care
22 Trust

23 Anne Grosskurth, CHI Support Investigations Manger

24 Dr Tony Luxton, consultant geriatrician, Lifespan Healthcare
25 NHS Trust

26 Julie Miller, CHI Lead Investigations Manager

27 Maureen Morgan, Independent Consultant and former Community
28 Trust Nurse Director

29 Dr Mary Parkinson, Retired GP and Lay Member (Age Concern)

30 Jennifer Wenborne, Independent Occupational Therapist
31

32 The team was supported by:

33 Liz Fradd, CHI Nurse Director, lead CHI director for the
34 investigation

35 Nan Newberry, CHI Senior Analyst

36 Kellie-Ann Rehill, CHI Investigations Coordinator

37 A medical notes review group established by CHI to review
38 anonymised medical notes (see appendix E)

1

2 *The investigation process*

3 The investigation consisted of five inter related parts:

4

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

10

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

17

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

25

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

30

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

Chapter 2 - Background to the investigation

Events surrounding the CHI investigation

Police investigations

The death of a 91 year old female patient in August 1998 on Daedalus ward led to a complaint to the trust by the family regarding her care and treatment. A daughter of the patient contacted the police in September 1998 alleging that her mother had been unlawfully killed. A range of issues were identified by the police in support of the allegation. Following an investigation, documents were referred to the Crown Prosecution Service (CPS) in November 1998 and again in February 1999. The CPS responded formally in March 1999 indicating that in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.

The police investigation begun in 1998 was the subject of a complaint to the police. A further police investigation was begun in August 1999. Subsequently, in December 2000 further information was submitted to the CPS concerning the circumstances of the patient's death. In August 2001 the CPS advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

Local media coverage in March 2001 resulted in eleven other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate. Two expert reports were received in November and December 2001 which were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.

In February 2002, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the GMC, the UKCC, the trust and the Isle of Wight, Portsmouth and East Hampshire Health Authority.

Action Taken by Professional Regulatory Bodies

General Medical Council (GMC)

The case of one doctor is currently being reconsidered by the GMC, no interim suspension order has been made. Status of Dr Lord referral?

1
2 *United Kingdom Central Council (UKCC) and after 1.4.02*
3 *Nursing and Midwifery Council (NMC)*
4 Three nurses were referred to the UKCC's Preliminary Orders
5 Committee in June 2001, which has the authority to suspend
6 nurses, the cases were closed. Following receipt of further
7 information from the police, these cases have been reopened
8 and are under investigation by the UKCC's successor body the
9 NMC. *(This paragraph is subject to change and update)*

10

11 *Complaints to the Trust*

12 There have been ten complaints to the trust concerning
13 patients treated on Daedalus, Dryad and Sultan wards since
14 1998. Three complaints between August and November 1998
15 raised concerns which included the use of diamorphine and
16 levels of sedation on Daedalus and Dryad wards, including
17 the complaint which triggered the initial police
18 investigation, which was not pursued through the NHS
19 Complaints Procedure.

20

21 *Action taken by Health Authority*

22 In the context of this investigation, the Isle of Wight,
23 Portsmouth and East Hampshire Health Authority had two
24 responsibilities. Firstly, as the statutory body, in 1998,
25 responsible for commissioning NHS services for local people
26 and secondly as the body through which GPs are permitted to
27 practice. Some of the care provided to patients at the
28 Gosport War Memorial Hospital, as in community hospitals
29 throughout the NHS, is delivered on hospital premises by
30 GPs. A number of actions were taken:

31

32 (a) In June 2001, the prescribing practice of a local GP
33 was reviewed through the health authority voluntary
34 Local Procedure for the Identification and Support of
35 Primary Care Medical Practitioners whose Practice is
36 Giving Cause for Concern. No concerns were found. *(did*
37 *they talk to the trust?)*

38

39 (b) In July 2001, the Chief Executive of the health
40 authority asked CHI for assistance in a local enquiry
41 in order to re-establish public confidence in the
42 services for older people in Gosport. The health
43 authority contact with CHI was made at the same time
44 the police contacted CHI. CHI then began a screening
45 process to determine whether CHI should initiate an
46 investigation.

47

48 © Following receipt of the police expert witness reports
49 in February 2002, the health authority sought changes

1 in relation to the prescription of certain pain killers
2 (opiates and benzodiazepines) in general practice.
3

4 *Action taken by NHSE South East Regional Office*

5 For the period of the investigation, the Regional Offices of
6 the NHSE were responsible, for the strategic and performance
7 management of the NHS, including trusts and health
8 authorities. The South East Regional Office was unable to
9 demonstrate to CHI, a robust system for monitoring trust
10 complaints relating to the Portsmouth Healthcare NHS Trust
11 which would have demonstrated an awareness of local
12 concerns. Serious Untoward Incident reports were completed
13 in April and July 2001 in response to articles surrounding
14 the death of a patient at the Gosport War Memorial Hospital
15 in the media.

16 *(when did RO contact HA? When did trust contact RO?)*

1 Chapter 3 - National and Local Context

2

3 *National context*

4

5 The standard of NHS care for older people has long caused
6 concern. A number of national reports, including the NHS
7 National Plan and the Standing Nursing and Midwifery
8 Committee's 2001 report found care to be deficient. Amongst
9 national concerns raised have been, an inadequate and
10 demoralised workforce, poor care environments, lack of
11 seamless care within the NHS and ageism. The NHS Plan's
12 section "Dignity, Security and Independence in Old Age"
13 published in July 2000, outlined the government's plans for
14 the care of older people which would be detailed in a
15 National Service Framework.

16

17 The National Service Framework for Older People was
18 published in March 2001 and sets standards of care of older
19 people in all care settings. It aims to ensure high quality
20 of care and treatment, regardless of age. Older people are
21 to be treated as individuals with dignity and respect. The
22 framework places special emphasis on the involvement of
23 older patient's and their relatives in the care process,
24 including care planning. There are to be local mechanisms
25 to ensure the implementation of the framework with progress
26 expected by June 2001.

27

28 National standards, called Essence of Care published in
29 2001, provide benchmarks for assessing nursing practice
30 against fundamental aspects of care such as nutrition,
31 pressure sores and privacy and dignity. These have been
32 produced by the Department of Health as an audit tool to
33 ensure good practice and have been widely disseminated
34 across the NHS.

35

36 *Trust Background*

37 Gosport War Memorial Hospital was part of Portsmouth
38 Healthcare NHS Trust (PHCT) between April 1994 and April
39 2002. The hospital is situated on the Gosport peninsula and
40 has 113 beds. Together with outpatient services and a day
41 hospital, there are beds for older people and maternity
42 services. The hospital does not admit patients who are
43 acutely ill, it has neither an A&E nor intensive care
44 facilities. PHCT provided a range of community and hospital
45 based services for the people of Portsmouth, Fareham,
46 Gosport and surrounding areas. These services included
47 mental health (adult and elderly), community paediatrics,
48 elderly medicine, learning disabilities and psychology.

49

1 The trust was one of the largest community trusts in the
2 south of England and employed almost 5,000 staff. In
3 2001/02 the trust had a budget in excess of £100 million,
4 over 20% of income was spent on its largest service, elderly
5 medicine. All financial targets were met in 2000/01.

6
7 *Move Towards the Primary Care Trust*

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

22
23 *Portsmouth NHS Healthcare Trust Strategic Management*

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

32
33 CHI heard that the Trust was well regarded in the local
34 health community and had developed constructive links with
35 the Health Authority and local PCGs. For example in the
36 lead up to the new PCT, PHCT's Director of Operations worked
37 for two days each week for the East Hampshire PCT. Other
38 examples included the joint work of the PCG and the Trust on
39 the Development of Intermediate Care and Clinical
40 Governance. High regard and respect for trust staff was
41 also commented on by the Local Medical Committee, UNISON and
42 the RCN.

43
44 *Local Services for Older People*

45 Before April 2002, all services for older people in
46 Portsmouth, including acute care, rehabilitation and
47 continuing care were provided by the department of medicine
48 for elderly people which was managed by the Portsmouth
49 Healthcare NHS Trust. Acute services are based in the Queen

1 Alexandra and St Mary's Hospitals, part of the Portsmouth
2 Hospitals NHS Trust. Though an unusual arrangement,
3 precedents for this model of care did exist, in Southampton
4 Community Trust for example. Management of all services for
5 older people has now transferred to the East Hampshire PCT.
6 Until August 2001, the Royal Hospital Haslar, a Ministry of
7 Defence military hospital on the Gosport peninsula also
8 provided acute medical care to older civilians as well as
9 military staff.

10

11 *Service Performance Management*

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

21

22 *In patient services for older people at the Gosport War 23 Memorial Hospital 1998-2002*

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

31

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

35

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.

1

2 *Admission criteria*3 *Dryad and Daedalus wards*

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

12

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

17

18 *Sultan ward*

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

26

27 *Elderly mental health*

28 Though not part of the CHI investigation, older patients are
29 also cared for on the Mulberry ward, a 40 bed assessment
30 unit comprising of the Collingwood and Ark Royal wards.

1 Patients admitted to this ward are under the care of a
2 consultant in elderly mental health.
3

1 *Terminology*

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

11

12 *Findings*

13 Throughout the timeframe of the CHI investigation, CHI saw
14 evidence of strong leadership at corporate and divisional
15 level with a shared set of values. The senior management
16 team was well established and functioned, together with the
17 trust board, as a cohesive team. The chief executive was
18 accessible to staff and well regarded by staff both within
19 the trust and in the local health economy. Good links had
20 been developed with local PCGs.

21

22 CHI considers the divisional management quarterly review
23 process to have been an appropriate method of monitoring the
24 performance of the Fareham and Gosport division.

25

26 There is lack of clarity amongst all groups of staff, which
27 is communicated to patients and relatives, about the purpose
28 of each of the wards caring for older people and the levels
29 of care provided.

30

31 *Recommendations*

32 The Fareham and Gosport PCT and East Hampshire PCT should
33 work together to build on the many positive aspects of
34 leadership developed by PHCT in order to take the provision
35 of care for older people at the Gosport War Memorial
36 Hospital forward. The PCTs should devise an appropriate
37 performance monitoring tool to ensure that any quality of
38 care and performance shortfalls are identified and addressed
39 swiftly.

40

41 The findings of this investigation should be used to
42 influence the nature of local monitoring of the National
43 Service Framework for older people which CHI will ultimately
44 study.

45

46 The Department of Health should assist in the promotion of
47 an NHS wide shared understanding of the various terms used
48 to describe levels of care for older people.

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.

Patient experience

CHI examined in detail the experience of older patients admitted to the Gosport War Memorial Hospital between 1998 and 2001 and that of their relatives and carers. This was carried out in two ways. Firstly, stakeholders were invited, through local publicity, to make contact with CHI. The police also wrote to relatives who had expressed concern to them informing them of the CHI investigation. Views were invited in person, in writing, over the telephone and by questionnaire. A total of 36 patients and relatives contacted CHI during the investigation.

Secondly, CHI made a number of observation visits, including at night, to Daedalus, Dryad and Sultan wards during the site visit week in January 2002, some of which were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed.

Stakeholder views

The term stakeholder is used by CHI to define a range of people that are affected by, or have an interest in, the services offered by an organisation. CHI heard of a range of experiences of the care of older people from those who contacted CHI, both positive and negative. The most frequently raised concerns with CHI were; the use of medicines, the attitude of staff, incontinence management, nutrition and fluids and use of patients' own clothing. More detail on each of these areas is included below.

