

INVESTIGATION AT GOSPORT WAR MEMORIAL HOSPITAL

EXECUTIVE SUMMARY

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

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001.

Key findings

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

CHI believes that the use of diamorphine and the combination of medicines with a sedative effect administered to patients in 1998 was excessive and outside of accepted practice. There were no trust policies in place to ensure the correct use of an 'analgesic ladder' and some [or was it all??] patients had been administered strong opiate analgesia on admission. There had been a practice of anticipatory prescribing of high dose ranges of medicines, with nursing staff being given the discretion to administer as required.

Portsmouth Healthcare NHS Trust failed to act on the triggers provided in 1998 by a police investigation, a pattern of patient complaints and the trust's own pharmacy data to undertake an immediate review of prescribing practice on the wards caring for older people.

Portsmouth Healthcare NHS Trust has, since 2001, a policy relating to the assessment of pain. This includes guidance

on appropriate prescribing. Following a review of the case notes of patients in late 2001 and early 2002, CHI believes that appropriate prescribing is now being undertaken and anticipatory prescribing is no longer happening. The trusts own review ?????

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

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

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

Recommendations

Kellie to add

[the recommendations need to be added to the exec summary grouped by organisation aimed toward.]

CHAPTER 1 TERMS OF REFERENCE AND PROCESS OF THE

INVESTIGATION

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

1.2 On ??? launched a--an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust was responsible at the Gosport War Memorial Hospital. CHI's decision was based on evidence of high risk activity and the

likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

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

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

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

- i) staffing and accountability arrangements, including out of hours
- ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management
- iii) arrangements for the prescription, administration, review and recording of drugs
- iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations
- v) arrangements to support patients and their relatives and carers towards the end of the patient's life
- vi) supervision and training arrangements in place to enable staff to provide effective care

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

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

1.5 CHI's investigation team were:

- Alan Carpenter, Chief Executive, Somerset Coast Primary Care Trust
- Anne Grosskurth, CHI Support Investigations Manger
- Dr Tony Luxton, Consultant Geriatrician, Lifespan Healthcare NHS Trust
- Julie Miller, CHI Lead Investigations Manager
- Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
- Mary Parkinson, lay member (Age Concern)
- Jennifer Wenborne, independent Occupational Therapist

1.6 The team was supported by:

- Liz Fradd, CHI Director of Nursing, lead CHI director for the investigation
- Nan Newberry, CHI Senior Analyst
- Kellie-Ann Rehill, CHI Investigations Coordinator
- a medical notes review group established by CHI to review anonymised medical notes (see appendix E)
- Dr Barry Tennison ????

The investigation process

1.7 The investigation consisted of five inter related parts:

- review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (see appendix A for a list of documents reviewed)
- analysis of views received from 36 patients, relatives and friends about care received at Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls and a short questionnaire (see appendix B for an analysis of views received)
- a five day visit by CHI's investigation team to Gosport War Memorial Hospital when a total of 59 staff from all groups involved in the care and treatment of older people at the hospital and relevant trust management were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards (see appendix C for a list of all staff interviewed)
- interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (see appendix D for a list of organisations interviewed)
- an independent review of anonymised clinical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this specific piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendix E

Acknowledgements

1.8 CHI wishes to thank the following people for their help and cooperation with the production of this report:

- the patients and relatives who contributed either in person, over the phone or in writing. CHI recognises how difficult some of these contacts were for the relatives of those who have died
- staff interviewed by CHI's investigation team (see appendix D) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millet, Chief Executive (until 31.3.02) and Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust (since 1.4.02)
- staff and patients who welcomed the CHI team on to the wards during observation work
- Detective Superintendent John James, Hampshire Constabulary
- the agencies listed in appendix D who gave their views and submitted relevant documents to the investigation

CHAPTER 2 BACKGROUND TO THE INVESTIGATION

Events surrounding the CHI investigation

Police investigations

- 2.1 The family of a 91 year old female patient who died in August 1998 on Daedalus ward made a complaint to the trust about 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 in November 1998 and again in February 1999. The Crown Prosecution Service responded formally in March 1999 indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.
- 2.2 The police investigation begun in 1998 was the subject of a complaint to the police. A further police investigation was started in August 1999. Subsequently, in December 2000, further information was submitted to the Crown Prosecution Service concerning the circumstances of the patient's death. In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.
- 2.3 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 and these were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.
- 2.4 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 General Medical Council, the United Kingdom Central Council (after 1 April 2002, the Nursing and Midwifery Council), the trust, the Isle of Wight, Portsmouth and East Hampshire Health Authority and the NHS south east regional office.

Action taken by professional regulatory bodies

2.5 The case of one doctor is currently being reconsidered by the General Medical Council. No interim suspension order has been made. *Status of Dr Lord referral?*

2.6 Three nurses were referred to the United Kingdom Central Council's preliminary orders committee in June 2001, which has the authority to suspend nurses; the cases were closed. Following receipt of further information from the police, these cases have been reopened and are under investigation by the United Kingdom Central Council's successor body the Nursing and Midwifery Council. *(This paragraph is subject to change and update)*

Complaints to the trust

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

Action taken by health authority

2.8 In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people in 1998 and, secondly, as the body through which GPs are permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered by GPs on hospital premises.

2.9 In June 2001, the health authority voluntary local procedure for the identification and support of primary care medical practitioners whose practice is giving cause for concern reviewed the prescribing practice of one local GP. No concerns were found. *(did they talk to the trust?)*

2.10 In July 2001, the chief executive of the health authority asked CHI for advice in obtaining a source of expertise ?? in order to reestablish public confidence in the services for older people in Gosport. This was the same time as the police contacted CHI. CHI then began a screening process to determine whether to initiate an investigation.

2.11 Following receipt of the police expert witness reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers (opiates and benzodiazepines) in general practise.

Action taken by NHS south east regional office

2.12 For the period of the investigation, the NHS regional offices were responsible for the strategic and performance management of the NHS, including trusts and health authorities. The NHS south east regional office was unable to demonstrate a robust system for monitoring trust complaints relating to the Portsmouth Healthcare NHS Trust, which would have demonstrated an awareness of local concerns. Serious untoward incident reports were completed in April and July 2001 in response to media articles about the death of a patient at the Gosport War Memorial Hospital.

