

1 Gosport Investigation - Proposed Framework

2

3 *Acknowledgements*

4 To be added

5

6 **Executive Summary**

7

8 *Introductory Background*

9

10 In reaching conclusions CHI has addressed whether, since
11 1998, there had been a failure of trust systems to ensure
12 good quality patient care in the following areas:

13

- 14 • Arrangements for the administration of drugs

15

16 Information provided by three expert police witness reports
17 which suggest that diamorphine, haloperidol and midazolam
18 had been prescribed in and around 1998 without sufficient
19 cause and in sufficient doses and combinations which could
20 adversely affect frail patients.

21

22 Clear that great efforts have been made by the trust to
23 develop policies and procedures governing prescribing for
24 pain and the use of syringe drivers and to familiarise staff

1 with them. Palliative care guidelines are in general use
2 and expert advice is provided by the Palliative care
3 specialists and others with specialist input.

4

5 Data provided by the trust for 1999, 2000 and 2001 indicate
6 a reduction in the supply of injectable diamorphine,
7 haloperidol and midazolam in Deadlus and Dryad wards. CHI
8 undertook an independent review of case notes and reached

9

10 • Transfer arrangements

11

12 Some confusion over purpose of wards at the GWMH and
13 therefore the patients who should be admitted. Evidence
14 that relatives were given raised expectations on discharge
15 from the acute trust in order to free up beds. The
16 rehabilitation team are not involved in assessing patients
17 before transfer and unsuitable patients are admitted. (Could
18 check readmission rates here). Nurses spoke of patients
19 being increasingly ill on admission in recent years and die
20 fairly shortly after admission.

21 Some degree of time lag between medical assessment in the
22 acute setting prior to discharge and assessment on
23 admission.

24

1 Discharge arrangements appeared sound with multi
2 disciplinary assessment and patchy social services input.
3 Some ambiguity around setting and working towards discharge
4 dates. Feedback from local nursing home suggest a
5 constructive working relationship, with nursing home staff
6 encouraged to assess and meet patients prior to discharge.

7

8 Still work to do with acute/MOD hospital here.

9

- 10 • Responsibility for patient care

11

12 Medical accountability appears sound for trust employed
13 doctors, appraisal systems and personal development plans
14 are in place. All patients admitted to Dryad and Deadalus
15 wards are under the care of a consultant. Patients admitted
16 to Sultan ward are under the care of a named GP who is
17 responsible for their medical care. Concern over
18 supervision/appraisal of clinical assistants and contracted
19 GPs and responsibility out of hours. Nursing accountability
20 appeared sound, though supervision arrangements less so.

21

- 22 • Culture of care

23

1 Culture of the trust that of the caring employer, unclear as
2 to the priority given for patient involvement in a strategic
3 way, this may have been compromised due to the recent PCT
4 reorganisations.

5

6 Concern over the culture of care afforded to elderly
7 patients with dementia, who are sometimes perceived as a
8 "problem" some concern in 1998 over the use of drugs to
9 manage behaviour rather than pain. (need to link with
10 evidence in report)

11

12 Multi disciplinary working in infancy though commitment
13 exists from the staff.

14

15 Academic approach of nurse director showed no real
16 commitment to patient involvement. (need to link with
17 evidence in report?)

18

19 Trust still in denial to some extent over the complaints in
20 1998 and subsequent police involvement. Managed to convince
21 itself that they had been exonerated and still firmly
22 believe this, though some obvious contradiction over the
23 amount of work done to address the prescribing concerns.

24

1 *Key conclusions*

2 That the use of diamorphine, haloperidol and midazolam in
3 1998, was not in line with best practice? and may have
4 adversely affected frail older patients.

5

6 Considerable work has been done by the trust to produce a
7 policy framework for the prescription of analgesia. This
8 work was supported by relevant training and has become
9 established practice.

10

11 Increasingly sicker older patients are being admitted into
12 the Gosport War Memorial Hospital as a result of pressures
13 in the acute sector. Patients and relatives are sometimes
14 given false expectation of recovery.

15

16 The trust has good appraisal/performance management systems
17 in place for all trust employed staff. However, there are
18 no such arrangements in place for clinical assistants and
19 contracted GPs.

20

21 The trust has a dedicated senior team and is a good employer
22 with a committed workforce.

23

1 The trust did not respond cohesively to the triggers around
2 prescribing highlighted by the police investigation and
3 complaints of relatives.

4

5

6 *Key recommendations*

7

8 Pharmacy safeguards?

9 Audit?

10 Need for systems to ensure safe practice of clinical
11 assistants and GPs

12 How to move culture on in new trust?

13 Role of NPSA in working with trusts to establish patterns
14 and identify risks?

15 Possibility of police being more explicit with trusts of
16 concerns at an earlier stage?

17 Clarification of function and level of care provided on
18 different wards.

19 Clarification of transfer arrangements between acute and
20 community hospitals.

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

3

4 During the summer of 2001, concerns were raised with CHI
5 about the use of drugs and the culture of care provided to
6 older people at the Gosport War Memorial Hospital. These
7 concerns included the following:

8

- 9 (i) Arrangements for the administration of drugs
10 (ii) Transfer arrangements between the Gosport War
11 Memorial Hospital and other local hospitals
12 (iii) Responsibility for patient care
13 (iv) The culture in which care is provided

14

15 The trust was asked to provided CHI with a chronology of
16 events surrounding the death of one patient, together with
17 an outline of how the issues raised had been addressed.

18

19 On 18 September 2001, CHI's Investigations and Fast Track
20 Clinical Governance Programme Board decided to undertake an
21 investigation into the management, provision and quality of
22 healthcare for which Portsmouth Healthcare NHS Trust is
23 responsible at the Gosport War Memorial Hospital. The
24 reason behind this decision was evidence of high risk

1 activity and the likelihood that action by CHI would result
2 in lessons for the whole of the NHS.

3

4 *Terms of reference*

5

6 The terms of reference were informed by discussions with the
7 trust, the Isle of Wight, Portsmouth and South East
8 Hampshire Health Authority and the NHS South East Regional
9 Office to ensure that the terms of reference would deliver a
10 comprehensive report with the maximum learning for the NHS.

11

12 The terms of reference agreed on 9 October 2001 are as
13 follows;

14

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

21

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

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

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

6 (iv) Communication and collaboration between the trust
7 and patients, their relatives and carers and with
8 partner organisations.

9 (v) Arrangements to support patients and their relatives
10 and carers towards the end of the patients' life.

11 (vi) Supervision and training arrangements in place to
12 enable staff to provide effective care.

13

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

17

18 The investigation will also look at the adequacy of the
19 trusts clinical governance arrangements to support inpatient
20 continuing and rehabilitation for older people.