Use of medicines

The use of pain relieving medicines and the use of syringe drivers to administer them was commented on by a number of relatives. One relative commented that her mother "certainly was not in pain prior to transfer to the War Memorial". Though a number of relatives confirmed that staff did speak to them before medication was delivered by a

1 syringe driver, CHI also received comments that families
2 would have liked more information "doctors should disclose
3 all drugs and why and what side effects are. There should
4 be more honesty".

5

6 *Attitude of staff*

7 Comments ranged from the very positive "Everyone was so kind
8 and caring towards him in both Deadalus and Dryad wards and
9 "I received such kindness and help from all the staff at all
10 times" to the less positive "I was made to feel an
11 inconvenience because we asked questions" and "I got the
12 feeling she had dementia and her feelings didn't count."

13

14 *Incontinence Management*

15 Continence management is an important aspect of the care of
16 older people, the underlying objective is to promote or
17 sustain continence as part of an holistic assessment
18 including maintaining skin integrity (prevention of pressure
19 sores). Where this is not possible, a range of options,
20 including catheterisation are available and it is imperative
21 that these are discussed with patients, relatives and
22 carers. Some stakeholders raised concerns regarding the
23 "automatic" catheterisation of patients on admission to the
24 War Memorial. "They seem to catheterise everyone, my
25 husband was not incontinent, the nurse said it was done
26 mostly to save time". Relatives also spoke of patients
27 waiting for long periods of time to be helped to the toilet
28 or for help in using the commode.

29

30 *Patients clothing*

31 Many relatives were distressed about patients who were not
32 dressed in their own clothes, even when labelled clothes had
33 been provided by families. "They were never in their own
34 clothes". Relatives also thought patients being dressed in
35 other patients clothes as a potential cross infection risk.
36 The trust did apologise to families who had raised this as a
37 complaint and explained the steps taken by wards to ensure
38 patients were dressed in their own clothes. This is an
39 important means by which patients dignity can be maintained.

40

41 *Transfer arrangements between local hospitals*

42 Concern was expressed regarding the physical transfer of
43 patients from one hospital to another. Amongst concerns
44 were lengthy waits prior to transfer, inadequate clothing
45 and covering such as blankets during the journey and the
46 method used to transfer a patient "carried on nothing more
47 than a sheet". This concern was acknowledged by PHCT who
48 sought an apology from the referring hospital who did not
49 have the appropriate equipment available.

1
2 During the period of the investigation, the Hampshire
3 Ambulance Service, who were responsible for patient
4 transfers received no complaints relating to the transfer of
5 patients to and from the Gosport War Memorial Hospital.

6
7 *Nutrition and fluids*

8 Concerns were expressed by relatives around a perceived lack
9 of nutrition and fluids as patients drew to the end of life,
10 "no water and fluids for last four days of life". Comments
11 were also raised about unsuitable, unappetising food and
12 patients left to eat without assistance. A number of
13 stakeholders commented on untouched food being cleared away
14 without patients being given assistance to eat.

15
16 Following comments by stakeholders, CHI reviewed trust
17 policy for nutrition and fluids. The trust conducted an
18 audit of minimum nutritional standards between October 1997
19 and March 1998, as part of the five year national strategy
20 "Feeding People". The trust policy dated 2000 "Prevention
21 and Management of Malnutrition" includes the designation of
22 an appropriately trained lead person in each clinical area,
23 who would organise training programmes for staff and improve
24 documentation to ensure 100% compliance. The standards
25 state:

- 26
- 27 - all patients must have a nutritional risk assessment on
28 admission
 - 29 - Registered nurses must plan, implement and oversee
30 nutritional care and refer to an appropriate
31 professional as necessary.
 - 32 - All staff must ensure that documented evidence supports
33 the continuity of patient care and clinical practice.
 - 34 - All clinical areas should have a nominated nutritional
35 representative who attends training/updates and is a
36 resource for colleagues.
 - 37 - Systems should be in place to ensure that staff have
38 the required training to implement and monitor the
39 'Feeding People' standards.
- 40

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

1 As a result of the review of recent case notes, CHI noted
2 that appropriate recording of patient intake and output was
3 taking place. CHI was concerned that nurses did not appear
4 to be able to make swallowing assessments, which could be
5 delayed over weekends, for example, when speech and language
6 staff would next be available.

7
8 *Outcome of CHI observation work*

9 The CHI team spent time on Dryad, Sultan and Daedalus wards
10 throughout the week of 7 January 2002 to observe first hand
11 the environment in which care was given and the interactions
12 between staff and patients and between staff. Ward staff
13 welcomed the CHI team and were friendly and open. Though
14 CHI observed a range a good patient experiences this could
15 only take the form of a "snap shot" during the site visit
16 and may not be fully representative. However, many of the
17 positive aspects of patient care observed were confirmed by
18 CHIs review of recent patient notes.

19
20 *Ward environment*

21 All wards were built during the 1991 expansion of the
22 hospital and are modern, welcoming and bright. This view
23 was echoed by stakeholders who were complimentary about the
24 décor and patient surroundings. Wards were tidy, clean and
25 fresh smelling.

26
27 Day rooms are pleasant and Daedalus ward has direct access
28 to a well designed garden suitable for wheelchair users.
29 The garden is paved with a variety of different textures to
30 enable patients to practice mobility. There is limited
31 storage space in Daedalus and Dryad wards and as a result
32 the corridors had become cluttered with equipment which was
33 observed as problematic for patients using walking aids.
34 Daedalus ward has an attractive, separate single room for
35 independent living assessment with its own sink and
36 wardrobe.

37
38 *Staff attitude*

39 The CHI team saw patients addressed by name in a respectful
40 and encouraging way and saw examples of staff helping
41 patients with dressing and conducting friendly
42 conversations. The staff handovers observed were well
43 conducted, held away from the main wards areas, with
44 relevant information about patient care exchanged
45 appropriately.

46
47 *Mealtimes*

48 Mealtimes were well organised with patients given a choice
49 of menu options and portion size. Patients who needed help

1 to eat and drink were given assistance. There appeared to
2 be sufficient staff to serve meals, and to note when meals
3 were not eaten. CHI did not observe any meals returned
4 untouched. Healthcare support workers told CHI that they
5 were responsible for making a note when meals were not
6 eaten.

7
8 *Daytime activities*

9 Patients are able to watch the television in day rooms,
10 where there are large print books, puzzles and current
11 newspapers. The CHI team saw little evidence of social
12 activities taking place, though some patients did eat
13 together in the day room. Bells to call assistance were
14 available to patients by their beds, though less accessible
15 to patients in the day rooms. The wards do have an
16 activities co-ordinator, though the impact of this post has
17 been limited.

18
19 *Communication with patients and relatives*

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

26
27 *Administration of medicines*

28 CHI observed two medicine rounds, both of which were
29 conducted in an appropriate way with two members of staff
30 jointly identifying the patient, checking the prescription
31 sheet with one member of staff handing out the medicines and
32 the other overseeing the patients as medicines were taken.
33 Medicines were safely stored on the wards in locked
34 cupboards.

35
36 *Findings*

37- Relatives speaking to CHI had some serious concerns about
38 the care their relatives received on Daedalus and Dryad
39 wards between 1998 and 2001. The instances of concern
40 expressed to CHI were at their peak in 1998. Fewer concerns
41 were expressed regarding the quality of care received on
42 Sultan ward.

1-
2 Table to show the wards and dates of which less positive
3 concerns about care were raised by stakeholders to CHI
4

	Dryad	Daedalus	Sultan	Other	TOTAL
1998		8		2	10
1999	1	5			6
2000		3	3	1	7
2001		1		1	2
General				2	2
TOTAL	1	17	3	6	27

5
6 Based on CHI's observation work and review of recent case
7 notes, CHI has no significant concerns regarding the
8 standard of nursing care provided to the patients of
9 Deadalus, Dryad and Sultan ward.

10
11 - The ward environments and patient surroundings are
12 good.

13
14 - Some notable steps had been taken, on Daedalus ward to
15 facilitate communication between patients and their
16 relatives with ward staff.

17
18 CHI was concerned regarding one area of potential risk
19 surrounding any inability of ward staff to undertake
20 swallowing assessments as required to be an area of
21 potential risk to patients whose swallowing reflex may have
22 been affected by a stroke, for example.

23
24 Opportunities for patients to engage in daytime activities
25 in order to encourage orientation and promote confidence are
26 limited.

27
28 *Recommendations*

29
30 - That all patient complaints and comments both informal
31 and formal, should be used at ward level to improve
32 patient care. The PCT must ensure a mechanism is
33 in place to ensure that shared learning is disseminated
34 amongst all staff caring for older people.

35 - That, as a priority, a performance management system is
36 established by the PCT to ensure the early
37 identification of any trends in all patient complaints.
38 The performance management system should include
39 measurements of quality and standards of care.

40 - Steps should be taken to ensure that relevant staff are
41 appropriately trained to undertake swallowing

- 1 assessments, to ensure that there are no delays out of
2 hours.
- 3 - Daytime activities for patients should be increased.
4 The role of the activities coordinator should be
5 revised and clarified, with input from patients,
6 relatives and all therapists in order that activities
7 compliment therapy goals.
- 8
- 9 - The PCT must ensure that all local continence
10 management and nutrition and hydration practices are in
11 line with the national standards set out in the Essence
12 of Care guidelines.

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

3
4 *Police Inquiry and Expert Witness Reports*

5 CHIs terms of reference for its investigation in part
6 reflected those of the earlier inquiry by the police, whose
7 reports were made available to the CHI team.

8
9 Though the police expert witnesses reviewed the care of five
10 individual patients who died in 1998, general comments were
11 also made in the reports about the clinical leadership and
12 arrangements for the management of patients on the wards.
13 Their examination of the use of medicines in Daedalus, Dryad
14 and Sultan wards, caused them to express concern about three
15 drugs, the amounts which had been prescribed, the
16 combinations in which they were used and the method of their
17 delivery. A summary of those comments is as follows:

- 18
19 • The inappropriate prescription and dose escalation of
20 strong opiate analgesia as the initial response to
21 pain. It was the view of the police expert witnesses
22 that a more reasonable response would be to prescribe a
23 mild to moderate medicine initially with appropriate
24 review of any pain followed up.
25 • The inappropriate subcutaneous combined administration
26 of diamorphine, midazolam and haloperidol, which could
27 carry a risk of excessive sedation and respiratory
28 depression in older patients, leading to death.
29 • An assumption by clinical staff that patients had been
30 admitted for palliative, rather than rehabilitative
31 care.
32 • There was a failure to recognise potential adverse
33 effects of prescribed medicines by clinical staff.
34 • The failure of clinical managers to routinely monitor
35 and supervise care on the ward.

36
37 *Medicine useage*

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

1 of medicines actually administered. A detailed breakdown of
2 medicines for each ward is attached at appendix H.