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

CHAPTER 3 NATIONAL AND LOCAL CONTEXT

National context

- 3.1 The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS Plan and the Standing Nursing and Midwifery Committee's 2001 report found care to be deficient. National concerns raised include: an inadequate and demoralised workforce, poor care environments, lack of seamless care within the NHS and ageism. The NHS Plan's section *Dignity, security and independence in old age*, published in July 2000, outlined the government's plans for the care of older people, to be detailed in a later national service framework.
- 3.2 The national service framework for older people was published in March 2001 and sets standards of care of older people in all care settings. It aims to ensure high quality of care and treatment, regardless of age. Older people are to be treated as individuals with dignity and respect. The framework places special emphasis on the involvement of older patient's and their relatives in the care process, including care planning. There are to be local mechanisms to ensure the implementation of the framework with progress expected by June 2001.
- 3.3 National standards called *Essence of Care*, published in 2001, provide benchmarks for assessing nursing practice against fundamental aspects of care such as nutrition, pressure sores and privacy and dignity. These have been produced by the Department of Health as an audit tool to ensure good practice and have been widely disseminated across the NHS.

Trust background

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

paediatrics, elderly medicine, learning disabilities and psychology.

- 3.5 The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/2002 the trust had a budget in excess of £100 million and over 20% of income was spent on its largest service, elderly medicine. All the trust's financial targets were met in 2000/2001.

Move towards the primary care trust

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

Portsmouth Healthcare NHS Trust strategic management

- 3.7 The trust board consisted of a chair, five non executive directors, the chief executive, the executive directors of operations, medicine, nursing and finance and the personnel director. The trust was organised into six divisions, two of which are relevant to this investigation. The Fareham and Gosport division, which managed the Gosport War Memorial Hospital, and the department of elderly medicine.

- 3.8 CHI heard that the trust was well regarded in the local health community and had developed constructive links with the health authority and local primary care groups (PCGs). For example, in the lead up to the formation of the new PCT, Portsmouth Healthcare NHS Trust's director of operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the trust on the development of intermediate care and clinical governance. High regard and respect for trust staff was also commented on by the local medical committee, Unison and the Royal College of Nursing.

Local services for older people

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

Service performance management

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

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

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

3.12 In 1998 four wards at Gosport War Memorial Hospital admitted older patients : Dryad, Daedalus, Sultan and Mulberry. This is still the case in 2002.

Figure 3.1 Inpatient provision at Gosport War Memorial Hospital by ward

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 provided 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 Portsmouth Healthcare NHS Trust staff.	The situation is as in 1998, except that staff are now employed by a PCT.

Admission criteria

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

3.14 The case note review undertaken by CHI confirmed that the admission criteria for these two wards were being adhered to in recent months and that appropriate patients were being admitted.

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

Elderly mental health

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

Terminology

3.17 CHI found considerable confusion about the terminology describing the various levels of care for older people in written information and in interviews with staff. For example, the terms stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care were all used. CHI was not aware of any common definition for these terms in use at the trust. CHI stakeholder work confirmed that this confusion extends to patients and relatives in terms of their expectations of the type of care that will be received.

Key findings

1. Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team. The chief executive was accessible to and well regarded by staff both within the trust and in the local health economy. Good links had been developed with local PCGs.
2. CHI considers the divisional management quarterly review process to have been an appropriate method of monitoring the performance of the Fareham and Gosport division.
3. There was lack of clarity amongst all groups of staff about the purpose of each of the wards caring for older people and about the levels of care provided. This confusion had been communicated to patients and relatives.

Recommendations

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to progress the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should devise an appropriate performance monitoring

tool to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. The findings of this investigation should be used to influence the nature of local monitoring of the national service framework for older people.
3. The Department of Health should assist in the promotion of a shared understanding of the various terms used to describe levels of care for older people across the whole NHS.

CHAPTER 4 QUALITY OF CARE AND THE PATIENT EXPERIENCE

Introduction

4.1 . This chapter details CHI's findings following contact with patients and relatives. This needs to be put into the context of the 1725 finished consultant episodes for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Details 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

4.2 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 CHI's 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.

4.3 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 the visits were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed.

Stakeholder views

4.4 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 , both positive and negative, of the care of older people. The most frequently raised concerns with CHI were: the use of medicines, the attitude of staff, incontinence management, the use of patients' own clothing, transfer arrangements between hospitals and nutrition and fluids. More detail on each of these areas is included below.

4.5 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". Although a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI also received comments that families would have liked more information "doctors should disclose all drugs, why [they are being used] and what the side effects are. There should be more honesty".

- 4.6 Comments about the attitude of staff ranged from the very positive "Everyone was so kind and caring towards him in both Deadalus and Dryad wards" and "I received such kindness and help from all the staff at all times" to the less positive "I was made to feel an inconvenience because we asked questions" and "I got the feeling she had dementia and her feelings didn't count".
- 4.7 Contenance management is an important aspect of the care of older people, the underlying objective is to promote or sustain continence as part of a holistic assessment including maintaining skin integrity (prevention of pressure sores). Where this is not possible, a range of options including catheterisation are available and it is imperative that these are discussed with patients, relatives and carers. Some stakeholders raised concerns regarding the 'automatic' catheterisation of patients on admission to the War Memorial. "They seem to catheterise everyone, my husband was not incontinent; the nurse said it was done mostly to save time". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.
- 4.8 Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by their families. "They were never in their own clothes". Relatives also felt patients being dressed in other patients clothes was a potential cross infection risk. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes. This is an important means by which patients' dignity can be maintained.

- 4.9 Concern was expressed regarding the physical transfer of patients from one hospital to another. Amongst concerns were lengthy waits prior to transfer, inadequate clothing and covering during the journey and the methods used to transfer patients. One person claimed their relative was "carried on nothing more than a sheet". Portsmouth Healthcare NHS Trust, who sought an apology from the referring hospital, which did not have the appropriate equipment available, acknowledged this concern.
- 4.10 During the period of the investigation, the Hampshire Ambulance Service NHS Trust, who were responsible for patient transfers, received no complaints relating to the transfer of patients to and from the Gosport War Memorial Hospital.
- 4.11 Relatives expressed concern around a perceived lack of nutrition and fluids as patients neared the end of their life: "no water and fluids for last four days of life". Comments were also raised about unsuitable, unappetising food and patients being left to eat without assistance. A number of stakeholders commented on untouched food being cleared away without patients being given assistance to eat.
- 4.12 Following comments by stakeholders, CHI reviewed trust policy for nutrition and fluids. The trust conducted an audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy *Feeding People*. The trust policy, prevention and management of malnutrition (2000), includes the designation of an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure full compliance. The standards state:
- all patients must have a nutritional risk assessment on admission
 - registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary

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

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

4.14 As a result of the review of recent case notes, CHI noted that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses did not appear to be able to make swallowing assessments; this could lead to delays over weekends, for example, when speech and language therapy staff are not available.

Outcome of CHI observation work

4.15 CHI spent time on Dryad, Sultan and Daedalus wards throughout the week of 7 January 2002 to observe the environment in which care was given, the interactions between staff and patients and between staff. Ward staff were welcoming, friendly and open. Although CHI observed a range of good patient experiences this only provides a 'snapshot' during the site visit and may not be fully representative. However, many of the positive aspects of patient care observed were confirmed by CHI's review of recent patient notes.