21

22 *CHI's investigation team*

23

1 Alan Carpenter, chief executive, Somerset Coast Primary Care
2 Trust

3 Anne Grosskurth, CHI Support Investigations Manger

4 Dr Tony Luxton, consultant geriatrician, Lifespan Healthcare
5 NHS Trust

6 Julie Miller, CHI Lead Investigations Manager

7 Maureen Morgan, Independent Consultant and former Nurse
8 Director

9 Mary Parkinson, Lay Member (Age Concern)

10 Jennifer Wenborne, Independent Occupational Therapist

11 The team was supported by:

12

13 Liz Fradd, CHI Nurse Director, was the lead CHI director for
14 the investigation

15 Nan Newberry, CHI Senior Analyst

16 Kellie-Ann Rehill, CHI Investigations Coordinator

17

18 *The investigation process*

19

20 The investigation consisted of five inter related parts:

21

22 Review and analysis of a range of documents specific to the
23 care of older people at the trust, clinical governance

1 arrangements and relevant national documents (See appendix ?
2 for a list of documents reviewed).

3

4 Analysis of views received from over 40 patients, relatives
5 and friends about care received at the Gosport War Memorial
6 Hospital. Views were obtained through a range of methods,
7 including meetings, correspondence, telephone calls and a
8 short questionnaire. (See appendix ?? for an analysis of
9 views received.

10

11 A five day visit by the CHI investigation team to the
12 Gosport War Memorial Hospital when all groups of staff
13 involved in the care and treatment of older people at the
14 hospital and relevant trust management were interviewed.
15 (See appendix ?? for a list of all staff interviewed).

16

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

21

22 An independent review of the clinical notes of patients who
23 had recently died on Deдалus, Dryad and Sultan wards.

1 **Chapter 2 - Background to the investigation**

2

3 *Events leading up to the CHI investigation*

4

5 *Police investigations*

6 The death of a 91 year old patient in August 1998 on
7 DeaDalus ward led to a complaint by the family regarding her
8 care and treatment. Issues around the use of drugs were
9 subsequently referred to the police in December 1998 (?).
10 Following an initial police investigation, the Criminal
11 Prosecution Service (CPS) decided that there was
12 insufficient evidence to proceed to a prosecution (*can we*
13 *say what for?*) in March 1999. *What led to the reopening -*
14 *was it complaint to Police Complaints Authority - can we say*
15 *this?* The police investigation into the death of the 91 year
16 old patient was reopened and in January 2001 the CPS decided
17 *on the basis?* of a police expert witness report that there
18 was insufficient evidence to proceed/*prosecute?who for what?*
19
20 Local media coverage in April 2001 resulted in nine (?)
21 other families raising similar concerns with the police
22 regarding deaths which had occurred in 1998. Four further
23 deaths were then investigated by the police who commissioned
24 a further two expert witness reports which were made

1 available to CHI. These reports raised very serious concerns
2 regarding the prescribing practices used in the Trust in
3 1998. In January 2002 the CPS decided that there was
4 insufficient evidence to proceed towards a prosecution in
5 these four cases.

6

7 *Need to check how much detail to go into here with police.*

8

9 *GMC & UKCC*

10 The police referred one doctor to the General Medical
11 Council in ?? 2001 and four nurses to the UKCC *check*
12 *police/GMC/UKCC*

13

14 *Complaints to the trust*

15 There were nine complaints to the trust between 1998 and
16 2001, the period of the CHI investigation. Three complaints
17 between August and November 1998 raised concerns which
18 included the use of diamorphine and levels of sedation on
19 Deadalus and Dryad wards, one of which was subsequently
20 investigated by the police.

21

22 *Action taken by health authority*

23 The Isle of Wight, Portsmouth and South East Hampshire
24 Health Authority invoked its Local Procedure for the

1 Identification and Support of Primary Care Medical
2 Practitioners whose Proactice is Giving Cause for Concern in
3 respect of the prescribing practice of a clinical assistant
4 employed by the Trust in June 2001. The Performance
5 Steering Group, which was constituted in line with the
6 policy and included representation from the CHC, initiated a
7 preliminary investigation and decide not to make a referral
8 to the next stage of the process.

9

10 In July 2001, the Chief Executive of the Health Authority
11 asked CHI for assistance in a local enquiry in order to re-
12 establish public confidence in the services for older
13 people.

14 *Action taken by NHS Executive South East*

15 No apparent system for monitoring complaints. Serious
16 Untoward Incident reports produced in April and July 2001 in
17 response to articles surrounding the death of a patient in
18 the media. *Issues - should the trust have reported the*
19 *police investigation into the death of Mrs R to RO sooner?*
20 *What should have been picked up by patch management?*

21

22 *Trust Background*

23 Gosport War Memorial Hospital is part of Portsmouth
24 Healthcare NHS Trust (PHCT) which was formed in 1994. PHCT

1 provided a range of community based and specialised health
2 services for the people of Portsmouth, Fareham, Gosport and
3 surrounding areas. These services included mental health
4 (adult and elderly), community paediatrics, elderly
5 medicine, learning disabilities and psychology. PHCT was
6 dissolved in March 2002. Services have been transferred to
7 local Primary Care Trusts. Elderly medicine was transferred
8 to the Fareham and Gosport PCT when it became operational in
9 April 2002.

10

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

16

17 The local population is predominantly white (98.5%). The
18 age profile is very similar to that of England although the
19 proportion of people over the age of 65 is slightly higher
20 than the England average.

21

22 *Trust Strategic Management*

23 The Trust Board consisted of a Chair, 5 Non-Executive
24 Directors, the Chief Executive and the executive directors

1 of operations, medicine, nursing and finance, together with
2 the personnel director. The Board met five times in public
3 annually, with five strategic briefings which were not open
4 to the public. The trust was organised into 6 divisions,
5 two of which are relevant to this investigation. The
6 Fareham and Gosport Division which managed the Gosport War
7 Memorial Hospital and the Division of Elderly Medicine.

8

9 The district medicines and formulary group, the risk
10 management group and the clinical governance panel were
11 accountable to the Trust Board.

12

13 The Trust was well regarded in the local health economy and
14 has developed robust links with the Health Authority and
15 local PCGs *examples???* & *relationships with acute trust &*
16 *GPs CES*

17

18 *Transition to PCT*

19

20 *Services for Older People*

21 Services for older people in Portsmouth were provided by the
22 department of medicine for elderly people which is managed
23 by the Portsmouth Healthcare NHS Trust. The department
24 provides acute admission, rehabilitation, continuing care,

1 day hospitals and palliative care. Acute facilities are
2 based at Queen Alexandra Hospital with facilities at St
3 Mary's Hospital (both part of the local acute trust,
4 Portsmouth Hospitals NHS Trust). The department works
5 closely with the community hospitals in Fareham, Gosport
6 (the Gosport War Memorial Hospital) and Petersfield. (check
7 Havant & Emsworth & St Christophers?). Until ?? 2000, the
8 Haslar Hospital, a military hospital provided acute elderly
9 care to civilians.