3

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

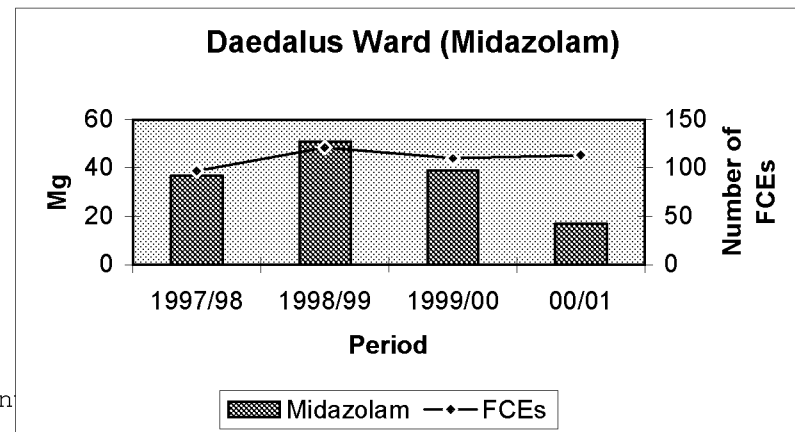
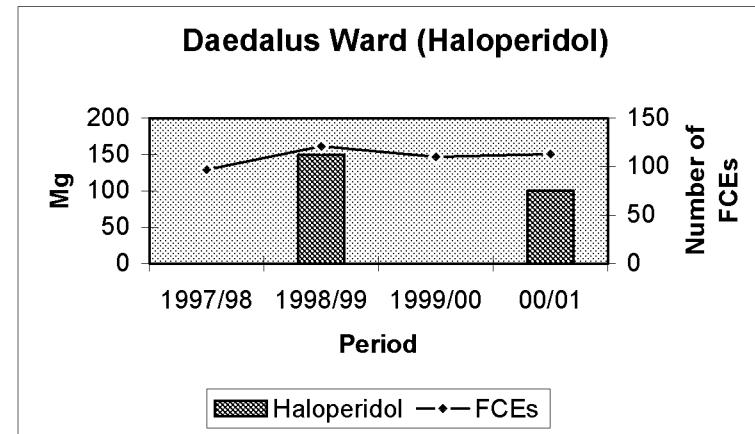
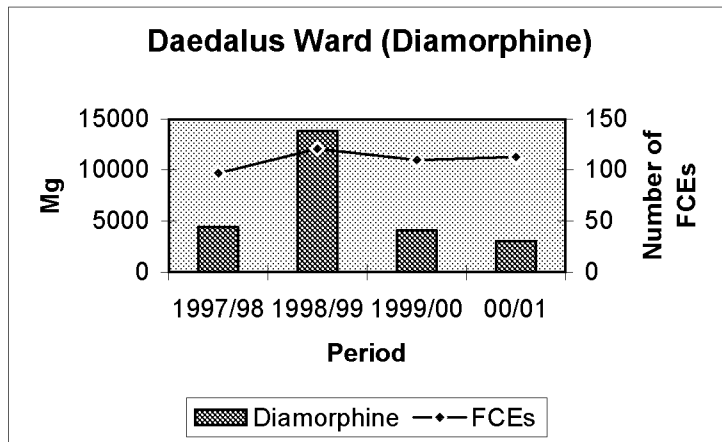
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8 Please see next page for graphs

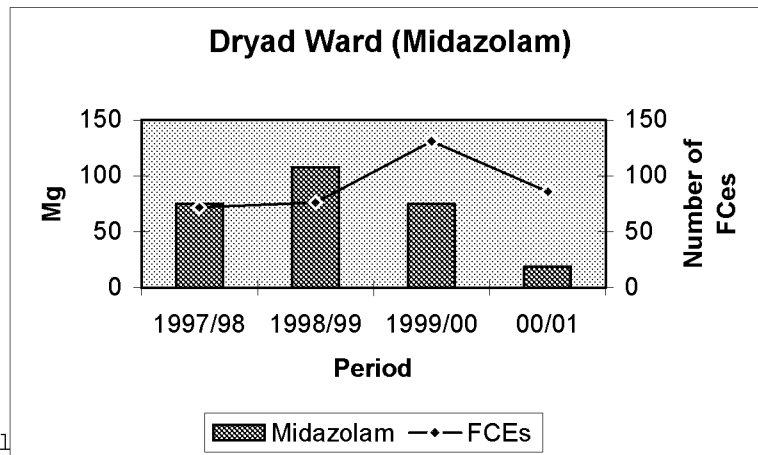
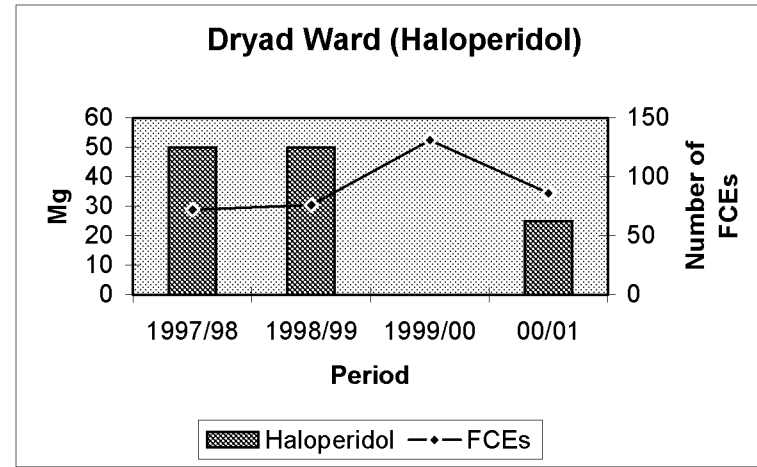
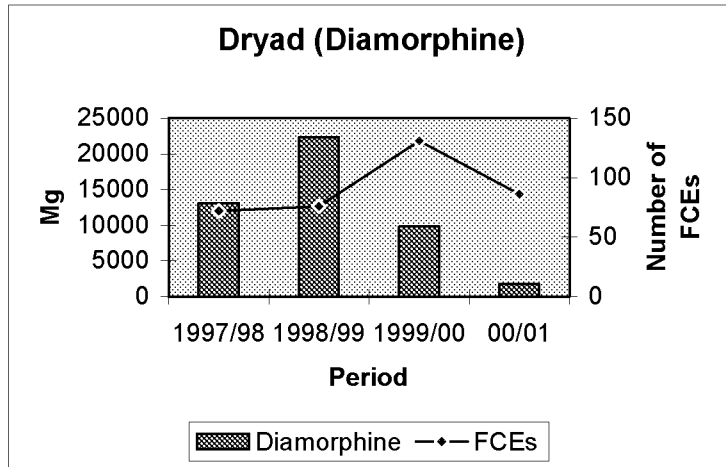
9

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

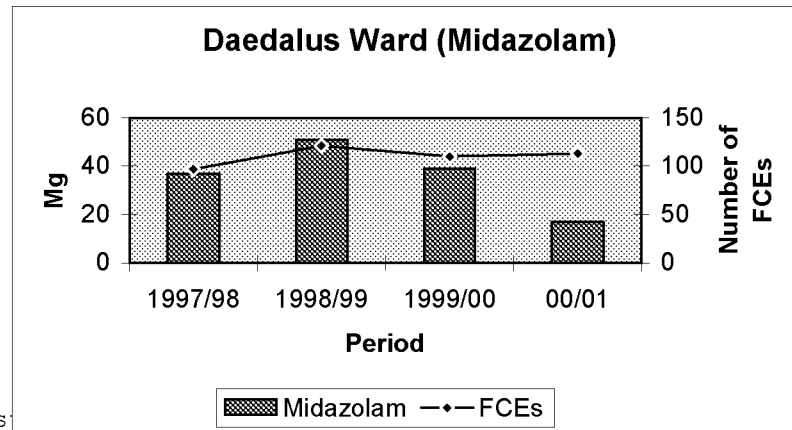
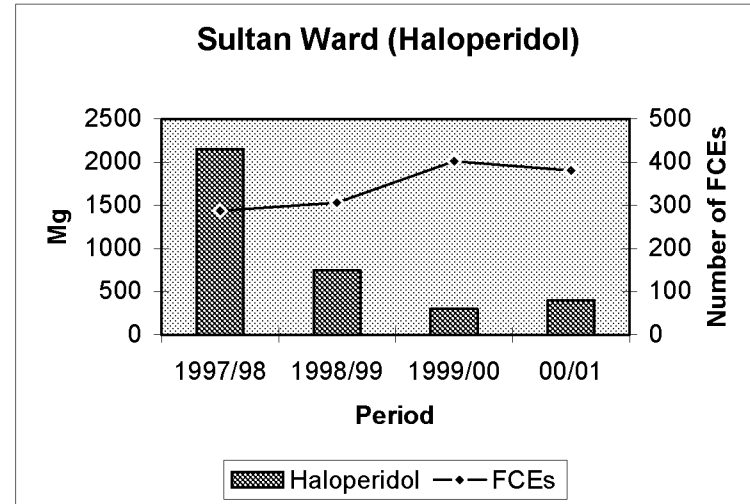
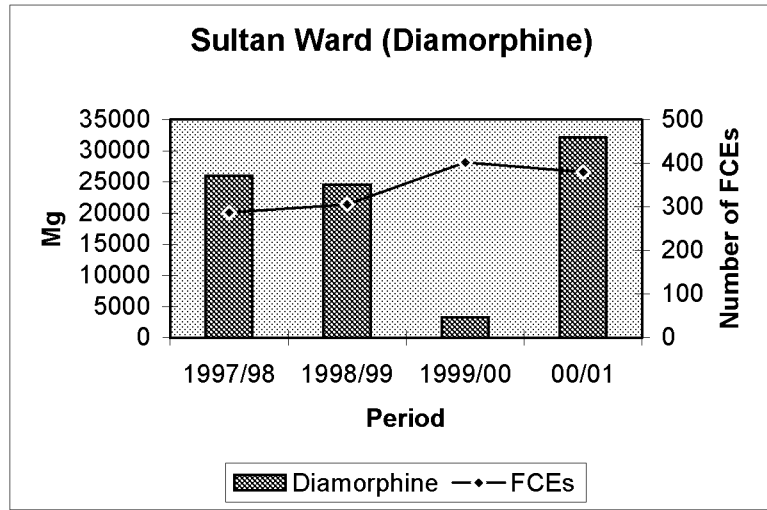
Graph 1. Daedalus



Graph 2 - Dryad



Graph 3. Sultan



1 *Assessment and management of pain*

2 The Trust's policy for the assessment and management of pain
3 was introduced in April 2001 in collaboration with
4 Portsmouth Hospitals NHS Trust and is due for review in
5 2003. The stated purpose of the document was to identify
6 mechanisms to ensure that all patients have early and
7 effective management of pain or distress. The policy places
8 responsibility for ensuring that pain management standards
9 are implemented in every clinical setting and sets out the
10 following:

11

- 12 - The prescription must be written by medical staff
13 following diagnosis of type(s) of pain and be appropriate
14 given the current circumstances of the patient.
- 15 - If the prescription states that medication is to be
16 administered by continuous infusion (syringe driver) the
17 rationale for this decision must be clearly documented.
- 18 - All prescriptions for drugs administered via a syringe
19 driver must be written on a prescription sheet designed
20 for this purpose.

21

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

30

31 At the same time, CHI was also told by some nursing staff
32 that following the introduction of the policy, it was now
33 taking longer for some patients to become pain free and that
34 there was a timidity amongst medical staff about prescribing
35 diamorphine. Nurses also spoke of a reluctance of some
36 patients to take pain relief. CHI's case note review
37 concluded that two of the fifteen patients reviewed were not
38 prescribed adequate pain relief for part of their stay in
39 hospital.

40

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

49

1 The guidelines are comprehensive and include detail, in line
2 with British National Formulary recommendations, (*need to*
3 *check*) on the use, dosage, and side effects of drugs
4 commonly used in a palliative care environment.

5
6 CHIs random case note review of fifteen recent admissions
7 concluded that the pain assistance and management policy was
8 being adhered to. CHI was told by staff of the previous
9 practice of anticipatory prescribing of palliative opiates.
10 As a result of the pain and assessment policy, this practice
11 has now stopped. CHI understands that one of the people who
12 initiated this change of practice was the staff grade
13 physician appointed in September 2000, who had expressed
14 concern over the range of anticipatory doses prescribed on
15 the wards, based on knowledge gained elsewhere.