Ward environment

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

4.17 Day rooms are pleasant and Daedalus ward has direct access to a well designed garden suitable for wheelchair users. The garden is paved with a variety of different textures to enable patients to practice

mobility. There is limited storage space in Daedalus and Dryad wards and, as a result, the corridors had become cluttered with equipment. This can be problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe.

- 4.18 CHI saw staff address patients by name in a respectful and encouraging way and saw examples of staff helping patients with dressing and conducting friendly conversations. The staff handovers observed were well conducted, held away from the main wards areas and relevant information about patient care was exchanged appropriately.
- 4.19 Mealtimes were well organised with patients given a choice of menu options and portion size. Patients who needed help to eat and drink were given assistance. There appeared to be sufficient staff to serve meals, and to note when meals were not eaten. CHI did not observe any meals returned untouched. Healthcare support workers told CHI that they were responsible for making a note when meals were not eaten.
- 4.20 There are day rooms where patients are able to watch the television and large print books, puzzles and current newspapers are provided. CHI saw little evidence of social activities taking place, although some patients did eat together in the day room. Bells to call assistance are situated by patients' beds, but are less accessible to patients in the day rooms. The wards have an activities coordinator, although the impact of this post has been limited.
- 4.21 Daedalus ward has a communication book by each bed for patients and relatives to make comments about day to day care. This is a two way communication process which, for example, allows therapy staff to ask relatives for feedback on progress and enables relatives to ask for an appointment with the consultant.

4.22 CHI observed two medicine rounds, both of which were conducted in an appropriate way with two members of staff jointly identifying the patient and checking the prescription sheet. One member of staff hands out the medicines while the other oversees the patients as medicines are taken. Medicines are safely stored on the wards in locked cupboards.

Key findings

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

Figure 4.1 Concerns about care raised by stakeholders by ward and date

	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

2. Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward.
3. The ward environments and patient surroundings are good.
4. Some notable steps had been taken on Daedalus ward to facilitate communication between patients and their relatives with ward staff.
5. CHI was concerned about the potential risk surrounding any inability of ward staff to undertake swallowing assessments as required for patients whose swallowing reflex may have been affected, for example, by a stroke.

6. Opportunities for patients to engage in daytime activities in order to encourage orientation and promote confidence are limited.

Recommendations

1. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.
2. A performance management system needs to be established as a priority by the PCT to ensure the early identification of any trends in patient complaints. The performance management system should include measurements of quality and standards of care.
3. Steps should be taken to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.
4. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities compliment therapy goals.
5. The PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

CHAPTER 5 - ARRANGEMENTS FOR THE PRESCRIPTION, ADMINISTRATION, REVIEW AND RECORDING OF MEDICINES

Police inquiry and expert witness reports

CHI's terms of reference for its investigation in part reflected those of the earlier inquiry by the police, whose reports were made available to CHI.

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

- there was inappropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain. It was the view of the police expert witnesses that a more reasonable response would be to prescribe a mild to moderate medicine initially with appropriate review of any pain followed up
- there was inappropriate subcutaneous combined administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death
- an assumption was made by clinical staff that patients had been admitted for palliative, rather than rehabilitative care
- there was a failure to recognise potential adverse effects of prescribed medicines by clinical staff
- clinical managers failed to routinely monitor and supervise care on the ward

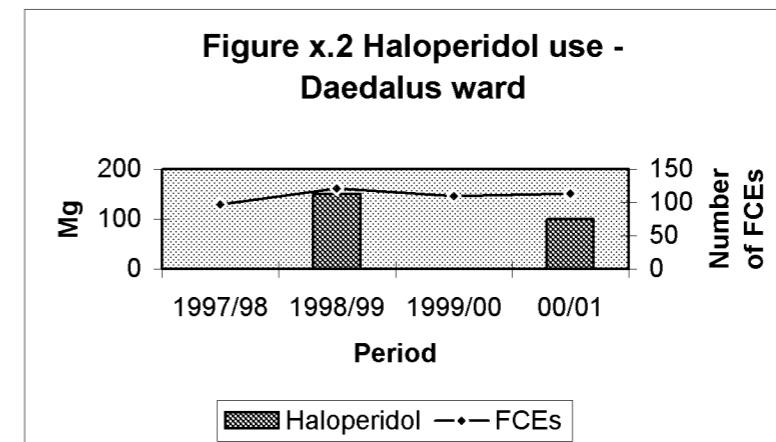
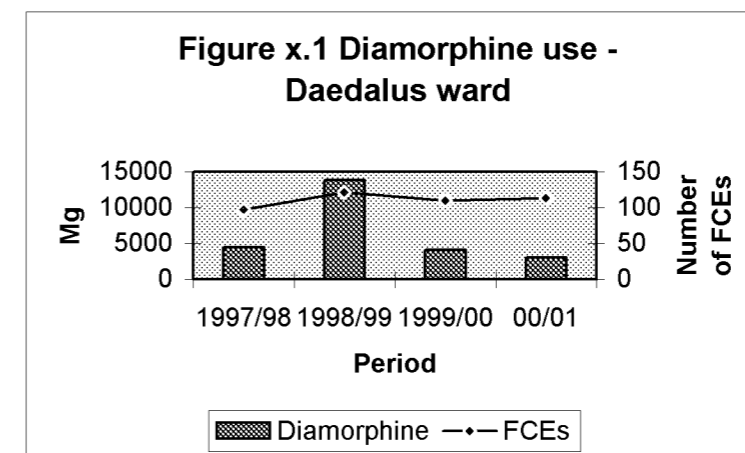
Medicine useage