10

11 Divisional management at the trust was well defined, with
12 clear systems for monitoring clinical governance, complaints
13 and risk. Leadership at divisional level was strong with
14 clear accounting structures to corporate level. *Comment on*
15 *service performance management at service level?*

16

17 The Gosport War Memorial Hospital provides continuing care,
18 rehabilitation, day hospital and outpatient services for
19 older people and was managed by the Fareham & Gosport
20 Division. The division also managed trust wide services
21 including physiotherapy and occupational therapy advice.
22 Responsibility transferred to the Fareham and Gosport Primary
23 Care Trust on 1 April 2002.

24

1 *In patient services for older people at the Gosport War*
2 *Memorial Hospital*

3 Four wards admit older patients at the War Memorial, Dryad;
4 Deadalus, Sultan and Mulberry wards.

5

6 Dryad Ward

7 20 bedded continuing care ward for frail elderly patients
8 who are admitted under the care of consultants from the
9 department of elderly medicine. Admission is arranged
10 following a GP referral to elderly medicine consultants
11 based at the acute hospitals (Day Hospital).

12

13 Deadalus Ward

14 24 bedded ward for continuing care (?)and slow stream
15 rehabilitation for elderly frail patients. Admission is by
16 GP referral to elderly medicine consultants based in the
17 local acute trust (Day Hospital).

18

19 Sultan Ward

20 Has 24 beds for patients whose care is managed by their own
21 GP. This care includes respite, rehabilitation, continuing
22 and palliative care. A sister, employed by the trust
23 manages the ward, which is staffed by trust nurses.
24 Admission is arranged by the GP directly with ward staff .

1

2

3

4 Mulberry Ward

5 A 40 bedded assessment ward comprising of the Collingwood
6 and Ark Royal Units for elderly mental health patients. This
7 ward has not been part of the CHI investigation.

8

9 The criteria for admission onto both Dryad and Deadalus
10 wards, were that the patient must be over 65 and be
11 registered with a GP within the Gosport PCG. In addition,
12 Dryad patients must have a Barthel score of under 4/20
13 (*Which means?*) and require specialist medical and nursing
14 intervention. Deadalus patients must require
15 multidisciplinary rehabilitation for strokes and other
16 conditions.

17

Ward	1998	2002
Dryad	Trust to complete	20 continuing care beds ? slow stream rehabilitation
Deadalus		24 rehabilitation beds; 8 general, 8

		fast and 8 slow stream (since November 2000)
Sultan		24 GP beds

1

2 There appears to be confusion around the various categories
3 of care, for example CHI heard of stroke rehab, slow stream
4 rehab, very slow stream rehab, intermediate and continuing
5 care. CHI is not aware of any common criteria defining
6 these areas in use at the trust.

7

8 *National context*

9 There have been many changes within the NHS and services for
10 older people since 1998, when the trigger events for this
11 investigation took place. It is important to note the
12 culture and expectations of 2002 may not have been the norm
13 in 1998.

14

15 The standard of NHS care for older people has long caused
16 concern. A number of national reports have found care to be
17 deficient. Amongst the concerns raised have been ageism, an
18 inadequate and demoralised workforce, poor care environments
19 and lack of seamless care within the NHS. The NHS Plan's
20 section "Dignity, Security and Independence in Old Age"

1 published in July 2000, outlined the government's plans for
2 the care of older people which would be detailed in a
3 National Service Framework .

4 The National Service Framework for Older People was
5 published in March 2001 and sets standards of care of older
6 people in all care settings. It aims to ensure high quality
7 of care and treatment, regardless of age. Older people are
8 to be treated as individuals with dignity and respect. The
9 framework places special emphasis on the involvement of
10 older patient's and their relatives in the care process,
11 including care planning. There are to be local mechanisms
12 to ensure the implementation of the framework with progress
13 expected by June 2001. (Chapter ??? highlights how the
14 Portsmouth Healthcare NHS Trust have addressed the NSF
15 targets).

16

17 Though focussing on the standards of nursing care for older
18 people in acute settings, the Standing Nursing and Midwifery
19 Advisory Committee's 2001 report found standards of care
20 provided to older people to be lacking. Fundamental aspects
21 of nursing care, such as nutrition, fluids and
22 rehabilitation needs were found to be poor. Amongst the
23 suggested reasons for this were lack of clinical leadership,
24 inadequate training and lack of resources.

1

2

3 *Findings*

4 The Trust has strong leadership at corporate and divisional
5 level focussed on staff and employees. The corporate team
6 is strong and competent, the chief executive prominent and
7 well regarded by staff.

8

9 There is confusion around the categories of care.

10

11 *Recommendations*

12 How does the PCT carry forward competent leadership style?

13 The findings of this investigation should be used to
14 influence national policy work under the National Service
15 Framework.

16

1 **Chapter 3 - Quality and the Patient Experience**

2

3 *Patient experience*

4 The investigation examined in detail the experience of older
5 patients admitted to the Gosport War Memorial Hospital
6 between 1998 and 2001 and that of their relatives and
7 carers. This was done in two ways. Firstly CHI made
8 contact with a total of 40 patients and relatives during the
9 stakeholder work. Secondly, CHI made a number of visits to
10 Deadalus, Dryad and Sultan wards during the site visit week
11 in January 2002.

12

13 CHI contacted over 40 patients and relatives towards the end
14 of 2001. There was a balance of opinion between positive and
15 negative experiences of the care of older people. At the
16 Gosport War Memorial Hospital. (Details of the comments
17 received can be found in appendix ??)

18

19 The most significant areas raised by stakeholders were; the
20 use of drugs, the attitude of staff, continence, patients
21 clothing and nutrition and fluids.

22

1 *Use of drugs*

2 The use of pain relief was commented on by a number of
3 relatives. One asked the question, "Why weren't milder
4 analgesics given before administration of diamorphine?".
5 (6) doctors should disclose all drugs and why and what side
6 effects are. There should be more honesty" (20).

7

8 *Attitude of staff*

9 Comments ranged from the very positive "Everyone was so kind
10 and caring towards him in both Deadalus and Dryad wards (doc
11 29) and "I received such kindness and help from all the
12 staff at all times" (28) to the less positive "I was made to
13 feel an inconvenience because we asked questions and "the
14 doctor leaned on the wall and told us the next thing would
15 be a lung infection and that will be it". "Got the feeling
16 she had dementia and her feelings didn't count." (17)

17

18 *Continence*

19 A number of stakeholders raised concerns regarding the
20 prompt catheterisation of patients on admission to the War
21 Memorial. "They seem to catheterise everyone, my husband
22 was not incontinent, the nurse said it was done mostly to
23 save time".

1

2 *Patients clothing*

3 Many relatives were distressed about patients who were not
4 dressed in their own clothes, even when labelled clothes had
5 been provided. "They were never in their own clothes".

6

7

8 *Nutrition and fluids*

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

16

17 *Outcome of CHI observation work (possibly better in an*
18 *Appendix)*

19 The CHI team visited Dryad, Sultan and Deadalus wards
20 throughout the week of 7 January 2002 to observe first hand
21 the environment in which care was given and the intereactions
22 between staff and patients and between staff. Observation
23 periods included staff handovers, mealtimes and a
24 multidisciplinary team visit. The team also visited at

1 night. Ward staff welcomed the CHI team and were friendly
2 and open.