16
17 *Prescription writing policy*

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

24
25 The policy also covers a section on verbal orders.
26 Telephone orders for single doses of medicines can be
27 accepted over the telephone by a registered nurse if the
28 doctor is unable to attend the ward. According to UKCC
29 guidelines (October 2000), this is only acceptable where
30 the, "the medication has been previously prescribed and the
31 prescriber is unable to issue a new prescription. Where
32 changes to the dose are considered necessary, the use of
33 information technology (such as fax or e-mail) is the
34 preferred method. The UKCC suggests a maximum of 24 hours,
35 in which a new prescription confirming the changes should be
36 provided. In any event, the changes must have been
37 authorised before the new dosage is administered. "CHI
38 understands that arrangements such as these are common
39 practice in GP led wards and work well on the Sultan ward,
40 with arrangements in place for GPs to sign the prescription
41 within 12 hours. These arrangements were also confirmed by
42 evidence found in CHIs case note review.

43
44 *Administration of medication*

45 Medication can be administered in a number of ways, for
46 example, orally in tablet or liquid form, by injection and
47 under the skin via a syringe driver. Guidance for staff on
48 prescribing via syringe drivers is contained within the
49 Trust's policy for assessment and management of pain and

1 states that all prescriptions for continuous infusion must
2 be written on a prescription sheet designed for this
3 purpose.

4
5 Evidence from CHIs case note review demonstrated good
6 documented examples of communication with both patients and
7 relatives over medication and the use of syringe drivers.

8
9 *Role of nurses in medicines administration*

10 Registered nurses are regulated by the General Nursing
11 Council, (GNC) a new statutory body which replaced the UKCC
12 I April 2002. Registered nurses must work within their Code
13 of Professional Conduct (UKCC June 1992), the Scope of
14 Professional Practice (UKCC June 1992) clarified the way in
15 which registered nurses are personally accountable for their
16 own clinical practice and for care they provide to patients.
17 The Standards for the Administration of Medicines (UKCC
18 October 1992) details what is expected of nurses carrying
19 out this important function, each nurse should have a copy
20 of the standards.

21
22 Underpinning all of the regulations which govern nursing
23 practice, is the requirement that nurses act in the best
24 interest of their patients at all times. This could include
25 challenging the prescribing of other clinical staff.

26
27 Information provided by the Trust indicates that only two
28 qualified nurses from Sultan ward had taken part in a
29 syringe driver course in 1999. Five nurses had also
30 completed a drugs competencies course. No qualified nurses
31 from either Dryad or Deadalus ward had taken part in either
32 course between 1998 and 2001. Some nursing and healthcare
33 support staff spoke of receiving syringe driver information
34 and training from a local hospice.

35
36 *Review of medication*

37 The regular ward rounds and multi-disciplinary meetings
38 should include a review of medication by senior staff which
39 is recorded in the patient's case notes. CHI recognises
40 that the multi-disciplinary meeting is complex as the
41 consultant has to process information from a variety of
42 staff, engage in a dialogue to set and review goals and
43 record the essence of this discussion in the case notes.
44 The additional task of concurrently reading and amending the
45 prescription chart, listening to the observations of staff
46 about symptom and pain control and recording any medication
47 changes makes the process yet more complex. Despite this, a
48 process should be found to ensure that effective and regular
49 reviews of patient medication take place

1
2 In November 1999, a PHCT review of the use of neuroleptic
3 medicines, which includes tranquillisers such as
4 haloperidol, within all trust elderly care continuing care
5 wards concluded that neuroleptic medicines were not being
6 over prescribed. The same review revealed that "the weekly
7 medical review of medication was not necessarily recorded in
8 the medical notes". The findings of this audit and the
9 accompanying action plan, which included guidance on
10 completing the prescription chart correctly, was circulated
11 to all staff on Daedalus and Dryad wards, including part-
12 time staff and the clinical assistant. A copy was not sent
13 to Sultan ward. There was a re-audit in January 2000, when
14 it was concluded that ??? (*trust asked for copy*)

15

16 *Structure of pharmacy*

17 The PHCT have a service level agreement with the local acute
18 trust, Portsmouth Hospitals NHS Trust, for pharmacy
19 services. The contract is managed locally by a grade E
20 pharmacist and the service provided by a second pharmacist
21 who is the lead for older peoples services. Pharmacists
22 speaking to CHI spoke of a remote relationship between the
23 community hospitals and the main pharmacy department at
24 Queen Alexandra Hospital, together with an increasing
25 workload. Pharmacy staff were confident the pharmacist
26 would challenge large doses written up by junior doctors but
27 stressed the need for a computerised system which would
28 allow clinician specific records. There are some recent
29 plans to use the trust intranet to provide a "Compendium of
30 Drug therapy Guidelines, though CHI was told that the
31 intranet was not generally available.

32

33 Pharmacy training to other non-pharmacy staff was regarded
34 as "totally inadequate" and not taken seriously. There was
35 no awareness of any training offered to clinical assistants
36

37

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

1

2 *Findings*

3

4 - CHI has serious concerns regarding the quantity,
5 combination and lack of review of medicines prescribed
6 to older people on Dryad and Daedalus wards in 1997/98.
7 This is based on the findings of police expert
8 witnesses and pharmacy data provided for the wards.

9 - *Commentary on 1997/98 - 2000/01 Pharmacy Data*
10 *Daedalus*

11 The data provided by PHCT illustrates an increase in
12 the amount of diamorphine, haloperidol and midazolam
13 used on Daedalus ward in 1998, the quantity of
14 diamorphine used is most significant. The useage of
15 all three drugs in recent years illustrates a decline,
16 this was reinforced by trust staff interviewed by CHI
17 and by CHIs own review of recent case notes. This
18 should be seen against a slight rise in patient
19 numbers.

20

21 *Dryad*

22 Usage of the three drugs on Dryad ward also demonstrate
23 a decline, though this is against a decline in finished
24 consultant episodes.

25

26 *Sultan*

27 Sultan ward has also experienced a rise in patient
28 numbers, together with an increase in the use of
29 diamorphine, haloperidol and midazolam. There has been
30 a recent large increase in diamorphine used on the
31 ward.

32

33 The following graphs detail the decline in usage in
34 specific medicines between 1998 and 2001. Nursing staff
35 interviewed confirmed the decreased use of both
36 diamorphine and the use of syringe drivers since 1998.
37 CHI review of recent case notes confirmed that
38 prescribing levels of diamorphine, midazolam and
39 haloperidol had reduced substantially.

40

41 - CHI welcomes the introduction and adherence to policies
42 regarding the prescription, administration, review and
43 recording of medicines. Though the palliative care
44 "Wessex" guidelines refer to non-physical symptoms of
45 pain, the polices however do not include methods of
46 non-verbal pain assessment and rely on the patient
47 articulating when they are in pain.

48

- 1 - CHI found little evidence from the expert witness
2 reports commissioned by the police to suggest that
3 thorough whole patient assessments were being made by
4 multidisciplinary teams in 1998.
5
- 6 - Pharmacy support to the wards in 1998 was inadequate.
7 CHI remains unconvinced that there are adequate systems
8 in place to review and monitor prescribing at ward
9 level.

1

2

3

Recommendations

4

5

- The PCT should review the provision of pharmacy services to Dryad, Deadalus and Sultan wards, taking into account the change in casemix and useage of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

10

- The PCT must review the introduction of IT in maintaining records of prescribing.

11

12

- The PCT, in conjunction with the Pharmacy department, must ensure that all relevant staff are trained in the prescription, administration, review and recording of medicines

13

14

15

16

1
2 **Chapter 6 - Staffing Arrangements and Responsibility for**
3 **Patient Care**

4
5 *Responsibility for Patient Care*

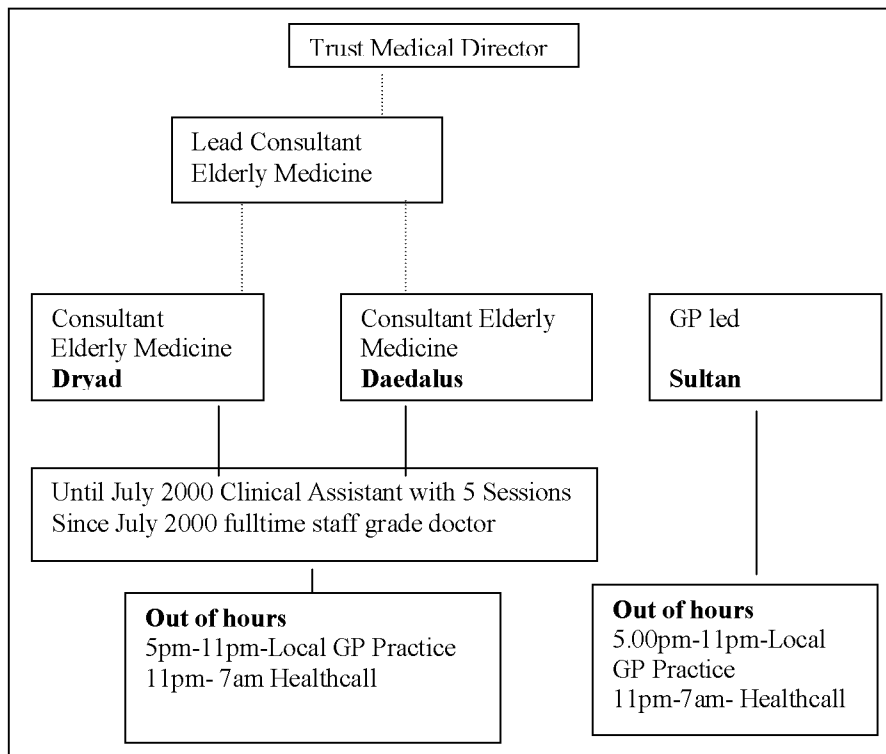
6 Patient care at the Gosport War Memorial for the period of
7 the CHI investigation was provided by a consultant led team
8 on Daedalus and Dryad wards. The complex needs of this
9 vulnerable group of patients are best met by a multi-
10 disciplinary, multi-professional team of appropriately
11 trained staff. This ensures that the total needs of the
12 patient are joined together in a care plan, discussed with
13 the patient and their relatives and carers, which reflects
14 the individual needs of each patient and is understood by
15 every member of the team. Solid care planning such as this
16 would ensure that all care decisions, such as prescribing,
17 were jointly owned by all members of the team, including the
18 lead consultant.

19
20 *Medical Responsibility*

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

37
38 In addition, since 2000 (*check with trust*) two elderly
39 medicine consultants provide 10 sessions in total of
40 consultant cover on Dryad and Daedalus wards. Since
41 September 2000, day to day medical support is provided by a
42 staff grade physician who is supervised by both consultants.
43 Before this, additional medical support was provided by a
44 Clinical Assistant until July 2000. Both consultants
45 undertake a weekly ward round with the staff grade doctor.
46 In 1998, there had been a fortnightly ward round on Daedalus
47 ward, CHI heard that ward rounds were less frequent than
48 this on Dryad ward.

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



*
 This line indicates managerial accountability and not clinical

40 *General Practice Role and Accountability*
 41 Local GPs worked at the Gosport War Memorial Hospital in
 42 three capacities during the period under investigation; as
 43 clinical assistants, as the clinicians admitting and caring
 44 for patients on the GP (Sultan) ward and as providers of out
 45 of hours medical support on each of the three wards.