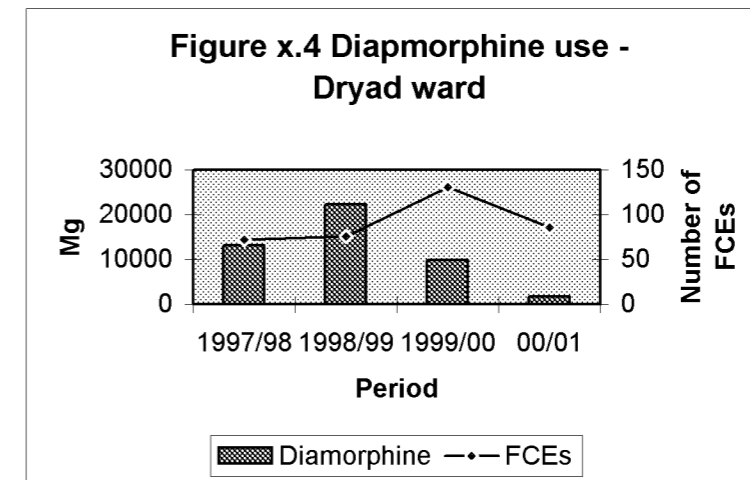
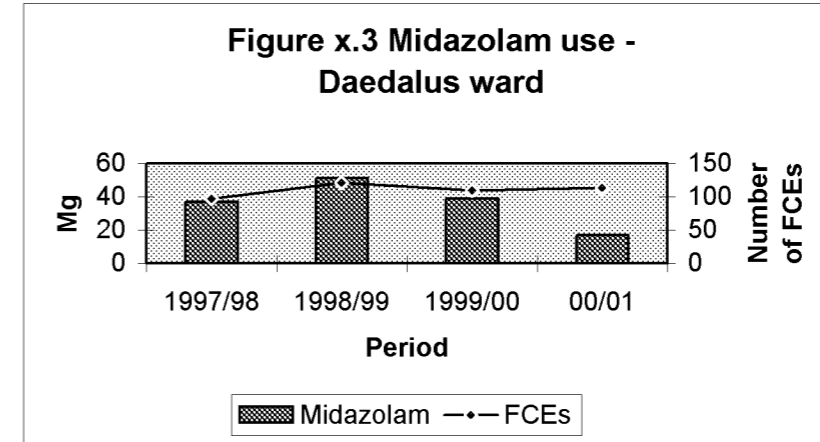
In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. Some of the medicines used in the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

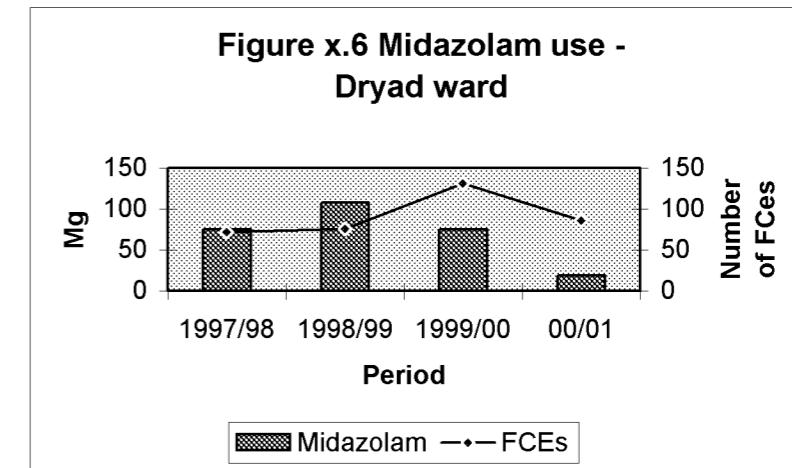
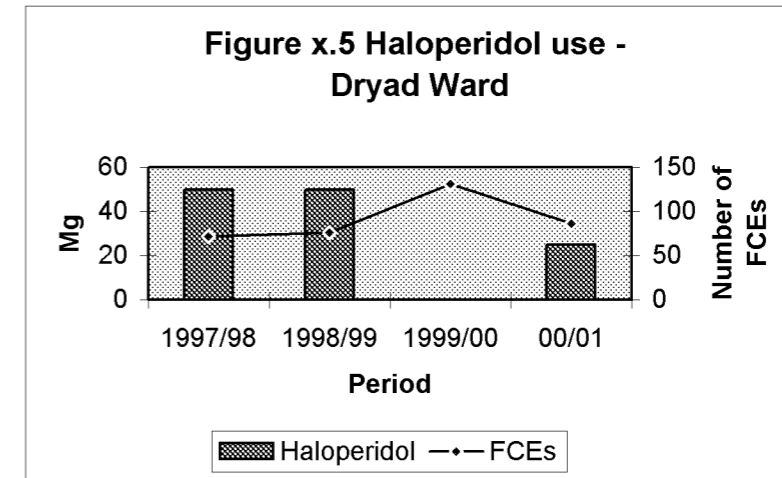
prove the amounts of medicines actually administered. A detailed breakdown of medicines for each ward is attached at appendix H.

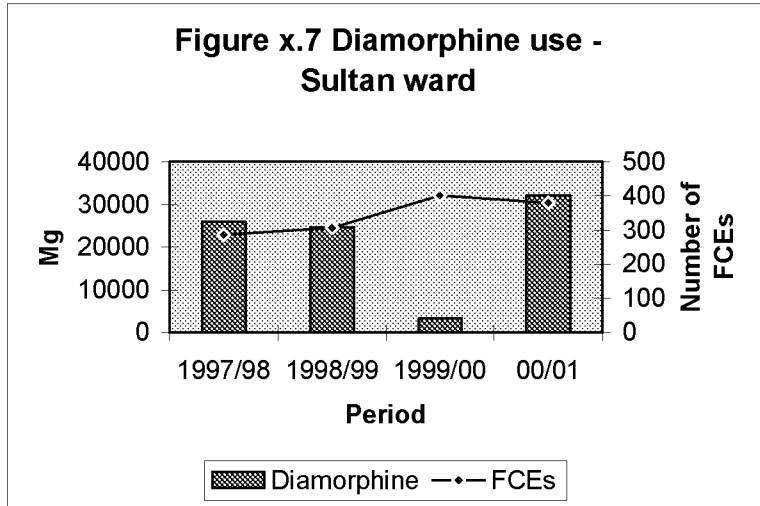
The experts commissioned by the police had serious concern about the level of use of these three medicines (diamorphine, haloperidol and midazolam). CHI shares this view and believes the use and combination of medicines used in 1998 was excessive and outside normal practice. The following charts indicate the use of the respective medicines by ward and year, plotted alongside the number finished consultant episodes.