3

4 *Ward environment*

5 All wards were built during the 1991 expansion of the
6 hospital and are modern, welcoming and bright. This view
7 was echoed by stakeholders who were complimentary about the
8 décor and patient surroundings. Wards were tidy, clean and
9 fresh smelling. Day rooms are pleasant and Deadalus ward
10 has direct access to a well laid out garden suitable for
11 wheelchair users with seating. Storage space in Deadalus
12 and Dryad wards appeared to be short and as a result the
13 corridors had become cluttered with equipment which appeared
14 problematic for patients using walking aids. Deadalus ward
15 has a separate single room for independent living assessment
16 with own sink and wardrobe.

17

18 *Staff*

19 The CHI team saw patients addressed by name in a friendly
20 way and saw examples of good patient staff interaction. The
21 staff handovers observed were well run and information
22 exchanged appropriately.

1

2 *Mealtimes*

3 Mealtimes were well ordered with patients given a choice of
4 options and portion size. Generally patients were assisted
5 to eat and drink. There appeared to be sufficient staff to
6 serve meals and to note when meals not eaten.

7

8 *Patient experience*

9 Patients are able to watch the television in day rooms,
10 where there are large print books puzzles and current
11 newspapers. The CHI team saw little evidence of social
12 activities such as eating together taking place, with the
13 exception of watching the television. Bells to call
14 assistance were available to patients, though less
15 accessible to patients in the day rooms. The input of the
16 activities co-ordinator is not optimum.

17

18 *Findings*

19 - Relatives speaking to CHI had some very real concerns
20 about the care their relatives received on Deдалus and
21 Dryad wards, largely around 1998 - 2000??. Fewer
22 concerns were expressed regarding Sultan ward.

23

1 - The ward environments and physical care of patient
2 observed is of good quality

3 *Recommendations (suggestions?)*

4

5 - That all patient complaints, informal and formal which
6 express any of the issues referred to paragraph ?? be a
7 regular item on all monthly ward meeting agendas.

8

9 - That all systems such as the whiteboard system used to
10 record patient comments in use on Deadalus ward be
11 explored on all elderly wards and emerging themes fed
12 into monthly ward meetings.

13

14 - That the role of the activities coordinator be revised
15 and strengthened.

16

1 **Chapter 4 - Staffing Accountability and Supervision**

2

3 *Medical Staff Accountability*

4 Medical accountability for the care of older people in
5 Deadalus and Dryad wards lies ultimately with the Medical
6 Director. There is a lead consultant for Elderly Medicine
7 who is contracted to provide ?? sessions at the War Memorial
8 Hospital on Deadalus and Dryad wards. The job description
9 for this post states that the post is a major challenge for
10 "a very part time role" There are ?? sessions of consultant
11 cover on Dryad and Deadalus wards. Both consultants report
12 to the lead consultant. All patients are admitted under the
13 care of a consultant. Junior medical support is provided by
14 a staff grade physician employed on Dryad ward since
15 September 2000.

16 In 1998 the lead consultant held a fortnightly ward round,
17 this increased in ?? to weekly.

18

19 *General Practice Role and Accountability*

20 Clinical Assistant post - to be completed.

21 Whilst under contract with the Trust as a Clinical
22 Assistant, accountable to the lead consultant. Clinical
23 Assistant support for 5 sessions up until 2001 when a staff
24 grade doctor was appointed. *Dr Barton subcontracted to other*

1 *partners - never had contract with the trust.* No apparent
2 lines of communication with GPs regarding workload,
3 guidelines and policy development.

4

5 Medical accountability for patients on Sultan ward lies with
6 the admitting GP. The trust issues admitting GPs with a
7 contract for working on trust premises, this is a legal
8 document and describes very little about the GPs role. GPs
9 visit their patient regularly and when requested by nursing
10 staff.

11

12 *Medical Supervision*

13 Regular appraisal systems are in place for all doctors
14 employed by the trust, including those on locum contracts.
15 All doctors interviewed by CHI, including the medical
16 director who works 5 sessions in the department of elderly
17 medicine, have regular appraisals. Those appraising the
18 work of other doctors have been trained to do so.

19

20 CHI found no evidence of supervision or appraisal
21 arrangements for GPs working as clinical assistants in the
22 Trust prior to ??2001 when appraisal for those working 5/6
23 sessions was introduced. *Expand following Dr B interview.*

1 *It is unclear how trust disciplinary procedures would apply*
2 *to the clinical assistant role.*

3

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

11

12 *? isolation of staff grade doctor by day?*

13 *Nursing Accountability*

14 Nurses are accountable to a clinical manager (G Grade) who
15 is accountable to a senior nurse (H Grade). The senior
16 nurse has responsibilities for continuing care and
17 rehabilitation across both wards, the post was created in
18 ??? . The senior nurse is accountable to the elderly
19 service manager who reports to the general manager for the
20 Fareham and Gosport division. The general manager is then
21 responsible jointly to the director of nursing and the
22 operational director.

23

24 *?chart here to explain structure*

1

2 *Nursing supervision*

3 The Trust has been working to adopt a model of clinical
4 supervision for nurses for a number of years and received
5 initial assistance from the Royal College of Nurses to
6 develop processes. The Trust focus had been on reflective
7 practice, the overall aim to ensure that staff had access to
8 good systems of clinical support to enhance their practice.
9 As part of the Trusts Clinical Nursing Development Programme
10 which ran between January 1999 and December 2000, nurses
11 were identified to lead the development of clinical
12 supervision. CHI was unclear how the strategic impact of
13 the introduction of clinical supervision and reflective
14 practice was being measured in terms of improved quality of
15 care for patients. The trust have acknowledged that the
16 main barriers to clinical supervision have been the
17 availability of appropriate supervisors and protected time.
18 An evaluation conducted in 1999 demonstrated the Department
19 of Elderly Medicine were the most dissatisfied in terms of
20 their supervision arrangements (41.2%). (*gerontological*
21 *nursing programme - add*)

22

23 Many of the nurses interviewed valued the principles of
24 reflective practice as a way in which to improve their own

1 skills and care of patients. The H grade senior nurse
2 coordinator post appointed in November 2000 was a specific
3 trust response to an acknowledged lack of nursing leadership
4 at the Gosport War Memorial Hospital. Regular clinical
5 supervision meetings are held on Sultan and Daedalus ward,
6 with less clear arrangements on Dryad ward which may be due
7 senior ward staff sickness.

8

9 *Accountability and supervision of therapists*

10 To be added with Jen

11

12 *Workforce and service planning*

13 In preparation for the change of use of beds in Dryad and
14 Deadalus wards in November 2000, the Trust undertook a skill
15 mix review which identified consultant cover and a possible
16 increased specialist intervention as risks. Plans were put
17 in place to increase consultant staffing and to train
18 qualified nursing staff appropriately. *Alert course -*
19 *complete.* Despite this, several members of staff expressed
20 their concern regarding the complexity of many patients
21 cared for at the Gosport War Memorial Hospital and spoke of
22 a system under pressure due to nurse shortages and high
23 sickness levels. Concerns were raised formally by the
24 Clinical Assistant in early 2000 around the increased

1 workload and complexity of patients. The Medical Director
2 acknowledged the growing stress within the system, though
3 there was no systematic attempt to review or seek solutions.