46
 47 *Clinical Assistant Role*
 48 Clinical assistants are GPs who are employed and paid by
 49 trusts to provide, largely part time, medical support on
 Gosport War Memorial Hospital Investigation

1 hospital wards. Clinical assistants have been a feature of
2 community hospitals within the NHS for a number of years.
3 PHCT employed a number of such GPs in this capacity in each
4 of their community hospitals. Clinical assistants work as
5 part of a consultant led team have the same responsibilities
6 as hospital doctors to prescribe medication, write in the
7 medical record and complete death certificates. Clinical
8 assistants should be accountable to a named consultant.
9

10 Between 1994 until the resignation of the post holder in
11 July 2000, a clinical assistant was employed for five
12 sessions at the Gosport War Memorial Hospital. The fees for
13 this post were in line with national rates. The job
14 description clearly states that the clinical assistant is
15 accountable to "named consultant physicians in geriatric
16 medicine". Cover for annual leave and any sickness absence
17 was the responsibility of the post holder to arrange with
18 practice partners, with whom the trust did not have a
19 contract for this purpose. The job description does state
20 that the post is subject to the Terms and Conditions of
21 Hospital Medical and Dental Staff, if identified, poor
22 performance could have been investigated through the trust's
23 disciplinary processes. Any concerns over the performance of
24 any clinical assistant could have been pursued through the
25 Trust disciplinary proceedings. CHI could find no evidence
26 to suggest that this option was explored.
27

28 CHI is not aware of any trust systems in place to monitor or
29 appraise the performance of the clinical assistant, this
30 lack of monitoring is still common practice within the NHS.
31 CHI could find no evidence of any system put in place by
32 consultants admitting patients to Dryad and Daedalus wards,
33 to whom the clinical assistant was accountable, to supervise
34 the practice of the clinical assistant. This includes any
35 review of prescribing. CHI could also find no evidence of
36 any formal lines of communication regarding policy
37 development, guidelines and workload. Staff interviewed
38 commented on the long working hours of the clinical
39 assistant, in excess of the five contracted sessions.
40

41 *Sultan Ward*

42 Medical responsibility for patients on Sultan ward lies with
43 the admitting GP. The trust issued admitting GPs with a
44 contract for working on trust premises, which clearly states
45 "you will take full clinical responsibility for the patients
46 under your care". CHI was told that GPs visit their patients
47 regularly and when requested by nursing staff. This is a
48 common arrangement in community hospitals throughout the

1 NHS. GPs have no medical accountability framework within the
2 trust.

3
4 GPs managing their own patients on Sultan ward could be
5 subject to the Health Authority's voluntary process for
6 dealing with doctors whose performance is giving cause for
7 concern. However, this procedure can only be used in regard
8 to their work as a GP, and not any contracted work performed
9 in the trust as a clinical assistant. Again, this
10 arrangement is common throughout the NHS.

11 12 *Out of Hours Cover Provided by GPs*

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

28
29 Nurses expressed concern over Healthcall GPs reluctance to
30 "interfere" with admitting GPs prescribing on Sultan and
31 Dryad wards.

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

34 35 36 *Appraisal of Hospital Medical Staff*

37 Since, April 2000, all NHS employers have been contractually
38 required to carry out annual appraisals, covering both
39 clinical and non-clinical aspects of their jobs.

40 All doctors interviewed by CHI, including the medical
41 director who works 5 sessions in the department of elderly
42 medicine, have regular appraisals. Those appraising the
43 work of other doctors have been trained to do so.

44 45 *Nursing Responsibility*

46 All qualified nurses are personally and legally accountable
47 for their own clinical practice. Their managers are
48 responsible for implementing systems and environments which
49 promote high nursing quality care.

1
2 Ward nurses on each ward are managed by a G grade clinical
3 manager, who reports to a senior, H grade nurse. This nurse
4 covers the three wards caring for older people, and was
5 managed by the general manager for the Fareham and Gosport
6 division. The general manager reported to both the director
7 of nursing and the operations director. An accountability
8 structure such as this is not unusual in a community
9 hospital. The director of nursing was ultimately
10 accountable for the standard of nursing practice within the
11 hospital.

12

13 *Nursing supervision*

14 Clinical supervision for nurses was recommended by the UKCC
15 in 1996, and again in the national nursing strategy, Making
16 a Difference, in 1999. It is a system through which
17 qualified nurses can maintain life-long development and
18 enhancement of their professional skills through reflection,
19 exploration of practice and identification of issues that
20 need to be addressed. There are a range of models, but in
21 the main, three are used: clinical supervision with an
22 expert; one to one supervision and group supervision.
23 Clinical supervision is not a managerial activity, but
24 provides an opportunity to reflect and improve on practice
25 in a non-judgemental environment. Clinical Supervision is a
26 key factor in professional self-regulation.

27

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

38

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

7
8 Regular ward meetings are held on Sultan and Daedalus wards,
9 with less clear arrangements on Dryad ward, which may be due
10 to long term senior ward staff sickness.

11 12 *Team working*

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

25
26 Arrangements for multi-disciplinary team meetings on Dryad
27 and Sultan wards are less well established. Occupational
28 therapy staff reported some progress towards multi-
29 disciplinary goal setting for patients though were hopeful
30 of more progress.

31 32 *Allied Health Professional Structures*

33 Allied Health Professionals (AHP's) are a group of staff
34 which include occupational therapists, dieticians, speech
35 and language therapists and physiotherapists. The
36 occupational therapy structure is in transition from a
37 traditional site based service to staff providing defined
38 clinical specialty (e.g. stroke rehabilitation) in the
39 locality. All referrals are received centrally. Staff
40 explained that this system enables the use of specialist
41 clinical skills and ensures continuity of care of patients,
42 as one occupational therapist follows the patient throughout
43 hospital admission(s) and at home. Occupational therapists
44 talking to CHI described a good supervision structure, with
45 supervision contracts and performance development plans in
46 place.

47 48 *Physiotherapy*

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

6

7 *Speech and Language Therapists*

8 Speech and language therapists also reported participation
9 in multi-disciplinary team meetings on Daedalus ward.
10 Examples were given to CHI of well developed in service
11 training opportunities and professional development such as
12 discussion groups and clinical observation groups.

13

14 *Dietetics*

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

19

20 *Workforce and service planning*

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

25

26 (i) consultant cover

27 (ii) medical risk with change in client group and the
28 likelihood of more patients requiring specialist
29 intervention. The trust believed that the introduction
30 of automated defibrillators would go some way to
31 resolve this. The paper also spoke of "the need for
32 clear protocols...within which medical cover can be
33 obtained out of hours".

34 (iii) the trust identified a course for qualified
35 nursing staff, ALERT, a technique for quickly assessing
36 any changes in a patients condition in order to provide
37 an early warning of any deterioration.

38

39 Despite this preparation, several members of staff expressed
40 concern to CHI regarding the complex needs of many patients
41 cared for at the Gosport War Memorial Hospital and spoke of
42 a system under pressure due to nurse shortages and high
43 sickness levels. Concerns were raised formally with the
44 trust in early 2000 around the increased workload and
45 complexity of patients, which were acknowledged by the
46 Medical Director, though CHI found no evidence of a
47 systematic attempt to review or seek solutions to the
48 evolving casemix.

1

2 *Access to specialist advice*

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

15

16 A joint palliative care booklet, published jointly in 1998
17 with PHCT, the Portsmouth Hospitals NHS Trust and a local
18 hospice which staff are aware of and use. The booklet
19 includes a number of guidelines on clinical management,
20 including symptom management, psychological and spiritual
21 care and bereavement. Staff spoke of strong links with the
22 Rowans hospice and MacMillian nurses. Nurses gave recent
23 examples of joint training with the hospice in the use of
24 syringe drivers.

25

26 CHIs audit of recent case notes indicated that robust
27 systems are in place for both specialist medical advice and
28 therapeutic support.

29

30 *Staff welfare*

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

39

40 However, many staff, at all levels in the organisation spoke
41 of the stress and low morale caused by the series of police
42 investigations and the referrals to the GMC, UKCC and the
43 CHI Investigation. Trust managers told CHI of their
44 encouragement of staff to use the trust's counselling
45 service and of organised support sessions for staff. Not
46 all staff speaking to CHI considered that they had been
47 supported by the trust, particularly those working at a
48 junior level, "I don't feel I've had the support I should

1 have had before and during the investigation-others feel the
2 same"

3

4 *Findings*

5 - There are clear accountability and supervisory
6 arrangements in place for trust doctors, nurses and AHP
7 staff. Currently, there is effective nursing
8 leadership on Daedalus and Sultan wards, this is less
9 evident on Dryad ward. CHI was concerned regarding the
10 potential for professional isolation of the staff grade
11 doctor.

12

13 - Systems are now in place to ensure that appropriate
14 specialist medical and therapeutic advice is available
15 for patients. Some good progress has been made towards
16 multi-disciplinary team working which should be
17 developed.

18

19 The PCHT did not have any systems in place to monitor
20 and appraise the performance of clinical assistants.
21 The clinical assistant working on Daedalus and Dryad
22 wards was allowed to practice without adequate
23 supervision arrangements. It was not made clear to CHI
24 how GPs working as clinical assistants and admitting
25 patients to Sultan wards are included in the
26 development of trust procedures and clinical governance
27 arrangements.

28

29 There was a planned approach to the service development
30 which brought about the change of use of beds in 2000.
31 The increasing dependency of patients and resulting
32 pressure on the service, whilst recognised by the
33 trust, was neither monitored nor reviewed as the
34 service developed.

35

36 - The PHCT should be congratulated for its progress
37 towards a culture of reflective nursing practice.

38

39 - The trust had a strong staff focus, with some notable
40 examples of good practice. Despite this, CHI found
41 evidence to suggest that not all staff were adequately
42 supported during the police and other recent
43 investigations.

44

45 - Out of hours medical cover for the three wards out of
46 hours is inadequate and does not reflect current levels
47 of patient dependency.

48

1 *Recommendations*

- 2 - National guidelines for employing trusts and for GPs
3 working as clinical assistants and those admitting
4 patients to for GPs working on GP led wards should be
5 developed by the Royal College of general
6 Practitioners.
7
- 8 - The provision of out of hours medical cover should be
9 reviewed. Should a contact be agreed with a deputising
10 service, advice must be taken from the British Medical
11 Association and PCT staff to ensure a shared philosophy
12 of care, adequate payment, waiting time standards and a
13 disciplinary framework are included in the contract.
14
- 15 - The new PCT responsible for the provision of care of
16 older people should continue to work with colleagues to
17 ensure that appropriate patients are being admitted to
18 the Gosport War Memorial Hospital with appropriate
19 levels of support.
20
- 21 - The PCT should ensure that recent arrangements to
22 ensure strong, long term, nursing leadership on Dryad
23 ward continue.

1

2 **Chapter 7 - Lessons Learnt from Complaints**

3

4 *CHI to check with HSC if they are looking at Mrs D (daughter*
5 *Mrs R - before publication)*6 A total of 129 complaints were made regarding the division
7 of elderly medicine since 1.4.97. These complaints include
8 care provided in other community hospitals as well as that
9 received on the acute wards of St Mary's and Queen Alexandra
10 Hospitals. In addition, CHI was told that over four hundred
11 letters of thanks had been received by the three wards at
12 the Gosport War Memorial Hospital during the same period.

13

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

26

27

28 *External review of complaints*29 One complaint was referred to the Health Services
30 Commissioner (Ombudsman) in May 2000. The medical advisor
31 found that the choice of pain relieving drugs was
32 appropriate in terms of medicines, doses and administration.
33 A complaint in January 2000 was referred to an Independent
34 Review Panel (IRP), which found that drug doses, though
35 high, were appropriate, as was the clinical management of
36 the patient. Though the external assessment of these two
37 complaints revealed no serious clinical concerns, both the
38 Health Services Commissioner and the review panel commented
39 on the need for the trust to improve its communication with
40 relatives towards the end of a patient's life.