Medicine usage 1997/1998-2000/2001 according to the number of finished consultant episodes per ward

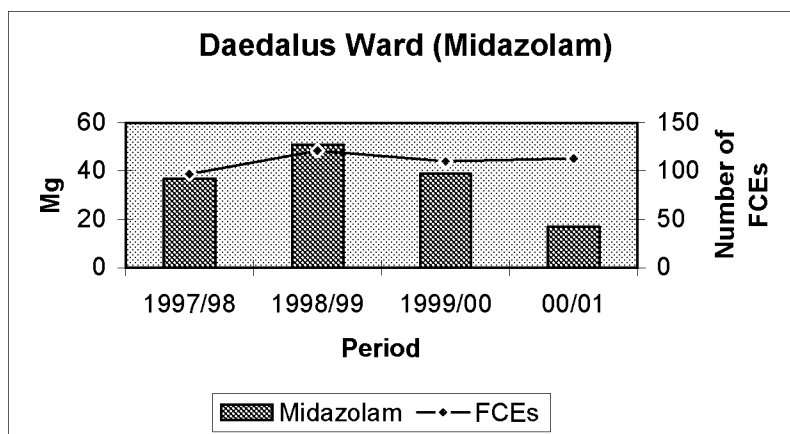
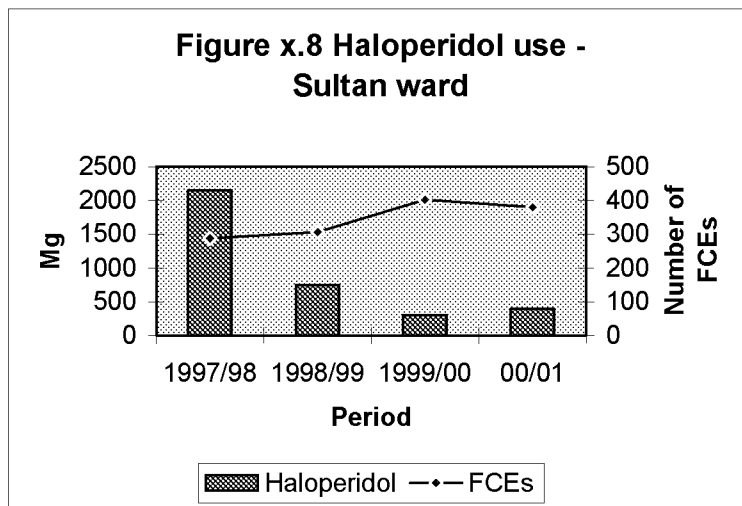








[where is midazolam chart for Sultan ward? Has last chart been wrongly titled?]



Assessment and management of pain

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

- the prescription must be written by medical staff following diagnosis of type(s) of pain and be appropriate given the current circumstances of the patient
- if the prescription states that medication is to be administered by continuous infusion (syringe driver) the rationale for this decision must be clearly documented
- all prescriptions for drugs administered via a syringe driver must be written on a prescription sheet designed for this purpose

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

CHI was told by some nursing staff that following the introduction of the policy, it took longer for some patients to become pain free and that medical staff were apprehensive about prescribing diamorphine. Nurses also spoke of a reluctance of some patients to take pain relief. CHI's case note review concluded that two of the fifteen patients reviewed were not prescribed adequate pain relief for part of their stay in hospital.

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

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

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

Prescription writing policy

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

The policy has a section on verbal orders. Telephone orders for single doses of medicines can be accepted over the telephone by a registered nurse if the doctor is unable to attend the ward. According to United Kingdom Central Council guidelines (October 2000), this is only acceptable where the, "the medication has been previously prescribed and the prescriber is unable to issue a new prescription. Where changes to the dose are considered necessary, the use of information technology (such as fax or email) is the preferred method. The UKCC suggests a maximum of 24 hours, in which a new prescription confirming the changes should be provided. In any event, the changes must have been authorised before the new dosage is administered." CHI understands that arrangements such as these are common practice in GP led wards and work well on the Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours. These arrangements were also confirmed by evidence found in CHI's case note review.

Administration of medication

Medication can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and under the skin via a syringe driver. Guidance for staff on prescribing via syringe drivers is contained within the

trust's policy for assessment and management of pain. The policy states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

Evidence from CHI's case note review demonstrated good documented examples of communication with both patients and relatives over medication and the use of syringe drivers.

Role of nurses in medicines administration

Registered nurses are regulated by the General Nursing Council, a new statutory body which replaced the United Kingdom Central Council on 1 April 2002. Registered nurses must work within their code of professional conduct (UKCC, June 1992). The scope of professional practice (UKCC, June 1992) clarified the way in which registered nurses are personally accountable for their own clinical practice and for care they provide to patients. The standards for the administration of medicines (UKCC, October 1992) details what is expected of nurses carrying out this function and every nurse should have a copy of the standards.

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

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

Review of medication

The regular ward rounds and multidisciplinary meetings should include a review of medication by senior staff, which is recorded in the patient's case notes. CHI recognises the complexity of the multidisciplinary meetings; the consultant has to process information from a variety of staff, engage in a dialogue to set and review goals and record the essence of this discussion in the case notes. The additional task of concurrently reading and amending the prescription chart, listening to the observations of staff about symptom and pain control and recording any medication changes makes the process yet more complex. Despite this, a process should be

found to ensure that effective and regular reviews of patient medication take place

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

Structure of pharmacy

Portsmouth Healthcare NHS Trust has a service level agreement for pharmacy services with the local acute trust, Portsmouth Hospitals NHS Trust. The contract is managed locally by a grade E pharmacist and the service provided by a second pharmacist, who is the lead for older peoples services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing workload. Pharmacy staff were confident the pharmacist would challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to use the trust intranet to provide a compendium of drug therapy guidelines, although the intranet is not easily available to all staff.

Pharmacy training for non pharmacy staff was described as "totally inadequate" and not taken seriously. Nobody knew of any training offered to clinical assistants

Portsmouth Healthcare NHS Trust did not have any systems that could have alerted them to any unusual or excessive patterns of prescribing, although the prescribing data was available for analysis. [are there systems now, or could this still be a problem?]

Key findings

- 1. CHI has serious concerns regarding the quantity, combination and lack of review of medicines prescribed

to older people on Dryad and Daedalus wards in 1997/1998. This is based on the findings of police expert witnesses and pharmacy data provided for the wards.

The data provided by Portsmouth Healthcare NHS Trust shows an increase in the amount of diamorphine, haloperidol and midazolam used on Daedalus ward in 1998. The quantity of diamorphine used is the most significant. The usage of all three drugs in recent years illustrates a decline, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. This should be seen against a slight rise in patient numbers.

There has also been a decline in the usage of the three drugs on Dryad ward, although this is against a decline in finished consultant episodes.

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

Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998. CHI's review of recent case notes confirmed that prescribing levels of diamorphine, midazolam and haloperidol has reduced substantially.

2. CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.
3. CHI found little evidence from the expert witness reports commissioned by the police to suggest that thorough whole patient assessments were being made by multidisciplinary teams in 1998.
4. Pharmacy support to the wards in 1998 was inadequate. CHI remains unconvinced that there are adequate systems in place to review and monitor prescribing at ward level.

Recommendations

1. The PCT should review the provision of pharmacy services to Dryad, Deadalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.
2. The PCT must review the introduction of IT to maintain records of prescribing.
3. 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

CHAPTER 6 – STAFFING ARRANGEMENTS AND RESPONSIBILITY FOR PATIENT CARE

Responsibility for patient care

Patient care on Daedalus and Dryad wards at Gosport War Memorial Hospital for the period of the CHI investigation was provided by consultant led teams. The complex needs of these vulnerable patients are best met by a multidisciplinary, multiprofessional team of appropriately trained staff. This ensures that the total needs of the patient are joined together in a care plan, discussed with the patient and their relatives and carers, that reflects the individual needs of each patient and is understood by every member of the team. Solid care planning such as this would ensure that all care decisions, such as prescribing, were jointly owned by all members of the team, including the lead consultant.