4

5 The trust has recently developed a predictive workforce
6 planning model and has a strategic recruitment and retention
7 policy. *Insert more*

8

9 *Staff welfare*

10 The trust has developed as a caring employee this is
11 demonstrated by support for further education, flexible
12 working hours and a ground breaking domestic violence
13 policy.

14

15 Many staff, at all levels in the organisation spoke of the
16 stress and low morale caused by the series of police
17 investigations and the referrals to the GMC, UKCC and the
18 CHI Investigation. The Trust have encouraged the use of the
19 trust's counselling service and organised support sessions
20 for staff. Though not all staff felt supported by the
21 trust, particularly those working at a junior level.

22

1 *Out of hours arrangements*

2 Between the hours of 9 - 5, trust doctors manage the care of
3 all patients on Dryad and Deдалus wards. Out of hours
4 medical cover, including weekends and bank holidays ? is
5 provided by a local GP practice from ?? to 11.00pm after
6 which nursing staff call on Healthcall, a local deputising
7 service for medical input between 11pm and 7.00am. Staff
8 interviewed by CHI on all wards expressed concern regarding
9 frequent long waits for the Healthcall service. There was
10 also concern over Healthcall GPs reluctance to "interfere"
11 with admitting GPs prescribing. In an emergency situation,
12 nursing staff call 999 for assistance and possible transfer
13 to the local A&E department. On Sultan ward, out of hours
14 cover is provided by the patients GPs practice on-call
15 arrangements. Emergency cover is provided through the 999
16 service.

17

18 The contract for the out of hours service is managed by the
19 director of HR.? There are no performance standards within
20 the contract which is due for renewal in??

21

22 *Night skill mix review - see file*

23

1 *Team working*

2 Staff interviewed by CHI spoke of teamwork , though in
3 several instances this was uniprofessional, for example a
4 nursing team. CHI observed a multi disciplinary team
5 meeting on Deadalus ward ?, which was attended by a
6 consultant, a senior ward nurse a physiotherapist and
7 occupational therapist. Access to social work input was
8 described as difficult and no junior staff were present.
9 All professions keep separate patient notes.

10

11 There are no multi-disciplinary team meetings on Dryad and
12 Sultan wards. ?CHI found no evidence of a service lead for
13 multi-disciplinary working. Therapy staff reported some
14 progress towards multi-disciplinary goal setting for
15 patients though wished to see more development.

16 Systems are in place to access expert psychiatric opinion.
17 There are good and supportive links with consultant
18 psychiatrists. The lead consultant for elderly mental
19 health reported close links with the three wards with
20 patients either given support on the ward or transfer to an
21 elderly mental health bed. *Any nursing links - joint*
22 *training?* There was also evidence of dietician, podiatry and
23 dentistry input.

24

1 The trust has recently appointed a nurse consultant in
2 stroke services

3

4 *Findings*

5

6 - The trust has a well developed supervision and
7 appraisal systems for all directly employed staff (*but*
8 *not AHPs?*). The principles of reflective practice are
9 becoming embedded in the culture of care. No such
10 systems were evident for the employment of clinical
11 assistants and GPs working on the Sultan ward.

12

13 - There was a planned approach to the service development
14 which brought about the change of use of beds in 2000.
15 The increasing complexity of patients and resulting
16 pressure, whilst recognised, was neither monitored nor
17 reviewed.

18

19 - The Trust has a strong employee focus, with some
20 notable examples of good practice.

21

22 - Out of hours medical cover for the three wards out of
23 hours is inadequate.

1 - There is no real driver for multi disciplinary team
2 working, though Daedalus ward has made significant
3 progress.

4

5 *Recommendations (just ideas)*

6

7 - The Trust should urgently review its use of clinical
8 assistants with the aim of establishing an appraisal
9 and supervision system in line with that for other
10 trust staff.

11

12 - The Royal College of GPs should develop national
13 safeguards for trusts and GPs employed as clinical
14 assistants and for GPs working on GP led wards.

15

16 - The provision of out of hours medical cover should be
17 reviewed and performance standards developed with staff
18 built into the contract on renewal.

19

20 - The trust should undertake a case-mix review of
21 patients admitted to Dryad, Daedalus and Sultan wards
22 to determine and address whether sicker patients are
23 being admitted.

24

1 - The trust should designate a lead for multi-
2 disciplinary working in the department of elderly
3 medicine and formulate a planned approach to its
4 development.

5

1 **Chapter 5 - Guidelines and Practices**

2

3 CHIs remit is to investigate the adequacy of systems to
4 support good patient care. CHI looked at a range of these
5 systems which have been developed into policies and
6 practices by the trust and have assessed their impact on
7 patient care.

8

9 *Refer to HAS standards, Essence of Care, NSF*

10 *Outline drivers for change*

11 *Outline process for writing/agreeing policy*

12

13 Policies looked at in relation to the TOR;

14

15 Patient transfer

16 Lack of OT input

17

18 DNR

19 Users and local groups were consulted on a leaflet
20 explaining "decision making around resuscitation"

21

22 Palliative care

23 Guidelines in place and good evidence of comprehension -
24 good links with local hospice the Rowans.

1

2 Nutrition and fluids

3 Leaflet produced on catering services which outlines
4 provision of meals and includes a feedback form.

5

6 Medical records

7 Continence

8 Consent

9 Control of infection - MRSA

10 Rehabilitation

11 Continuing care

12

13 *Findings*

14

15 *Recommendations*

16

1 Chapter 6 - Arrangements for the prescription,
2 administration, review and recording of drugs

3

4 The trust supplied the following breakdown of usage of
5 diamorphine, hydrocine and medazolam from 1999 until 2001
6 based on pharmacy data, this demonstrates a clear reduction
7 in these drugs. *(do we need to see 1998 figs and fentalyn
8 patch usage too?)*

9

10 *Insert table of pharmacy data*

11

12 CHI was told that concerns had been expressed to a ward
13 sister by nurses on Dryad ward in ?? about the amount of
14 morphine given to patients, the range of prescription and
15 the use of syringe drivers. These concerns were not
16 followed through.? *Check.* Nursing staff interviewed
17 confirmed the decreased use of both diamorphine and the use
18 of syringe drivers since 1998.

19

20 *Assessment and management of pain*

21 The Trust's policy for the assessment and management of pain
22 was introduced in April 2001 and is due for review in 2003.