41

42 The trust's Medical Director told CHI that following receipt
43 of Complaint 1, he confirmed with a colleague in a
44 neighbouring trust that prescribing parameters at the War
45 Memorial Hospital were within an acceptable range.

46

47 *Complaint Handling*48 The trust has a policy for handling patient related
49 complaints produced in 1997, based on national guidance

1 "Complaints: Guidance on the Implementation of the NHS
2 Complaints Procedure" published in 1996. (evidence of a
3 review?) A leaflet for patients detailing the various stages
4 of the complaints procedure was produced, this includes the
5 right to request an Independent Review if matters are not
6 resolved to their satisfaction together with the address of
7 the Health Service Commissioner. This leaflet was not
8 freely available on the wards.

9
10 Both the trust and the local CHC described a good working
11 relationship. The CHC however regretted that their
12 resources had, since November 2000, prevented them from
13 offering the level of advice and active support to trust
14 complainants they would have wished.

15
16 CHI found that letters to complainants in response to their
17 complaints did not always include an explanation of the IRP
18 process, though this is outlined in the leaflet mentioned
19 above, which is sent to complainants earlier in the process.
20 Audit standards for complaints handling are good with at
21 least 80% of complainants satisfied with complaint handling
22 and 100% of complainants resolved within national
23 performance targets. (CHI check date) All written complaints
24 were responded to by the Chief Executive. Staff interviewed
25 by CHI valued the Chief Executive's personal involvement in
26 complaint resolution and correspondence. Letters to patients
27 and relatives sent by the trust reviewed by CHI were
28 thorough and sensitive. The trust adopted an open response
29 to complaints and apologised for any shortcomings in its
30 services.

31
32 Once the police became involved in the initial complaint in
33 1998, the trust ceased internal investigation processes.
34 CHI found no evidence in board agendas that the trust board
35 were formally made aware of police involvement. One senior
36 trust manager told CHI that the trust would have
37 commissioned an internal investigation without question if
38 the police investigation had not begun. In CHI's view,
39 police involvement did not need to preclude an internal
40 clinical investigation. The doctor involved in the care of
41 this patient wrote to the trust's quality manager expressing
42 concern that she discovered by chance three months later
43 that a complaint had been made. Neither that doctor nor
44 portering staff involved in the transfer of the patient were
45 asked for statements during the initial trust investigation.

46 47 *Trust Learning Regarding Prescribing*

48 The trust did not connect the police investigation, the
49 review of the Health Service Commissioner, the Independent

1 Review Panel and the trust's own pharmacy data, to trigger a
2 review of prescribing practices. CHI was surprised that the
3 trust did not respond earlier and faster to concerns
4 expressed around levels of sedation.

5
6 Action was however taken to develop and improve trust
7 policies around prescribing and pain management (as detailed
8 in chapter??). In addition, CHI learnt that external
9 clinical advice sought by PHCT in September 1999, during the
10 course of a complaint resolution, suggested that the
11 prescribing of diamorphine with dose ranges from 20mgs to
12 200mgs a day was poor practice and "could indeed lead to a
13 serious problem". The comment was made that the patient had
14 been given doses ranging from 20mg to 40mg per day.

15
16 PHCT correspondence states that there was an agreed protocol
17 for the prescription of diamorphine for a syringe driver
18 with doses ranging between 20mg and 200mgs a day. CHI
19 understands this to be the "Wessex guidelines". Further
20 correspondence in October 1999, indicated that a doctor
21 working on the wards asked for a trust position policy on
22 the prescribing of opiates in community hospitals. This was
23 not addressed until April 2001, when the joint PHCT and
24 Portsmouth Hospitals NHS Trust policy for the assessment and
25 management of pain was introduced.

26 27 *Other Trust Lessons*

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

- 34
35 - An increase in the frequency of consultant ward rounds
36 on Daedalus ward, from fortnightly to weekly from
37 February 1999.
- 38 - The appointment of a staff grade doctor in September
39 2000 to increase medical cover following the
40 resignation of the clinical assistant.
- 41 - Piloting of pain management charts and prescribing
42 guidance approved in May 2001. Nursing documentation
43 is currently under review, with nurse input.
- 44 - One additional consultant session in ?? following a
45 district wide initiative with local PCGs around
46 intermediate care.
- 47 - Nursing documentation now clearly identifies prime
48 family contacts and next-of-kin information to ensure
49 appropriate communication with relatives.

1 All conversations with families are now documented in
2 the medical record. CHIs review of recent anonymised
3 case notes demonstrated frequent and clear
4 communication between relatives and clinical staff.

5
6 Comments were recorded in this workshop which were echoed by
7 staff interviewed by CHI, such as; the difficulty in
8 building a rapport with relatives when patients die a few
9 days after transfer, the rising expectations of relatives,
10 and the lack of control Gosport War Memorial staff have over
11 information provided to patients and relatives prior to
12 transfer.

13

14 *Monitoring and Trend Identification*

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

26

27 The PHCT offered specific training in complaints handling,
28 customer care and loss, death and bereavement, which many,
29 though not all, staff interviewed by CHI were aware of and
30 had attended.

31

32 The Trust had a well defined and respected line management
33 structure through which staff are confident emerging themes
34 from complaints would now be identified.

1

2 *Findings*

3

4 - PHCT did not use the issues raised through complaints
5 made between 1998 and 2001 and an ongoing police
6 investigation as a trigger for an internal review of
7 prescribing within the Gosport War Memorial Hospital.

8

9

10 - PHCT did effect changes in patient care, including
11 increased medical staffing levels and improved
12 processes for communication with relatives, though this
13 learning was not consolidated until 2001. CHI saw no
14 evidence to suggest that the impact of these changes
15 had been robustly monitored and reviewed.

16

17 - Systems are not yet in place to ensure that the impact
18 of these changes have been robustly monitored and
19 reviewed.

20

21 - That there has been some, though not comprehensive,
22 training of all staff in handling patient complaints
23 and communicating with patients and carers.

24

25 *Recommendations*

26

27 That CHI work with the Association of Chief Police
28 Officers to develop a protocol for sharing information
29 regarding patient safety and potential systems failures
30 within the NHS as early as possible. CHI will also
31 work with the Association of Chief Police Officers to
32 develop police awareness of the NHS and its management
33 and accountability structures.

34

35 That CHI work with the National Patients Safety Agency
36 to ensure that any trends demonstrating serious
37 concern, within individual NHS organisations, which
38 emerge from the prescription of any medicines be
39 referred immediately to the National Patients Safety
40 Agency.

41

42 - That the relevant PCT ensures that the learning and
43 monitoring of action arising from complaints undertaken
44 through the PHCT quarterly performance management
45 system is maintained under the new management
46 arrangements.

47

48 - That the relevant PCT, through it's appraisal and
49 personal development planning process, ensures that all

1 staff working on these three wards, who have not
2 attended customer care and complaints training events
3 do so. Any new training programmes should be developed
4 with staff, patients and relatives to ensure that
5 current concerns and the particular needs of the
6 bereaved are addressed.
7
8
9
10
11
12

1 Chapter 8 - Communication

2

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

6

7 *Patients, Relatives and Carers*

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

18

19 The Health Advisory Service Standards for Health and Social
20 Care Services for Older People (2000) states that "each
21 service should have a written information leaflet or guide
22 for older people who use the service. There should be good
23 information facilities in inpatient services for older
24 people, their relatives and carers". CHI saw a number of
25 separate information leaflets provided for patients and
26 relatives during the site visit.

27

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

41

42 *Communication Towards the End of Life*

43 Staff spoke of the "Wessex" palliative care guidelines in
44 use on the wards which talks about breaking bad news and
45 communicating with the bereaved. Many clinical staff, at all
46 levels spoke of the difficulty in managing patient and
47 relative expectations following discharge from the acute
48 sector. "They often painted a rosier picture than
49 justified". Staff spoke of the closure of the Royal Haslar

1 acute beds leading to increased pressure at Portsmouth
2 Hospitals NHS Trust hospital, Queen Alexandra and St Mary's
3 Hospitals to discharge patients too quickly to the Gosport
4 War Memorial Hospital. Staff were aware of more medically
5 unstable patients being transferred in recent years.

6
7 *Staff Communication*

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

14
15 *Transfer into the community*

16 CHI talked to staff from the nursing homes which most
17 frequently receive patients from the Gosport War Memorial
18 Hospital. Nursing home staff spoke of good, collaborative
19 relationships with ward staff. Patients admitted into local
20 nursing homes recently, were thought by staff to have been
21 well cared for at the Gosport War Memorial Hospital. No
22 concerns were raised with CHI regarding skin integrity
23 (pressure sores) and nutritional status for example. These
24 positive views were echoed by district nurses.

25
26 *Findings*

- 27 - CHI found evidence of good communication within the
28 trust, both with staff and partner organisations in the
29 local health community.
30
31 - CHI found a strong theoretical commitment to patient
32 and user involvement.

33
34 *Recommendations*

- 35 - The PCTs must find ways to continue the staff
36 communication developments made by the PHCT.
37
38 - Within the framework of the new PALS, as a priority,
39 the PCT should consult with user groups, and consider
40 reviewing specialist advice from national support
41 groups, to determine the best way to improve
42 communication with older patients and their relatives
43 and carers.

44

1
2 **Chapter 9 - Clinical Governance**

3
4 *Introduction*

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

14
15 CHI has not conducted a clinical governance review of the
16 Portsmouth Healthcare NHS Trust but has looked at how trust
17 clinical governance systems support the delivery of
18 continuing and rehabilitative inpatient care for older
19 people at the Gosport War Memorial Hospital. This chapter
20 sets out the framework and structure adopted by the trust
21 between 1998 and 2002 to deliver the clinical governance
22 agenda and details those areas most relevant to the terms of
23 reference for this investigation; risk management including
24 medicines management and the systems in place to enable
25 staff to raise concerns.

26
27 *Summary*

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

39
40 *Clinical Governance Structures*

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

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

4
5 District Audit carried out an audit of the trust's clinical
6 governance arrangements in 1998/99. The report, dated
7 December 1999, states that the Trust had fully complied with
8 requirements to establish a framework for clinical
9 governance. The report also referred to the Trust's
10 document "Improving Quality - steps towards a First Class
11 Service" which was described as "of a high standard and
12 reflected a sound understanding of clinical governance and
13 quality assurance".

14
15 Whilst commenting favourably on the framework, the District
16 Audit Review also noted the following:

- 17
18 - The process for gathering user views should be more
19 focussed and the process strengthened.
20
21 - The clinical governance loop needed to be closed in
22 some areas to ensure that strategy, policy and
23 procedure resulted in changed/improved practice.
24 Published protocols were not always implemented by
25 staff; results of clinical audit were not always
26 implemented and re-audited; lessons learnt from
27 complaints and incidents not always used to change
28 practice and that R&D did not always lead to change in
29 practice.
30
31 - More work needed to be done with clinical staff on
32 openness and the support of staff alerting senior
33 management of poor performance.
34

35 Following the review, the trust drew up a trust-wide action
36 plan in December 1999 which focussed on widening the
37 involvement and feedback from nursing, clinical and support
38 staff regarding Trust protocols and procedures, and on
39 making greater use of R&D, clinical audit, complaints,
40 incidents and user views to lead to changes in practice.
41 *Outcome of this to be inserted????*
42

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

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

4
5 *Risk management*

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

21
22 The Trust had an operational policy for "Recording and
23 Reviewing Risk Events" introduced in 1994. New reporting
24 forms were introduced in April 2000 following a review of
25 the assessment systems for clinical and non-clinical risk.
26 The same trust policy is used to report clinical, non-
27 clinical and accidents. All events are recorded in the
28 Trust's Risk Event Database (CAREKEY). The procedure states
29 that this reporting system should also be used for near
30 misses and medication errors.