Medical responsibility

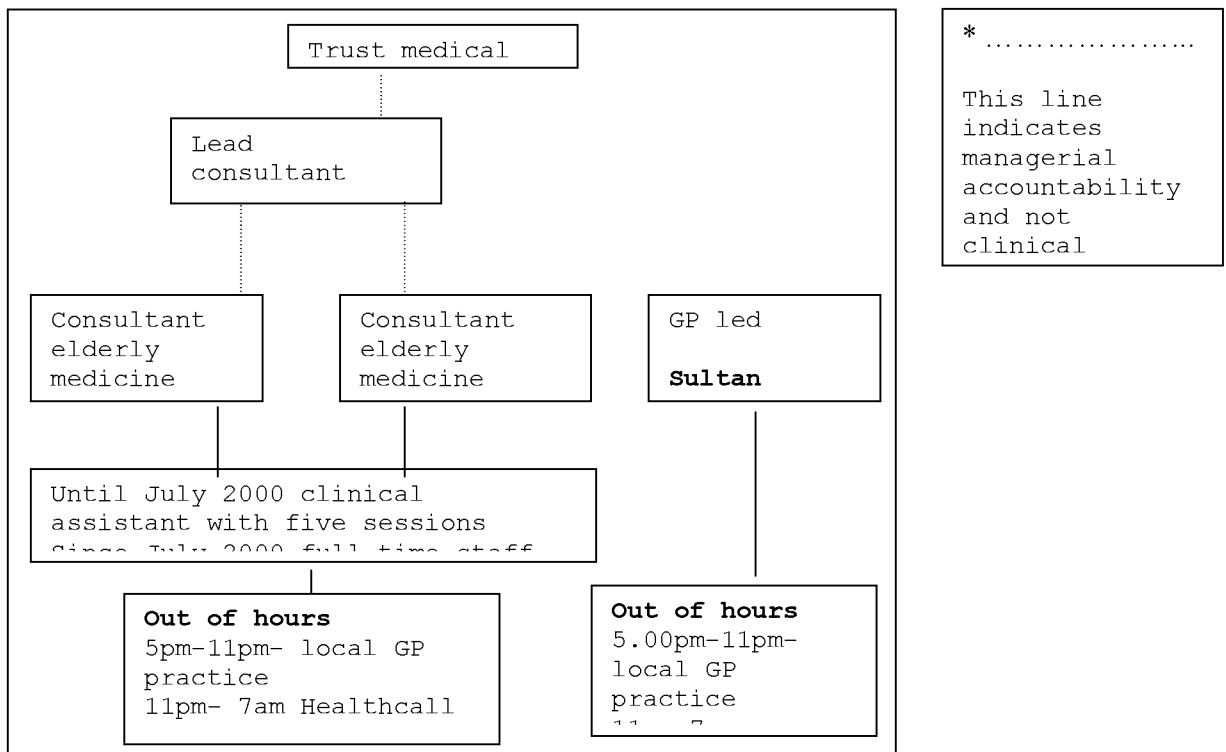
For the period covered by the CHI investigation and currently, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. All patients on both wards are admitted under the care of a consultant. Since 1999, there has been a lead consultant for elderly medicine who holds a two session contract (one session equates to half a day per week) for undertaking lead consultant responsibilities. These responsibilities include overall management of the department and the development of departmental objectives. The lead consultant is not responsible for the clinical practice of individual doctors. The post holder does not undertake any clinical sessions on the War Memorial site [this sounds contradictory to the earlier sentence describing the two session contract – do you mean they don't see any patients, or that they do the management from a distance??]. The job description for the post, outlines twelve functions and states that the post is a major challenge for "a very part time role".

In addition, since 2000 (*check with trust*) two elderly medicine consultants provide a total of 10 sessions of consultant cover on Dryad and Daedalus wards. Since September 2000, day to day medical support is provided by a staff grade physician who is supervised by both consultants. Until July 2000, a clinical assistant provided additional medical support. Both consultants currently undertake a weekly ward round with the staff grade doctor. In 1998 there

was a fortnightly ward round on Daedalus ward; on Dryad, ward rounds were less frequent .

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

Figure x.1 Line management accountabilities



General practice role and accountability

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

Clinical assistant role

Clinical assistants are GPs employed and paid by trusts, largely on a part time basis, to provide medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years. Portsmouth Healthcare NHS Trust employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants work as part of a consultant led team have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

From 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states that the clinical assistant is accountable to "named consultant physicians in geriatric medicine". The post holder was responsible for arranging cover for annual leave and any sickness absence with practice partners. The trust and the practice partners did not have a contract for this work. The job description does state that the post is subject to the terms and conditions of hospital medical and dental staff. Any concerns over the performance of any clinical assistant could have been pursued through the trust's disciplinary proceedings. CHI could find no evidence to suggest that this option was explored.

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

Sultan ward

Medical responsibility for patients on Sultan ward lies with the admitting GP. The trust issued admitting GPs with a contract for working on trust premises, which clearly states "you will take full clinical responsibility for the patients under your care". CHI was told that GPs visit their patients regularly as well as when requested by nursing staff. This

is a common arrangement in community hospitals throughout the NHS. GPs have no medical accountability framework within the trust.

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

Out of hours cover provided by GPs

Between the hours of 9.00am and 5.00pm on weekdays, hospital doctors employed by the trust manage the care of all patients on Dryad and Deadalus wards. Out of hours medical cover, including weekends and bank holidays, is provided by a local GP practice from 5.00pm to 11.00pm, after which, between 11.00pm and 7.00am, (check 7am-9am gap with trust) nursing staff call on either the patient's practice or Healthcall, a local deputising service for medical input. If an urgent situation occurs out of hours, staff call 999 for assistance.

Some staff who were interviewed by CHI expressed concern about long waits for the Healthcall service, although the trust has no system for formal reporting of long waits. It was suggested that waiting times for Healthcall to attend to a patient could sometimes take between three and five hours. However, evidence provided by Healthcall contradicts this. Nurses expressed concern over Healthcall GPs' reluctance to "interfere" with the prescribing of admitting GPs on Sultan and Dryad wards. The contract with Healthcall is managed by a local practice. (check contract)

Appraisal of hospital medical staff

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

Nursing responsibility

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

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

Nursing supervision

Clinical supervision for nurses was recommended by the United Kingdom Central Council in 1996 and again in the national nursing strategy, *Making a difference*, in 1999. It is a system through which qualified nurses can maintain lifelong development and enhancement of their professional skills through reflection, exploration of practice and identification of issues that need to be addressed. There are a range of models, but three are most widely used: clinical supervision with an expert; one to one supervision and group supervision. Clinical supervision is not a managerial activity, but provides an opportunity to reflect and improve on practice in a non judgemental environment. Clinical supervision is a key factor in professional self regulation.