23 The stated purpose of the document was to identify
24 mechanisms to ensure that all patients have early and

1 effective management of pain or distress. The policy places
2 responsibility for ensuring that pain management standards
3 are implemented in every clinical setting and sets out the
4 following:

5

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

17

18 CHI has also seen evidence of a pain management cycle chart,
19 audit forms for assessing standards in pain assessment and
20 management and an analgesic ladder. The analgesic ladder
21 indicates the drug doses for different levels of pain, how
22 to calculate opiate doses and advice on how to evaluate the
23 effects of analgesia and how to observe for any side
24 effects. Nurses interviewed by CHI demonstrated a good

1 understanding of pain assessment tools and the progression
2 up the analgesic ladder. At the same time, CHI was also
3 told that it was now taking longer for patients to be made
4 pain free and that there was a timidity amongst medical
5 staff about using diamorphine.

6

7 The CHIs review of random case notes of recent admissions
8 concluded that the pain assistance and management policy was
9 ??? and was being adhered to.

10

11 *Prescription writing policy*

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

18

19 The policy also covers a section on verbal orders.
20 Telephone orders for single doses of drugs can be accepted
21 over the telephone by a registered nurse if the doctor is
22 unable to attend the ward. CHI understands that this is
23 common practice in GP led wards and works well on the Sultan
24 ward, with arrangements in place for GPs to sign the

1 prescription within 12 hours. (*possible back up of evidence*
2 *from case note review?*)

3

4 CHI was told of the practice of prior prescription of
5 palliating opiates. Policy has now changed (*which one &*
6 *when?*) CHI understands that one of the drivers for this
7 policy was the staff grade physician appointed in September
8 2000, who expressed concern over the range of anticipatory
9 doses prescribed on the wards, based on knowledge gained
10 elsewhere. CHI's case note review confirmed that anticipatory
11 prescribing no longer occurs. (*confirm true for out of hours*
12 *& Sultan too*)

13

14 *Administration - use of syringe drivers*

15 Guidance for staff on prescribing via syringe drivers is
16 contained within the policy for assessment and management of
17 pain and states that all prescriptions for continuous
18 infusion must be written on a prescription sheet designed
19 for this purpose. *evidence from note review group that being*
20 *adhered to?Maureen/Tony is this adequate guidance - just*
21 *seems to deal with the recording rather than rationale*
22 *behind decision.*

23 *Role of nurses & HCSW - checking of competencies?*

24

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

9

10 *Review of medication*

11 In November 1999, a review of neuroleptic drugs within
12 trust elderly care continuing care wards concluded that
13 neuroleptic drugs were not being over prescribed. The same
14 review revealed that the weekly medical review of medication
15 was not necessarily recorded in the medical notes. This was
16 re-audited in January 2000, when it was concluded that ???

17 *CHIs review of clinical notes saw evidence to suggest??*

18

19 *Findings*

20

21 - CHI has serious concerns regarding the quantity,
22 combination and review of drugs prescribed to older
23 people on Dryad and Deadalus wards in 1998.

24

- 1 - Concerns were raised and not listened to by staff
2 regarding the amounts of drugs administered via syringe
3 driver in 1998 ?? & 1999 - *Check*
- 4 - Policies have been developed and are being adhered to
5 (*evidence to include case note audit*) regarding the
6 prescription, administration, review and recording of
7 drugs.

8

9

10 *Recommendations*

11

- 12 - Role of pharmacy?
- 13 - Link to whistleblowing recommendation in clinical
14 governance chapter?
- 15 - Adequacy of syringe driver policy?

16

17

18

1 **Chapter 7 - Communication**

2

3 *Patients*

4 The HAS Standards for Health and Social Care Services for
5 Older People (2000) states that "each service should have a
6 written information leaflet or guide for older people who
7 use the service. There should be good information
8 facilities in inpatient services for older people, their
9 relatives and carers". During the site visit, CHI saw a
10 number of separate information leaflets provided for patient
11 and relatives, though in one case these were stored too
12 high. Photographs of staff were evident, though they may be
13 difficult to see with any visual impairment.

14

15 The trust uses patient surveys as part of its patient
16 involvement strategy, issues raised by patients are
17 addressed by action plans discussed at clinical managers
18 meetings. Ward specific action plans are distributed to
19 ward staff (*example of positive change following survey*
20 *comment?*)

21

22 *Relatives and carers*

23 Examples of involvement in decision making eg discharge
24 planning and use of syringe drivers

1

2 *Staff*

3 Most staff interviewed by CHI spoke of good internal
4 communications, and were well informed about the transfer of
5 services to the Fareham and Gosport PCT. The trust intranet
6 is ???.

7

8 *Primary care*

9 Interfaces with existing PCGs, GPs, GPs on Sultan ward

10

11 *Acute trust/Haslar*

12 In general - transfer issues will need to be picked up
13 elsewhere.

14

15 *Social Services*

16 Joint planning arrangements, involvement in discharge
17 planning. Community Enabling Scheme. Good OT relationships,
18 joint visits. Head OT due to be seconded to social services
19 for two days per week to enhance joint working.

20

21 MDT meetings - often not have input from social services -
22 little continuity. Funding assessment and care package
23 delays. Sultan 25% of bed blocking ue to lack of cae
24 package (*needs expanding*)

1

2 *Nursing homes*

3 Positive stakeholder feedback from top three local nursing
4 homes.

5 *Examples of good joint working*

6 *Findings*

7

8 *Recommendations*

9 The PCT must find a way to continue the developments made in
10 staff communication by the PHCT.

11

1 **Chapter 8 - End of Life**

2

3 Casemix issues, increasing acuity of patients and impact.

4 Expectation issues at referring hospital. Unclear use of

5 term rehabilitation, what does continuing care mean?

6 Definition of terms.

7

8 *Specialist input*

9 Staff demonstrated good knowledge regarding how to access

10 expert palliative care advice, both from a palliative care

11 consultant (*is he from acute trust?*) and the local hospice.

12 CHI heard evidence of some joint training with the hospice

13 on the use of syringe drivers for example.

14

15 *How patient care is delivered?*

16 Staff are aware of a palliative care guidelines book

17 (*Wessex? what's this??*) which is available on the wards

18

19 *How are clinical staff trained?*

20

21 *How are relatives supported?*

22 The Trust has provided a range of leaflets guiding relatives

23 through the practicalities after a death. The patient

1 affair manager provides an excellent and supportive service
2 for relatives after death.

3

4 *DNR*

5 Use and understanding - how are relatives engaged, how
6 recorded. Sultan ward - some GOS reluctant to make decision
7 re DNR.

8

9 *How does the trust support staff?*

10 Staff have access to a Trust counselling service ??? and
11 spoke of receiving emotional support from colleagues.
12 Gerontological nursing programme?