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

37
38 The Clinical Governance Development Plan for 2001/02 states
39 that the focus for risk management in 2000/01 was the safe
40 transfer of services to successor organisations, with the
41 active involvement of PCTs and PCGs in the Trust's Risk
42 Management Group. Meetings have been held with each
43 successor organisation to agree future arrangements for such
44 areas as; risk event reporting, health and safety, infection
45 control and medicines management.

46
47 *Raising concerns*

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

1 The policy sets out the process staff should follow if they
2 wish to raise a concern about the care or safety of a
3 patient in the event of other procedures having failed or
4 being exhausted. NHS guidance requires systems to enable
5 concerns to be raised outside of the usual management chain.
6 The trust policy informs staff that they can use the
7 Whistleblowing process when staff have concerns "that cannot
8 be resolved be resolved by the appropriate procedure".
9

10 Most staff interviewed were clear about how to raise
11 concerns within their own line management structure and were
12 largely confident of receiving support and an appropriate
13 response. There was less certainty around the existence of
14 the Trust's Whistleblowing Policy.
15

16 *Clinical Audit*

17 CHI heard of no demonstrable examples during interviews with
18 staff of positive changes in patient care as a result of
19 clinical audit outcomes. Despite a great deal of work on
20 revising and creating policies to support good prescribing,
21 there has been no planned audit of outcome.
22

23 *Need to include outcome of trust recent prescribing audit*
24 *here.*
25

26 *Findings*

- 27
- 28 - That the trust has responded proactively to the
29 clinical governance agenda and had a robust framework
30 in place with strong corporate leadership.
31
 - 32 - That although a robust system is in place to record
33 risk events, understanding of clinical risk was not
34 universal. The trust did have a Whistleblowing policy
35 in place. However, this did not make it explicitly
36 clear that staff could raise concerns outside of the
37 usual management channels if they felt unable to raise
38 concerns in this way.

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Recommendations

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- That the relevant PCT fully embrace the clinical governance developments made and direction set by the Trust.

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- That all staff groups be required to complete risk and incident reports. Training must be put in place to reinforce the need for rigorous risk management. and training put in place to reinforce.

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- That the clinical governance panel regularly identify and monitor trends revealed by risk reports and ensure appropriate action taken.

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- That the PCT considers a revision of the Whistleblowing policy to make it clear that concerns may be raised outside of normal management channels.

APPENDIX A

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1. **Mrs D - Local Resolution**, background papers (minus correspondence). Independent review panel papers (including local resolution correspondence). Correspondence with Mrs R and Max Millett during independent review process, 12 July 2000. Independent review panel, agenda 22 May 2001. Independent review panel report and trust action plan, produced 10 August 2001. Independent review panel notes from Hearing /Interviews. Correspondence with Ombudsman, 12 October 2001.
2. **Complaint:- Mrs W. & Portsmouth Healthcare NHS Trust (undated)**
3. **Complaint:- Mr C. & Portsmouth Healthcare NHS Trust (undated)**
4. **Complaint:- Mr S. & Portsmouth Healthcare NHS Trust (undated)**

5. Mr/Mrs?? B/G report June 2000.
6. Complaint:- Mr R. & Portsmouth Healthcare NHS Trust, (undated)
7. Complaint:- Mrs H. & Portsmouth Healthcare NHS Trust, (undated)
8. Patient leaflets, Your views matter. How the Health Service Ombudsman can help you April 1996. Your views matter. Making comments or complaints about our services. Complaints, listening acting improving. Portsmouth Healthcare NHS Trust (Undated)
9. Analysis of complaints, Gosport War Memorial Hospital, Workshop notes and action plans, February 2001.
10. Bleep holder policy review, 15 May 2001.
11. Gosport War Memorial Hospital, Patients survey information and action plan, Portsmouth Healthcare NHS Trust, October 2001.

NEW EVIDENCE

12. Complaint Mrs Wh. letter and reply from Max Millet, Chief Executive, Portsmouth Healthcare NHS Trust, February/March 2002

(M) Documents relating to Portsmouth Healthcare NHS Trust: Clinical Governance - Volume I

1. *Community Hospitals, Governance framework - January 2001.*
2. *Community Hospitals, Clinical Governance Development Plan - 2001/02.*
3. *General Rehabilitation Clinical Governance Group, minutes of meeting 6 September 2001.*
4. *Day Hospital Clinical Governance meeting, 9 October 2001.*
5. *Stroke Service Clinical Governance meeting, minutes of meeting 12 October 2001.*

6. Continuing Care Clinical Governance Group, minutes of meeting 7 November 2001. **Portsmouth Healthcare NHS Trust**
7. Community Hospitals Clinical Leadership Programme Update, 19 November 2001. **Portsmouth Healthcare NHS Trust**
8. Practice Development Programme, **Portsmouth Healthcare NHS Trust, March 1999.**
9. Third Quarter quality/clinical governance report, Community Hospitals Service Lead Group, **Portsmouth Healthcare NHS Trust, January 2000.**
10. Community Hospitals Clinical Governance Baseline Assessment Action Plan, September 1999.
11. Notes of a Community Hospital Service Lead Group Meeting, **Portsmouth Healthcare NHS Trust, 26 May 2000.**
12. Mandatory training by contract group, November 2000.
13. **Clinical Governance Development Plan 2001/2002.** Portsmouth Healthcare NHS Trust
14. **Clinical Governance - Annual Report - 1999/2000.** Portsmouth Healthcare NHS Trust
15. **Clinical Governance: Minimum Expectations of NHS Trust and Primary Care Trusts from April 2000.** Action Plan - Review March 2001. Portsmouth Healthcare NHS Trust
16. **Clinical Governance - Annual Report - 2000/2001.** Portsmouth Healthcare NHS Trust
17. **Risk Management Strategy 2000 - 2003.** Portsmouth Healthcare NHS Trust

(M) Documents relating to Portsmouth Healthcare NHS Trust: Clinical Governance - Volume II

1. Portsmouth Healthcare NHS Trust, Risk Event forms and Instructions.
2. South East Region, Clinical Governance and Clinical Quality Assurance, The Baseline Assessment Framework, **NHS Executive - 1999.**
3. Clinical Governance, District Audit 1998/1999. **Portsmouth Healthcare NHS Trust**
4. Clinical Governance Baseline Assessment, Trust Wide Report, 1999. **Portsmouth Healthcare NHS Trust**
5. Trust Clinical Governance Panel, Meeting held 16 May 2001. **Portsmouth Healthcare NHS Trust**
6. Memorandum, Implementation of clinical governance, 11 June 1999. **Portsmouth Healthcare NHS Trust**
7. Risk Management Strategy, 1999/2002. **Portsmouth Healthcare NHS Trust**
8. .Risk Management Strategy, 1998/2001.

NEW EVIDENCE

9. Clinical governance development plan, **Portsmouth Healthcare NHS Trust, 2001/2002**

C) Documents relating the Elderly medicine at the Gosport War Memorial Hospital

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1. **The department of medicine for elderly people -
Services provided.** (undated)
2. **Intermediate care and rehabilitation services, March
2001 Final monitoring report intermediate Care.** Fareham
and Gosport primary care groups, May 2000.

**Documents relating to Portsmouth Healthcare NHS Trust:
Service Strategic**

Documents relating to Portsmouth Healthcare NHS Trust:
Quality - Volume I

1. **Letter from lead consultant David Jarrett, from
department of medicine for elderly people at Portsmouth
Healthcare NHS Trust re: National sentinel audit of
stroke 1999, 8 March 2000.**

Documents relating to Portsmouth Healthcare NHS Trust:
Staffing and Accountability - Volume I

2. **Department of medicine for elderly people, Job
description, Service manager** Portsmouth Healthcare NHS
Trust ,22 November 2001.
3. **Job Description, Service Manager, Community Hospitals
Fareham & Gosport,** Portsmouth Healthcare NHS Trust,
February 2000.
4. **Portsmouth Healthcare NHS Trust - Welcome pack
Department of Medicine for Elderly People Doctor's
Handbook,**
5. **University of Portsmouth, Clinical nursing governance
in a department of elderly medicine: an exploration of
key issues and proposals for future development,** Eileen
Thomas, Portsmouth Healthcare NHS Trust, May 2000.
6. **A review of nursing in the department of elderly mental
health,** Eileen Thomas, Portsmouth Healthcare NHS Trust,
July 2001.

7. **One year on: aspects of clinical nursing governance in the department of elderly medicine**, Eileen Thomas, Portsmouth Healthcare NHS Trust, September 2001.
8. **Operational policy, bank/overtime/agency, Fareham and Gosport community hospitals and elderly mental health**, Portsmouth Healthcare NHS Trust, 1 May 2001.
9. **Department of medicine for elderly people, Full time staff grade physician**. Portsmouth Healthcare NHS Trust
10. **Portsmouth Healthcare NHS Trust, Department of medicine for elderly people, Essential information for medical staff, Mastercopy**. (undated)
11. **Department of medicine for elderly people, Full time staff grade physician**. Portsmouth Healthcare NHS Trust,
12. **Development of intermediate care and rehabilitation services within the Gosport locality**. Portsmouth Healthcare NHS Trust, (undated)

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1. **Winter escalation plans elderly medicine and community hospitals**. Portsmouth Healthcare NHS Trust, (undated)
2. **Audit of detection of depression in elderly rehabilitation patients, January - November 1998**. Portsmouth Healthcare NHS Trust (undated)

NEW EVIDENCE

3. **Stepping stones - self help group for patients and carers**. Shirley Dunleavy, Team leader in Physiology, (undated)

**Documents relating to Portsmouth Healthcare NHS Trust:
Drugs**

1. **Audit of Neuroleptic Prescribing in Elderly Medicine**, Portsmouth Healthcare NHS Trust, Nov 98 - July 99.

Documents relating to Portsmouth Healthcare NHS Trust:
Communication

Documents relating to Portsmouth Healthcare NHS Trust:
End of Life

Documents relating to Portsmouth Healthcare NHS Trust:
Supervision and Training - Volume I

2. Department of Medicine for Elderly People - Wednesday Lunch Meetings, 1996 - 2001.
3. Department of Medicine for Elderly People - Friday Lunchtime Journal Club, 1999 - 2001.
4. Portsmouth Healthcare NHS Trust, Memo - 19 October 2001, Clinical Assistant Teaching Elderly Medicine, Osteoporosis & Falls - 14 November 2001.

NEW EVIDENCE

5. Science Committee day conference - palliative care for older people: can we improve its scientific basis? The Association of Palliative Medicine of Great Britain and Ireland, November 2001

Documents relating to Portsmouth Healthcare NHS Trust:
Complaints

*Documents relating to Portsmouth Healthcare NHS Trust:
Clinical Governance - Volume I*

APPENDIX B

Views from patients and relatives/friends

1. Methods of obtaining views

- i. The investigation sought to establish the views of people who had experience of services for older people at the Gosport War Memorial Hospital.

CHI sought to obtain views about the service through a range of methods. People were invited to;

- Meet with members of the investigation team
 - Fill in a short questionnaire
 - Write to the investigation team
 - Contact by telephone or email
- ii. In November 2001 information was distributed about the CHI investigation at Gosport War Memorial Hospital to Stakeholders, Voluntary Organisations and Statutory Stakeholders. This information included posters advertising stakeholder events, information leaflets about the investigation, questionnaires and general CHI information leaflets. Press releases were issued in local newspapers and radio stations. The Hampshire police force were asked to forward CHI contact details to families who had previously expressed their concerns to them.