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

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

Regular ward meetings are held on Sultan and Daedalus wards. Arrangements are less clear on Dryad ward, possibly due to the long term sickness of senior ward staff.

Teamworking

Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. Staff interviewed by CHI spoke of teamwork, although in several instances this was uniprofessional, for example a nursing team. CHI observed a multidisciplinary team meeting on Daedalus ward which was attended by a consultant, a senior ward nurse, a physiotherapist and an occupational therapist. No junior staff were present. Hospital staff describe access to input from social services as good, although not always available. [this seems contradictory??]

Arrangements for multidisciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multidisciplinary goal setting for patients, but were hopeful of further development.

Allied health professional structures

Allied health professionals are a group of staff including occupational therapists, dieticians, speech and language therapists and physiotherapists. The occupational therapy structure is in transition from a traditional site based service to a defined clinical specialty service (such as stroke rehabilitation) in the locality. All referrals are received centrally. Staff explained that this system enables the use of specialist clinical skills and ensures continuity of care of patients, as one occupational therapist follows the patient throughout hospital admission(s) and at home. Occupational therapists talking to CHI described a good supervision structure, with supervision contracts and performance development plans in place.

Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right

through to home treatment. Physiotherapists illustrated good levels of training and supervision and involvement in Daedalus ward's multidisciplinary team meetings.

Speech and language therapists also reported participation in multidisciplinary team meetings on Daedalus ward. Examples were given to CHI of well developed in service training opportunities and professional development, such as discussion groups and clinical observation groups.

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

Workforce and service planning

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

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

Despite this preparation, several members of staff expressed concern to CHI regarding the complex needs of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages and high sickness levels. Concerns were raised formally with the trust in early 2000, and acknowledged by the medical director, around the increased workload and complexity of patients, although CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix.

Access to specialist advice

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

Staff are aware of and refer to the joint palliative care booklet, published jointly in 1998 with Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust and a local hospice. The booklet includes a number of guidelines on clinical management, including symptom management, psychological and spiritual care and bereavement. Staff spoke of strong links with the Rowans hospice and Macmillian nurses. Nurses gave recent examples of joint training with the hospice in the use of syringe drivers.

CHI's audit of recent case notes indicated that robust systems are in place for both specialist medical advice and therapeutic support.

Staff welfare

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

However, many staff, at all levels in the organisation spoke of the stress and low morale caused by the series of police investigations and the referrals to the General Medical Council, the United Kingdom Central Council and the CHI investigation. Trust managers told CHI they encouraged staff to use the trust's counselling service and support sessions for staff were organised. Not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, "I don't feel I've had the support I should have had before and during the investigation - others feel the same".

Key findings

1. Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. The clinical assistant working on Daedalus and Dryad wards was allowed to practice without adequate supervision arrangements. It was not made clear to CHI how GPs working as clinical assistants and admitting patients to Sultan wards are included in the development of trust procedures and clinical governance arrangements.
2. There are clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff. Currently, there is effective nursing leadership on Daedalus and Sultan wards, this is less evident on Dryad ward. CHI was concerned regarding the potential for professional isolation of the staff grade doctor.
3. Systems are now in place to ensure that appropriate specialist medical and therapeutic advice is available for patients. Some good progress has been made towards multidisciplinary team working which should be developed.
 3. There was a planned approach to the service development that brought about the change in use of beds in 2000. The increasing dependency of patients and resulting pressure on the service, whilst recognised by the trust, was neither monitored nor reviewed as the service developed.
5. Portsmouth Healthcare NHS Trust should be congratulated for its progress towards a culture of reflective nursing practice.
6. The trust has a strong staff focus, with some notable examples of good practice. Despite this, CHI found evidence to suggest that not all staff were adequately supported during the police and other recent investigations.
7. Out of hours medical cover for the three wards out of hours is inadequate and does not reflect current levels of patient dependency.

Recommendations

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

CHAPTER 7 LESSONS LEARNT FROM COMPLAINTS

CHI to check with HSC if they are looking at Mrs D (daughter Mrs R - before publication)

A total of 129 complaints were made regarding the division of elderly medicine since 1 April 1997. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra Hospitals. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

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

External review of complaints

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

The trust's medical director told CHI that following receipt of a complaint in Mrs Lack/Mckensie? he confirmed with a colleague in a neighbouring trust that prescribing parameters at the War Memorial Hospital were within an acceptable range.

Complaint handling

The trust has a policy for handling patient related complaints produced in 1997, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure*, published in 1996. (evidence of a review?) A leaflet for patients detailing the various stages of the complaints procedure was produced, which indicates the right to request an independent review if matters are not resolved to their satisfaction together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards.

Both the trust and the local community health council (CHC) described a good working relationship. The CHC regretted, however, that their resources since November 2000 had prevented them from offering the level of advice and active support to trust complainants they would have wished.

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

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

Trust learning regarding prescribing

The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not trigger the trust to undertake a review of prescribing practices. CHI was surprised that the trust did not respond earlier and faster to concerns expressed around levels of sedation.

Action was taken, however, to develop and improve trust policies around prescribing and pain management (as detailed in chapter??). In addition, CHI learnt that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem". The comment was made that the patient had been given doses ranging from 20mg to 40mg per day. [This may need further explanation - is this comment from the external clinical advice or the trust - what does it indicate (are they claiming a lower dose than the complaint suggests???)]

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

Other trust lessons

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

- an increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999
- the appointment of a staff grade doctor in September 2000 to increase medical cover following the resignation of the clinical assistant

- piloting pain management charts and prescribing guidance approved in May 2001. Nursing documentation is currently under review, with nurse input
- one additional consultant session in ?? following a district wide initiative with local PCGs around intermediate care
- nursing documentation now clearly identifies prime family contacts and next of kin information to ensure appropriate communication with relatives
- all conversations with families are now documented in the medical record. CHI's review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff.

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

Monitoring and trend identification

A key action identified in the 2000/2001 clinical governance action plan was a strengthening of trust systems to ensure that actions following complaints have been implemented. Until the dissolution of Portsmouth Healthcare NHS Trust, actions were monitored through the divisional review process, the clinical governance panel and trust board. A trust database was introduced in 1999 to record and track trends in recent complaints. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

Portsmouth Healthcare NHS Trust offered specific training in complaints handling, customer care and loss, death and bereavement, which many staff interviewed by CHI were aware of and had attended.