13

14 *Cultural and spiritual needs*

15 Examples were given by staff of discussions with patients
16 and relatives regarding cultural and spiritual needs. The
17 Trust employs a chaplain who has access to practitioners of
18 different faiths. (*follow up with Mary*)

19 *Findings*

20

21 *Recommendations*

22

1

2 **Chapter 9 - Complaints**

3

4 The trust forwarded details of nine complaints made
5 surrounding the care and treatment of patients on Dryad,
6 Deadalus and Sultan wards between 1998 and 2001. CHI was
7 told that over four hundred letters of thanks had been
8 received during the same period. A number of the complaints
9 raised concerns regarding the use of drugs, especially the
10 levels of sedation administered prior to death. Complaint 3
11 was referred to the Health Services Commissioner (Ombudsman)
12 whose medical advisor found the choice of pain relieving
13 drugs appropriate in terms of drug, doses and
14 administration. Complaint 5 was referred to an Independent
15 Review Panel, which found that drug doses, though high, were
16 appropriate, as was the clinical management of the patient.
17 The Medical Director told CHI that following receipt of
18 Complaint 1, he confirmed with a colleague in a neighbouring
19 trust that prescribing parameters at the War Memorial
20 Hospital were within acceptable range.

21

22 **(Initials must be removed in later drafts)**

23

24

1 August 1998 Complaint 1 (MRS R)
2 Care and treatment on Deadalus ward (concerns
3 subsequently raised with police regarding use
4 of pain relief)
5
6 October 1998 Complaint 2 (MR C)
7 Use of syringe driver to deliver diamorphine
8 on Dryad ward.
9
10 November 1998 Complaint 3 (MRS P)
11 Medical and nursing care. Diamorphine usage
12 on Dryad ward.
13 This complaint was reviewed by the Health
14 Service Commissioner
15
16 December 1999 Complaint 4 (MR S)
17 Quality of nursing care on Deadalus.
18
19 January 2000 Complaint 5 (MRS D)
20 Clinical care, including use of sedation and
21 communication with family on Dryad ward.
22 This complaint was reviewed by an Independent
23 Review Panel
24

1 June 2000 Complaint 6 (MRS G)
2 Nursing care and pain relief of Dryad ward.
3
4 June 2000 Complaint 7 (MR R)
5 Nursing care and communication on Sultan ward
6
7 August 2000 Complaint 8 (MRS W)
8 Care received on Sultan ward
9
10 May 2001 Complaint 9 (MRS H)
11 Transfer arrangements from acute hospital to
12 Sultan ward.

13

14 *Complaint Handling*

15 The trust has a policy for handling patient related
16 complaints produced in 1997, based on national guidance
17 "Complaints: Guidance on the Implementation of the NHS
18 Complaints Procedure" published in 1996. A leaflet for
19 patients detailing the various stages of the complaints was
20 produced, though this not freely available on the wards.
21 This includes the right to request an Independent Review if
22 matters are not resolved to their satisfaction together with
23 the address of the Health Service Commissioner.

24

1 Both the Trust and the local CHC described a good working
2 relationship. The CHC however regretted that their own
3 resources had, since ???, prevented them from offering the
4 kind of advocacy services to Trust complainants they would
5 have wished.

6 CHI found that letters to complainants in response to their
7 complaints do not always include an explanation of the IRP
8 process, though this is outlined in the leaflet forwarded to
9 complainants earlier in the process. Audit standards for
10 complaints handling (1.4 p6??) are good with at least 80% of
11 complainants satisfied with complaint handling and
12 performance targets for responses met. All written
13 complaints are responded to centrally. Staff interviewed
14 spoke favourably of the Chief Executive's personal
15 involvement in complaint resolution and correspondence and
16 valued his input. Letters to patients and relatives sent by
17 the trust reviewed by CHI were thorough and sensitive. The
18 trust adopts an open response to complaints and apologises
19 for any shortcomings in its services.

20

21 Once the police became involved in Complaint 1 the trust
22 ceased internal investigation processes. One senior trust
23 manager told CHI that would have commissioned an
24 investigation without question if the police investigation

1 had not begun. In CHI's view, police involvement did not need
2 to preclude an internal investigation. The GP Clinical
3 Assistant involved in the care of this patient wrote to the
4 trust's quality manager expressing concerns that she
5 discovered Complaint 1 had been made by chance three months
6 later (?). Porters interviewed by CHI expressed concern
7 that they were not asked for statements during the initial
8 investigation of this complaint, given their close
9 involvement with the patient during transfer.

10

11 *Trust Learning*

12 Action was taken to develop and improve trust policies
13 around prescribing and pain management (as detailed in
14 chapter??), this was not the result of a fundamental review
15 of prescribing practice prompted by the emerging themes from
16 complaints. In addition, the trust did not use the police
17 involvement, that of the Health Service Commissioner nor the
18 fact that an Independent Review Panel had been convened, to
19 trigger a review of prescribing practices. CHI was
20 surprised that the trust did not respond earlier and faster
21 to concerns expressed around levels of sedation.

22

23 Lessons around areas other than prescribing have been learnt
24 by the trust, though the workshop to draw together this

1 learning was not held until early 2001 when the themes
2 discussed were communication with relatives, staff attitudes
3 and fluids and nutrition. Action taken by the trust is as
4 follows:

5

- 6 - Piloting of pain management charts and prescribing
7 guidance approved in May 2001.
- 8 - The appointment of a staff grade doctor in September
9 2000.
- 10 - One additional consultant session in ??(is this true?)
- 11 - Increase in consultants ward round from fortnightly to
12 weekly from February 1999.
- 13 - Nursing documentation now clearly identifies prime
14 family contacts and next-of-kin information.
- 15 - All conversations with families are now documented,
16 supported by training.

17

18 *Monitoring and Trend Identification*

19 A key action identified in the 2000/01 Clinical Governance
20 Action Plan was a strengthening of trust systems to ensure
21 that actions following complaints have occurred. The
22 Trust's Quality Manager plays a key role in this. Actions
23 are now monitored through the divisional review process and
24 the Clinical Governance Panel and Trust Board. A Trust

1 database was introduced in 1999 to record and track trends
2 in recent complaints. An investigations officer was also
3 appointed in order to improve fact finding behind
4 complaints.

5

6 The Trust offers specific training in complaints and
7 customer care which many, though not all, staff interviewed
8 by CHI were aware of and had attended. The Trust has a well
9 defined and respected line management structure through
10 which staff are confident emerging themes from complaints
11 would now be identified. CHI was told that some of those
12 staff most in need of customer care training were least
13 likely to attend.

14

15 *Findings*

16

17 - That the trust did not use the complaints made in 1998
18 and 1999 as a trigger for an internal investigation
19 into the prescribing practices of all clinicians
20 working in the department of elderly medicine.

21

22 - That the trust now have a robust system through the
23 Divisional Review Process, supported by the clinical
24 governance framework to identify and address potential

1 patterns of concern and failure highlighted by formal
2 complaints.

3

4 - That changes to improve the quality of care to older
5 people have been made by the trust as a result of
6 patient complaints.

7

8 - That there has not been consistent training of all
9 staff in dealing with patients and carers.

10

11 *Recommendations*

12

13 - That any trends demonstrating concern, within the NHS,
14 emerging from the prescription of opiates by referred
15 immediately to the National Patients Safety Agency.

16

17 - That the PCT, using the knowledge of ward and service
18 managers, ensure attendance of all staff on trust
19 customer care and complaints training events.