The written information was distributed to a large group of potential stakeholders. In total 36 Stakeholders and 59 Voluntary organisations will have received the above information. These people ranged from:

- **Voluntary organisations-** e.g. Motor Neurone Disease, Alzheimer Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- Statutory stakeholder- Portsmouth and SE Hampshire Community Health Council, Isle of Wight, Portsmouth and SE Hampshire Health Authority, Local Medical Council, Members of Parliament, Nursing Homes and Social Services, Local Primary Care Trusts and Primary Care Groups.

- **Stakeholders** who had contacted CHI-patients, relatives/carers/friends.

2. Stakeholder Responses

- i. As a result of the mail out of information in November 2001, CHI have received the following responses from patients, relatives/carers/friends and voluntary organisations

Letters	Questionnaires	Telephone Interviews	*Stakeholder Interviews
7	1	10	16

*Stakeholders were counted according to the number of attendees and not based on number of interviews

- ii. A number of people who contacted CHI did so using more than one method. In these cases any other form of submitted evidence, was incorporated as part of the Stakeholders contact.

3. Analysis of views received:

During the CHI investigation the stakeholder evidence highlighted both positive and negative views about patient care. The following analysis illustrated both types of experiences of patients/friends and relatives.

Positive Experiences

CHI received 9 letters from stakeholders commenting on the satisfaction of the care that the patients received and highlighting the excellent level of care and kindness demonstrated by the staff and how much the staff were appreciated. This was also supported by the many letters of thanks and donations received by the Gosport War Memorial Hospital.

Table to show the most frequent positive views of patient and relative/friend experiences

View	Frequency of responses
Staff Attitude	5
Environment	5
Other one of comments included: Access to Services, Transfer, Prescribing, End of Life arrangements, Communication and Complaints.	

The overall analysis of the stakeholder comments indicated that staff attitude and the environment were most highly commended. Examples of staff attitude included comments such as, "One lovely nurse on Dryad went to say hello to every patient even before she got her coat off" and "As a whole the ward was lovely and there were no complaints against the staff". The environment was described as being tidy and clean with good décor. Another comment recognised the ward's attention to maintaining patient dignity with curtains being drawn reducing attention to the patient. A stakeholder also commented on the positive experience they had when dealing with the trust concerning a complaint they had issued.

Negative Experiences

However, there were a number of frequent emerging negative experiences of patients/friends and relatives that were shared with CHI by stakeholders.

Table to show the most frequent negative views of patient and relative/friend experiences

View	Frequency of responses
Communication with relatives/carers/friends	14
Patient transfer	10
Nutrition and fluids	11
Prescription of medicines	9
Continence management, catheritisation	4, 4

Staff attitude	8
End of Life, Communication with: patients	
patients	4
relatives/carers/friends	6
Humanity of care i.e. access to buzzer, clothes	5,3

The table above highlights some of the more common negative views from the stakeholder responses, which are associated with the concerns, which have triggered the Investigation and are incorporated into the term of reference.

The specifics of the term of reference which stakeholders have commented on are:

- **The guidelines and practices in place at the trust to ensure good quality care and effective performance management**
- **Patient Transfer:** -
Three of the contacts commented on the complexity of the patient's health before and during the transfer, "Patients should be physically fit to transfer", "Family felt if they knew how ill their father was they would not have moved him from Queen Alexander Hospital" and "Hospital claimed that the patient is in very serious pain following their transfer from Queen Alexander Hospital" Two contacts mentioned the time that it took to transfer the patient and a further two highlighted the in appropriate method of transporting the patient, such as being carried " on a sheet, with no poles- like a sack of potatoes" or being transferred, " naked from the waist down apart from a piece of padding".
- **Nutrition and fluids:** -
Four of the contacts highlighted a lack of help in feeding patients. Three contacts commented on how dehydrated the patients appeared and others generally commented on the lack of positive communication between the relative/carer and the staff to overcome the relative/carer's concern about the level of nutrition and fluids.

- **Humanity of care: -**
The stakeholders commented consistently on incontinence management, the attitude of staff, proximity of bells and management of patients' clothes.

- Incontinence management- four stakeholders felt that there was limited help with patients that needed to use the toilet, "asked on three separate occasions but did not receive help" and "never able to reach emergency button so the patient wet herself "
- Attitude of staff- eight stakeholders commented on staff attitude mentioning waiting times for staff to respond, " waited 40 minutes for the nurse to come" other comments included, "basic care lacking in last few days e.g. moistening of mouth, clean pillows" and "main concern is culture on the ward especially manner of staff with patients and relatives". However, other stakeholders also observed some nurses being excellent and caring.
- Provision of bells - Five stakeholders observed that the bells were often out of the patients reach.
- Management of Clothing- 3 stakeholders commented, "that the patients were never in their own clothes" and that "one patient rarely had a cover on their legs"

- **Arrangements for the prescription, administration, review and recording of drugs**

- **Prescribing: -**
The majority of concerns were around the prescribing of diamorphine. Other concerns centred on those authorised to prescribe the medication to the patient, which was communicated to the relatives/carer.
- **Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations.**
- **Communication with relatives/carers: -**
Five interviews indicated a lack of staff contact with the relatives/carers about the condition of the patient and the patient's care plan. Other interviews commented on how some of the staff were not approachable. One interview referred to the

absence of lay terms to describe a patient's condition, making it difficult to understand the patient's status of health.

- **Arrangements to support patients and their relatives and carers towards the end of the patient's life.**

- End of life patients, relatives /carers: -
Stakeholders mainly felt that there was a lack of communication from the staff after their relative had died, this was feedback to CHI through comments such as, "no doctors entered room in last days of the patient's life", " family received no support from GWMH staff after told them that the patient would die".
- i. Three of the contacts had made complaints. Of these all were dissatisfied about the trust response. They felt that the complaints were not dealt with appropriately.

APPENDIX C

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

CHI is grateful to Caroline Harrington for scheduling interviews.

- Wood, Andy, Finance Director,
- Wilson, Angela, Senior Staff Nurse,
- Tubbitt, Anita, Senior Staff Nurse,
- Monk, Anne, Chairman,
- Haste, Anne, Clinical Manager,
- Robinson, Barbara, Deputy General Manager,
- Melrose, Barbara, Complaints,
- Hooper, Bill, Project Director,
- Phillips, Catherine, Speech & Language Therapist,
- Joice, Chris, ,
- Lee, David, Complaints Convenor & Non Executive Director
- Barker, Debbie, Staff Nurse,
- Law, Diane, Patient Affairs Manager,
- Yikona, Dr, Staff Grade Physician,
- Ravindrance, Dr, Consultant,
- Qureshi, Dr, Consultant,
- Lord, Dr Althea, Lead Consultant,
- Jarrett, Dr David, Lead Consultant,
- Banks, Dr Vicki, Lead Consultant,
- Thomas, Eileen, Nursing Director,
- Cameron, Fiona, General Manager,
- Walker, Fiona, Senior Staff Nurse,
- Hamblin, Gill, Senior Staff Nurse,
- Day, Ginny, Senior Staff Nurse,
- Langdale, Helen, Health Care Social Worker,
- Reid, Ian, Medical Director,
- Piper, Ian, Operational Director,
- Neville, J, ,
- Hair, James, Chaplain,
- Peach, Jan, Service Manager,
- Williams, Jane, Nurse Consultant,
- Parvin, Jane, Senior Personnel Manager,

- Watling, Jeff, Chief Pharmacist,
- Clasby, Jerry, Senior Nurse,
- O'Dell, Jo, Practice Development Facilitator,
- Dunleavy, Jo, Staff Nurse,
- Taylor, Jo, Senior Nurse,
- Lock, Joan, ,
- Jones, Julie, Corporate Risk Advisor,
- Mann, Katie, Senior Staff Nurse,
- Humphrey, Lesley, Quality Manager,
- Peagram, Lin, Physio Assistant,
- Woods, Linda, Staff Nurse,
- Barrett, Lynn, Staff Nurse,
- Wigfall, Margaret, Night Enrolled Nurse,
- Thorpe, Maria, Health Care Social Worker,
- Barker, Marilyn, Enrolled Nurse,
- Millett, Max, Chief Executive,
- Loney, Mick, Porter,
- Wilkins, Pat, Senior Staff Nurse,
- Carroll, Patrick, Occupational Therapist,
- Goode, Pauline, Health Care Social Worker,
- Wells, Penny, District Nurse,
- King, Peter, Personnel Director,
- Beed, Phillip, Clinical Manager,
- Crane, Rosemary, Senior Dietician,
- Brind, Shelly, Occupational Therapist,
- Hallman, Shirley, ,
- Dunleavy, Shirley, Physiotherapist,
- King, Steve, Clinical Risk Advisor,
- Nelson, Sue, ,
- Jones, Teresa, Ward Clerk,
- Douglas, Tina, Staff Nurse,
- Lawrence, Vanessa, Senior Nurse Coordinator,
- Pease, Yong, Staff Nurse,
- Clarke, Sally, Patient Transport Manager,

APPENDIX D**Meetings with external agencies with an involvement in Elderly care at the Gosport War Memorial Hospital.**

- **Haslar Hospital**

Sam Page, Bed Manager

- **Portsmouth Hospital Trust**

Gill Angus, Clinical Discharge Coordinator
 Wendy Peckham, Discharge Planner for Medicine, St Mary's Hospital
 Clare Bownass, Ward Sister, St Mary's Hospital
 Sonia Baryschpolec, Staff Nurse, St Mary's Hospital

- **Hampshire Ambulance Services**

Alan Lyford, Patient Transport Service Manager

- **Isle of Wight, Portsmouth & South East Hampshire Health Authority**

Dr Peter Olde, Director of Public Health
 Penny Humphries, Chief Executive
 Nicky Pendleton, Programme Lead for Elderly Care Services

- **NHS Executive- East Regional Office**

Mike Gill,

-

- **St Mary's Hospital**

- **Portsmouth and South East Hampshire Community Health Council**

Joyce Knight,
 Margaret Lovell, Chief Officer
 Christine Wilks,

- **Hampshire Constabulary**

DSI. John James

- **Social Services- Portsmouth Social Services Department for Older People**

Sarah Mitchell, Assistant Director
Tony Warns,
Helen Loren,

- **Alverstoke House Nursing and Residential Care Home**

Rose Cook,

- **Glen Heathers Nursing and Residential Care Home**

John Perkins,

Other

- **League of Friends**

Mary Tyrell, Chair

- **Motor Neuron Association**

Mrs Fitzpatrick

- MP
- PCT
- PCG
- Local Medical Council
- GWMH Medical Committee
- RCN
- Unison

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 CHI's 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 Director 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			●	
Substance misuse	●			
Clinical psychology	●			●
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 Sultan, Dryad and Daedalus.**

Table . Throughput data 1997/98 - 2000/01

Financial Year	Ward	FCEs	Spells
1997/98	Daedalus	97	27?
1997/98	Dryad	72	19?
1997/98	Sultan	287	106?
	GWMH	456	152?
1998/99	Daedalus	121	119
1998/99	Dryad	76	75
1998/99	Sultan	306	298
	GWMH	503	492
1999/00	Daedalus	110	110
1999/00	Dryad	131	130
1999/00	Sultan	402	383
	GWMH	643	623
2000/01	Daedalus	113	110
2000/01	Dryad	86	84
2000/01	Sultan	380	361
	GWMH	579	555

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

Further work needed on presentation of data and commentary.(1997/98 data incomplete to date)

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

Summary of Medicine Usage 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

Commission for Health Improvement

Factual Accuracy Draft

26/08/15

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 Usage 1997/98-2000/01 (Mar 2002), Portsmouth Hospitals Trust , Pharmacy Service)

APPENDIX I**Glossary**