Gosport Investigation – Proposed Framework

Acknowledgements

Executive Summary

Introductory Background

In reaching conclusions must address whether, since 1998, there had been a failure of trust systems to ensure good quality patient care in the following areas:

- Arrangements for the administration of drugs

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

Clear that great efforts have been made by the trust to develop policies and procedures governing prescribing for pain and the use of syringe drivers and to familiarise patients with them. Palliative care guidelines are in general use and expert advice is provided by the Palliative care team and others with specialist input.

Data provided by the trust for 1999,2000 an 2001 indicate a reduction in the supply of injectable diamorphine, haloperidol and midazolam in Deadlus and Dryad wards. CHI undertook an independent review of case notes and reached …… Regular training for nurses using syringe drivers is available.

- Transfer arrangements

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

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

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

Still work to do with acute/MOD hospital here.

- Responsibility for patient care

Medical accountability appears sound for trust employed doctors, appraisal systems in place. All patients admitted under a consultant, except in GP ward. Concern over supervision/appraisal of contracted GPs and responsibility out of hours. Nursing accountability appeared sound, though supervision arrangements less so.

- Culture of care

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

Concern over the culture of care afforded to elderly patients with dementia, who are sometimes perceived as a "problem" some concern in 1998 over the use of drugs to manage behaviour rather than pain.

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

Academic approach of nurse director showed no real commitment to patient involvement.

Trust still in denial to some extent over the complaints in 1998 and subsequent police involvement. Managed to confince themselves that they had bee exonerated and still firmly believe this, though some obvious contradiction over the amount of work done to address the prescribing concerns.

Key conclusions

Key recommendations

Chapter 1 - Terms of reference and process of the investigation

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

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

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

On 18 September 2001, CHI's Investigations and Fast Track Clinical Governance Programme Board decided to undertake an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust is responsible at the Gosport War Memorial Hospital.

Terms of reference

Prior to the final agreement of the investigation terms of reference by the Investigations and Fast Track Clinical Governance Programme Board in ????? discussions were 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 with the maximum learning for the NHS.

The agreed term of reference is as follows;

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

(i) Staffing and accountability arrangements, including out of hours.
(ii) The guidelines and practices in place at the trust to ensure good quality care and effective performance management.
(iii) Arrangements for the prescription, administration, review and recording of drugs.
(iv) Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations.
(v) Arrangements to support patients and their relatives and carers towards the end of the patients life.
(vi) Supervision and training arrangements in place to enable staff to provide effective care.

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

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

CHI's investigation team

Alan Carpenter, chief executive, Somerset Coast Primary Care Trust
Dr Tony Luxton, consulant geriatrician, Lifespan Healthcare NHS Trust
Julie Miller, CHI Investigations Manager
Maureen Morgan ???
Mary Parkinson, lay member (Age Concern)
Jennifer Wenborne??

The team was supported by:

Liz Fradd, CHI Nurse Director, was the lead CHI director for the investigation
Anne Grosskurth, CHI Investigations Manager
Nan Newberry, CHI Senior Analyst
Kellie-Ann Rehill, CHI Investigations Coordinator

The investigation process

The investigation consisted of six inter related parts:

Review and analysis of a range of documents specific to the care of older people at the trust, clinical governance arrangements and relevant national documents (See appendix ? for a list of documents reviewed).

Analysis of views received from (insert number) patients, relatives and friends about the care received at the Gosport War Memorial Hospital. Views were obtained through a range of methods which included meetings, correspondence, telephone call and a short questionnaire. (See appendix ?? for an analysis of views received.

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

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

An independent review of case notes ????

Chapter 2 – Background to the investigation

Events leading up to the CHI investigation

National context

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

The standard of NHS care for older people have long caused concern. A number of national reports have found care to be deficient. Amongst the concerns raised have been ageism, an inadequate and demoralised workforce, poor care environments and lack of seamless care within the NHS. 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 which would be detailed in a National Service Framework .

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 older patient's, their relatives and carers' involvement 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. (Chaper ??? highlights how the Portsmouth Healthcare NHS Trust have addressed the NSF targets).