20

21 - That the PCT ensures that the learning and monitoring
22 of action arising from complaints undertaken through
23 the Divisional Review system is maintained.

24

1 - Increased pharmacy safeguards?

2

3

4

5

1 Chapter 10 - Clinical Governance

2

3 *Introduction*

4 Clinical governance is a framework of systems and processes
5 which NHS organisations establish to deliver high quality
6 patient care. CHI has not conducted a clinical governance
7 review of the Portsmouth Healthcare NHS Trust but has looked
8 at how trust clinical governance systems support continuing
9 and rehabilitative inpatient care of older people at the
10 Gosport War Memorial Hospital. This chapter sets out the
11 framework and structure adopted by the trust between 1998
12 and 2002 to deliver the clinical governance agenda and
13 details those areas most relevant to this terms of
14 reference; risk management including medicines management
15 and the systems in place to allow to staff to raise
16 concerns.

17

18 *Summary*

19 The trust reacted swiftly and appropriately to the
20 principles of clinical governance outlined by the Department
21 of Health in NHS a First Class Service. In September 1998 a
22 paper outlining how the trust planned to develop a framework
23 for clinical governance was shared widely across the trust
24 and aimed to include as many staff as possible. Most staff

1 interviewed by CHI demonstrated a good understanding of
2 clinical governance and how it related to them in their
3 individual roles, although understanding of some aspects,
4 particularly risk management and audit was patchy.

5

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

14

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

17

18 - The process for gathering user views needed to be more
19 focussed and the process strengthened.

20

21 - The clinical governance loop needed to be closed in
22 some areas to ensure that strategy, policy and
23 procedure resulted in changed/improved practice.

24 Published protocols were not always implemented by

1 staff; results of clinical audit were not always
2 implemented and re-audited; lessons learnt from
3 complaints and incidents not always used to change
4 practice and that R&D did not always lead to change in
5 practice.

6

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

10

11 Following the Review, the Trust drew up a trust-wide action
12 plan in December 1999 which focussed on widening the
13 involvement and feedback from nursing, clinical and support
14 staff on Trust protocols and procedures and on making
15 greater use of R&D, clinical audit, complaints, incidents
16 and user views to lead to changes in practice.

17

18 Outcome of this????

19

20 *Structure*

21 The Medical Director took lead responsibility for clinical
22 governance. A Clinical Governance Panel was established as a
23 sub committee of the Trust Board, chaired by the Medical
24 Director. The Clinical Governance Panel was supported a

1 Clinical Governance Reference Group, whose membership
2 included representatives from each clinical service,
3 professional group, non-executive directors and the chair of
4 the Community Health Council. Five key themes were
5 identified for action at the groups first meeting in October
6 1999: continuing professional development, clinical audit,
7 evidence based practice, patient and user involvement and
8 clinical risk management

9

10 In addition, each service has its own Clinical Governance
11 Committee led by a designated clinician, including wide
12 clinical and professional representation. Baseline
13 assessments have been carried out in each specialty and
14 responsive action plans produced. The quarterly Divisional
15 Review system was modified to include reporting on clinical
16 governance in ??. The Medical Director and Clinical
17 Governance Manager attend Divisional Review meetings and
18 report key issues back to the Clinical Governance Panel.

19 The Trust produced an action plan for clinical governance by
20 May 2000 and submitted a progress report to the NHSE in
21 March 2001.

22

23 *Risk management*

24 Definition?????

1 A Risk Management group was established by the Trust in ??
2 to develop and oversee the implementation of Trust's Risk
3 Management strategy, to provide a forum in which risks could
4 be evaluated and prioritised and to monitor the
5 effectiveness of actions taken to manage risks. The Group
6 has links with other Trust groups such as the Clinical and
7 Service Audit Group, the Board and the Clinical Nursing
8 Governance Committee. Originally the Finance Director had
9 joint responsibility for strategic risk with the Quality
10 Manager, this was changed in the 2000/03 strategy to include
11 the Medical Director, who is the designated lead for
12 clinical risk.

13

14 The Trust has an operational policy for "Recording and
15 Reviewing Risk Events". New reporting forms were introduced
16 in April 2000 following a review of the assessment systems
17 for clinical and non-clinical risk. The same trust policy is
18 used to report clinical, non-clinical and accidents. All
19 events are recorded in the Trust's Risk Event Database. The
20 procedure states that this reporting system should also be
21 used for near misses and all drug and medication errors.

22 Nursing and support staff interviewed demonstrated a good
23 knowledge of the risk reporting system, though CHI received
24 no evidence to suggest that doctors regularly identified and

1 reported risks. CHI was told on a number of occasions, that
2 risk forms were regularly completed by wards in the event of
3 staff shortages. This is not one of the Trust's Risk Event
4 Definitions.

5

6 *Risk in Elderly Medicine??*

7 *Complete with team*

8 Key risk issues from each service are identified and
9 analysed through the Divisional Review system and actions
10 planned to prevent reoccurrence eg??

11

12 *Raising concerns*

13 The Trust has had a Whistleblowing policy in place since
14 1998 (*check as version I have is dated Nov 2001*) The policy
15 sets out the process staff should follow if they wish to
16 raise a concern about the care or safety of a patient in the
17 event of other procedures having failed or being exhausted.

18 *???? M - is it good practice to include a NED??*

19 Whistle-blowing policies should not rely on other procedures
20 being exhausted- but should allow concerns to be raised
21 without fear of retribution outside normal systems.

22

23 Staff interviewed were largely clear of how to raise
24 concerns within their own line management structure and were

1 largely confident of receiving an appropriate response.
2 There was less uncertainty around the existence of the
3 Trust's Whistleblowing Policy. The policy states that it
4 should come into effect once other channels have been
5 explored. A Whistleblowing policy should afford all staff
6 the right to raise concerns at the most senior level,
7 outside of the normal reporting and managerial channels.

8

9 *Clinical Audit*

10 *Needs to be completed.*

11 CHI received no demonstrable examples of changes in patient
12 care as a result of clinical audit. Despite a great deal of
13 work on revising and creating policies to support good
14 prescribing, there had been no planned audit of outcome.

15

16 *How structures will be taken forward by the PCT?*

17

18 The Clinical Governance Development Plan for 2001/02 states
19 that the focus for risk management in 2000/01 was the safe
20 transfer of services to successor organisations, with the
21 active involvement of PCTs and PCGs in the Trust's Risk
22 Management Group. Meetings have been held with each
23 successor organisation to agree future arrangements for such

1 areas as; risk event reporting, health and safety, infection
2 control and medicines management.

3

4 *Findings*

5

6 - That the Trust has responded well to the clinical
7 governance agenda and has a robust framework in place
8 with strong corporate leadership.

9 - That understanding of clinical risk was not universal.

10

11 *Recommendation*

12

13 - That the PCT fully embrace the developments made and
14 direction set by the Trust.

15 - That all staff groups be required to complete risk and
16 incident reports and training put in place to
17 reinforce.

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

21

22 That the PCT revise the Whistleblowing policy in line with
23 current best practice.