The trust had a well defined and respected line management structure through which staff are confident will help to identify emerging themes from complaints.

Key findings

1. Portsmouth Healthcare NHS Trust did not use the issues raised through complaints made between 1998 and 2001 and an ongoing police investigation as a trigger for an

internal review of prescribing within the Gosport War Memorial Hospital.

2. Portsmouth Healthcare NHS Trust did effect changes in patient care, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.
3. Systems are not yet in place to ensure that the impact of these changes have been robustly monitored and reviewed.
4. There has been some, but not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

Recommendations

1. That CHI work with the Association of Chief Police Officers to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible. CHI will also work with the Association of Chief Police Officers to develop police awareness of the NHS and its management and accountability structures.
2. That CHI work with the National Patients' Safety Agency to ensure that any trends that emerge from the prescription of any medicines demonstrating serious concern within individual NHS organisations, be referred immediately to the National Patients' Safety Agency.
3. That the relevant PCT ensures that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly performance management system is maintained under the new management arrangements.
4. That the relevant PCT, through it's appraisal and personal development planning process, ensures that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with staff, patients and relatives to ensure

that current concerns and the particular needs of the bereaved are addressed.

CHAPTER 8 COMMUNICATION

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

Patients, relatives and carers

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

The Health Advisory Service *Standards for health and social care services for older people* (2000) states that "each service should have a written information leaflet or guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers". CHI saw a number of separate information leaflets provided for patients and relatives during the site visit.

The trust uses patient surveys, given to patients on discharge, as part of its patient involvement framework, although the response rate is unknown. This was one of the action points arising from a complaints workshop in February 2001. Issues raised by patients in completed surveys are addressed by action plans discussed at clinical managers meetings. Ward specific action plans are distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, the relevant ward purchased thermometers to address the problem. CHI could find no evidence to suggest that the findings from patient surveys are shared across the trust.

Communication towards the end of life

Staff refer to the Wessex palliative care guidelines, which are in use on the wards and address breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure on Queen Alexandra Gosport War Memorial Hospital Investigation

and St Mary's hospitals to discharge patients too quickly to Gosport War Memorial Hospital. Staff were aware of increased numbers of medically unstable patients being transferred in recent years.

Staff communication

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

Transfer into the community

CHI talked to staff from the nursing homes that most frequently receive patients from the Gosport War Memorial Hospital. Nursing home staff spoke of good, collaborative relationships with ward staff. Patients admitted into local nursing homes recently, were thought by staff to have been well cared for at Gosport War Memorial Hospital. For example, no concerns were raised with CHI regarding skin integrity (pressure sores) or nutritional status. District nurses echoed these positive views.

Key findings

1. CHI found evidence of good communication within the trust, both with staff and partner organisations in the local health community.
2. The trust has a strong theoretical commitment to patient and user involvement.

Recommendations

1. The PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.
2. Within the framework of the new PALS, the PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support groups, to determine the best way to improve communication with older patients and their relatives and carers.

CHAPTER 9 CLINICAL GOVERNANCE

Introduction

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

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

Clinical governance structures

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

The medical director took lead responsibility for clinical governance in ?? and chaired the clinical governance panel, a sub committee of the trust board. A clinical governance reference group, whose membership included representatives from each clinical service, professional group, non executive directors and the chair of the community health council, supported the clinical governance panel. Each clinical service also had its own clinical governance committee. This structure had been designed to enable each service to take clinical governance forward into whichever Gosport War Memorial Hospital Investigation

PCT it found itself in after April 2002. Since February 2000, the trust used the divisional review process to monitor clinical governance developments.

The service specific clinical governance committees were led by a designated clinician and include wide clinical and professional representation. Baseline assessments have been carried out in each specialty and responsive action plans produced. The medical director and clinical governance manager attended divisional review meetings and reported key issues back to the clinical governance panel.

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

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

- the process for gathering user views should be more focused and the process strengthened
- the trust needed to ensure that in some areas strategy, policy and procedure is fed back to staff and results in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and reaudited; lessons learnt from complaints and incidents not always used to change practice and that research and development did not always lead to change in practice
- more work needed to be done with clinical staff on openness and the support of staff alerting senior management of poor performance

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

Risk management

A risk management group was established by the trust in ?? to develop and oversee the implementation of the trust's risk management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The group has links with other trust groups such as the clinical and service audit group, the board and the nursing clinical governance committee. Originally the finance director had joint responsibility for strategic risk with the quality manager; this was changed in the 2000/2003 strategy and now includes the medical director, who is the designated lead for clinical risk. The trust achieved the clinical negligence scheme for trusts (CNST) level one in 1999. A decision was taken not to pursue the level two standard due to dissolution of the trust in 2002..

The trust introduced an operational policy for recording and reviewing risk events in 1994. New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non clinical risk. The same trust policy is used to report clinical and non clinical risks and accidents. All events are recorded in the trust's risk event database (CAREKEY). The procedure states that this reporting system should also be used for near misses and medication errors.

Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, although CHI was less confident that medical staff regularly identified and reported risks. CHI was told that risk forms were regularly submitted by wards in the event of staff shortages. Staff shortage is not one of the trust's risk event definitions.

The clinical governance development plan for 2001/2002 states that the focus for risk management in 2000/2001 was the safe transfer of services to successor organisations, with the active involvement of PCTs and PCGs in the trust's risk management group. Meetings have been held with each successor organisation to agree future arrangements for areas areas such as risk event reporting, health and safety, infection control and medicines management.

Raising concerns

The trust has a whistle blowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. The policy sets out the process staff should follow if they wish to raise a concern about the care or safety of a patient in the event of other procedures having failed or

being exhausted. NHS guidance requires systems to enable concerns to be raised outside the usual management chain. The trust policy informs staff that they can use the whistle blowing process when staff have concerns "that cannot be resolved be resolved by the appropriate procedure".

Most staff interviewed were clear about how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. Fewer staff were aware of the trust's whistle blowing policy.

Clinical audit

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

Need to include outcome of trust recent prescribing audit here.

Key findings

1. The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.
2. Although a robust system was in place to record risk events, understanding of clinical risk was not universal. The trust had a whistle blowing policy, which not all staff were aware of. The policy did not make it sufficiently clear that staff could raise concerns outside of the usual management channels if they wished.

Recommendations

1. The relevant PCT must fully embrace the clinical governance developments made and direction set by the trust.
2. The completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

3. That clinical governance arrangements regularly identify and monitor trends revealed by risk reports and a system developed to ensure that appropriate action is taken.
4. The PCT considers a revision of the whistle blowing policy to make it clear that concerns may be raised outside of normal management channels.