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

Trust context

Gosport War Memorial Hospital is part of Portsmouth Healthcare NHS Trust (PHCT) which was formed in 1994. PHCT provided a range of community based and specialised health 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. PHCT was dissolved in March 2002. Services have been transferred to local Primary Care Trusts. Elderly medicine has been transferred to the Fareham and Gosport PCT when it became operational in April 2002.

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

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

Services for Older People

Services for older people in Portsmouth are provided by the department of medicine for elderly people. The department provides acute admission, rehabilitation, continuing care, day hospitals and palliative care. The department is based at Queen Alexandra Hospital with facilities at St Mary's Hospital (both part of the local acute trust, Portsmouth Hospitals NHS Trust). The department works closely with the community hospitals in Fareham, Gosport (the Gosport War Memorial Hospital) and Petersfield. (check Havant & Emsworth?). The Gosport War Memorial Hospital provides continuing care, rehabilitation, day hospital and outpatient services.

As part of the Portsmouth Healthcare NHS Trust, the Gosport War Memorial Hospital was managed by the Fareham & Gosport Division of the trust. The division also managed trust wide services including physiotherapy and occupational therapy advice. Responsibility has now transferred to the Fareham and Gosport Primary Care Trust.

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

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

Dryad Ward
20 bedded continuing care ward for frail elderly patients who are admitted under the care of a consultant from the department of elderly medicine and clinical assistants (?). Admission is arranged following GP referral of elderly medicine consultants based at the acute hospitals.

Deadalus Ward
24 bedded ward for continuing care (?)and slow stream rehabilitation for elderly frail patients. Admission is by GP referral or elderly medicine consultants.

Sultan Ward
Has 24 beds for patients whose care is managed by their own GP. A sister, employed by the trust manages the ward. Admission is arranged by the GP directly with ward staff .

Mulberry Ward

A ??? bedded assessment ward comprising of the Collingwood and Ark Royal Units for elderly mental health patients.

The criteria for admission onto both Dryad and Deadalus 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. Deadalus patients must require multidisciplinary rehabilitation for strokes and other conditions.

Ward	**1998**	**2002**
Dryad		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

Findings

Recommendations

Chapter 3 – Staffing and Accountability

Organisation of care
Outline of how nursing care is delivered, accountability arrangements, skill mix
Outline of how medical care is delivered – GP ward & clinical assistant role
Outline of how AHP support is delivered

Workforce and service planning
Recruitment and retention
Possible grid of staffing arrangements in 1998 and 2002
Staff welfare

Out of hours arrangements
Nursing and medical staffing levels, outcome of recent skill mix review, GP healthcall, 999s

Team working
How expert opinion is sought – within the team and without. Interfaces with palliative care, EMH, stroke service, social services.

Findings

Recommendations

Chapter 4 – Quality and the Patient Experience

Explain quality indicators used and how assessed.

Staff attitude
Effectiveness and outcomes
Access to services
Organisation of care
Humanity of care
Environment
Patient experience

Outcome of stakeholder work
Outcome of observation work

Findings

Recommendations

Chapter 5 – Guidelines and Practices

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

Refer to HAS standards, Essence of Care
Outline drivers for change
Outline process for writing/agreeing policy

Policies looked at in relation to the TOR;

Patient transfer
DNR
Palliative care
Nutrition and fluids
Medical records
Continence
Consent
Control of infection – MRSA
Rehabilitation
Continuing care

Findings

Recommendations

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

Detailed look at the policies used around drugs. Assess changes made since 1998, look at the drivers for that change and assess how policies were developed and support training delivered.

Assessment and management of pain
New policy, how developed and how implemented. Training? Role of nurses, what happens out of hours/weekends. Medical input.

Prescription writing policy
How developed and implemented and training. Use of Sultan ward? Out of hours?

Control and administration of medicines by nursing staff
How competencies are checked/maintained. Role of HCSW.

Use of syringe driver policy
How competencies are checked, combination of drugs usesd.

Chapter 7 - Communication

Patients
Outline of how the trust & service engage with patients and demonstrable outcomes. Patient and User Framework, surveys etc.

Relatives and carers
Examples of involvement in decision making eg discharge planning and use of syringe drivers

Staff
Good internal communications systems, staff aware of impact of PCT etc.

Primary care
Interfaces with existing PCGs, GPs, GPs on Sultan ward

Acute trust/Haslar
In general – transfer issues will need to be picked up elsewhere.

Social Services
Joint planning arrangements, involvement in discharge planning.

Nursing homes
Positive stakeholder feedback from top three local nursing homes.
Examples of good joint working

Findings

Recommendations

Chapter 8 – End of Life

Casemix issues, increasing acuity of patients and impact. Expectation issues at referring hospital. Unclear use of term rehabilitation, what does continuing care mean?

Definition of terms.

Specialist input
Palliative care team, local hospice – some joint training etc.

How patient care is delivered?

How are relatives supported?

DNR
Use and understanding – how are relatives engaged, how recorded.

How does the trust support staff?

Cultural and spiritual needs

Chapter 9 – Supervision and training

Possible link into Chapter 3, staffing and accountability?

Medical supervision
Consultant appraisal, junior medical staff supervision, role of medical director, GP assistants and GPs on Sultan ward?
How is poor performance addressed?

Nursing supervision
How does this work? Role of Ward Managers and service management strusture. Role of Nurse Director.
How is poor performance addressed?

AHP supervision
Structures and methods used. Interface with acute trust?

Induction training

Mandatory training

Examples of joint training

Findings

Recommendations

Chapter 10 – Complaints

August 1998	Complaint 1 (MRS R) Care and treatment on Deadalus ward (concerns subsequently raised with police regarding use of pain relief)
October 1998	Complaint 2 (MR C) Use of syringe driver to deliver diamorphine on Dryad ward.
November 1998	Complaint 3 (MRS P) Medical and nursing care. Excessive dosages of diamorphine on Dryad ward).
December 1999	Complaint 4 (???) Lack of nursing care on Deadalus.
January 2000	Complaint 5 (MRS D) Clinical care, including use of sedation and communication with family on Dryad ward.
June 2000	Complaint 6 (MRS G) Nursing care and pain relief of Dryad ward.
August 2000	Complaint 7 (MRS W) Care received on Sultan ward

Need to add Mr R & Mr S

Chronology of complaints in 1998/99. How complaints are managed, why were themes not addressed by an internal investigation? Role of CE,MD & ND.

Systems used now to identify and address themes – divisional review meetings etc.

What lessons were learnt?

Communication with patients now recorded in notes.
Back to drivers for drug policy changes?

Findings

Recommendations

Chapter 11 – Clinical Governance

Introduction
Clinical governance is.... CHI description .....divided into seven strands; clinical audit, research and effectiveness, risk management, staffing and staff management, patient experience, use of information, training and education. Many of these strands of clinical governance have been addressed elsewhere in the report. 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 this terms of reference; risk management including medicines management and the systems in place to allow to staff to raise concerns.

Summary
The trust reacted swiftly and appropriately to the principles of clinical governance outlined in ???? In September 1998 a paper outlining how the trust planned to develop a framework for clinical governance was shared widely across the trust, aiming to include as many staff as possible. Staff interviewed by CHI showed a good understanding of clinical governance and how it related to them in their individual roles.

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" was 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 needed to be more focussed and the process strengthened.

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

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

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

Outcome of this????

Structure
The Medical Director took lead responsibility for clinical governance. A Clinical Governance Panel was established as a sub committee of the Trust Board, chaired by ??? The Clinical Governance Panel was supported 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. Five key themes were identified for action at the groups first meeting in October 1999: continuing professional development, clinical audit, evidence based practice, patient and user involvement and clinical risk management

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

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

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

The Trust has an operational policy for "Recording and Reviewing Risk Events". New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non-clinical risk. The same trust policy is used to report clinical, non-clinical and accidents. All events are recorded in the Trust's Risk Event Database.

The procedure states that this reporting system should also be used for near misses and all drug and medication errors.
Staff interviewed demonstrated a good knowledge of the risk reporting system ..... CHI was told on a number of occasions, that risk forms were regularly completed by wards in the event of staff shortages. This is not one of the Trust's Risk Event Definitions.

Risk in Elderly Medicine??

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

Raising concerns

The Trust has had a Whistleblowing policy in place since 1998 (check as version I have is dated Nov 2001) 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. ???? M – is it good practice to include a nED??

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

How structures will be taken forward by the PCT?

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