DRAFT

Evaluation of the CHI investigation into Gosport War Memorial Hospital

Introduction

1. This paper presents the results of the evaluation of the CHI investigation into the Gosport War Memorial Hospital.

Aim

The evaluation is aimed to answer the following questions:

- Did the combination of methodology, activity and administrative arrangements lead to a successful investigation?
- What worked well?
- What did not work well?

Objective

3. To improve and develop CHI's investigation process

Lessons from evaluations to date

4. The evaluation process is an important part of the continuous quality improvement of CHI's investigations, and is integral to CHI's commitment to ensure that the methods and processes adopted are robust, evidence based, fair and effective.

5. As a result of the most recent evaluations of St George's NHS Trust, Loughborough and the West of London Breast Screening Service investigations, and discussion between investigation managers, some processes have been refined. These are:

PP to insert issues from Loughborough evaluation

Issue: *anxiety created by a press release, which was "clearly designed to create headlines", and which those commenting felt was misleading*

*The lead investigation manager discussed having greater involvement with CHI's communications department regarding the press release in future-****what was outcome? (PP to doublecheck with RN, if not take out) Also PP to check outcome from PB.***

Issue: *Case notes were so extensive, it was difficult to assess them rigorously. There was also a suggestion that there should have been an opportunity for the group to discuss their conclusions with the clinicians involved in the care of the patients* ***(being considered by the PB-PP to check outcome)***

The investigation team has acknowledged that greater time is needed when reviewing case notes and this has been incorporated into current process, e.g. Ashford & St Peter's **(RN – is this true??!!)** CHI's Medical Director has also stated that in the future the investigation team will consider the sharing of case note review conclusions with relevant clinicians. **(RN – I'm pretty sure this is what Linda said at that lovely meeting, but will check the minutes, what is your recollection??)**

Issue: *the delay and timing in sending out the evaluation forms*

Evaluation forms are now sent to arrive within two to three days after the individual has received their copy of the investigation report.

- *the support provided to stakeholders post report publication* – **PP to check what discussions IM's have had with LP re this & outcomes**

- **Method used for the evaluation**

6. The evaluation is designed to concentrate on the key stages of the investigation process canvassing the views of:

- Stakeholders
  - external agencies
  - patients and public attending meetings
  - patients and public commenting by telephone/letter
- Trust staff
- Case note reference group
- Investigating team members
- Investigations manager
- Investigations Programme Board

7. Each of these groups was asked to comment using a specifically tailored questionnaire approximately after publication of the report. Each questionnaire was designed to elicit quantative information, with additional space provided for written feedback and open comment. Responses were made against a five point Lickert scale (strong agree to strongly disagree). All information was treated in confidence and respondents were told that they did not need to include their names.

8. The lead investigation manager was also asked to comment (using a different questionnaire) and the key points from that are also considered in this report.

Key themes emerging from the evaluation

Detailed analysis of the questionnaires is attached as appendices A-F. Key themes can be summarised as follows:

- ***Stakeholders*** (detailed analysis appendix A)

Of the **PP to insert number** questionnaires circulated to stakeholders attending meetings, 25 were returned, all of which responded positively to their involvement and the process.

Of the **PP to insert number** questionnaires circulated to stakeholders talking to CHI on the telephone, or writing to CHI, 11 were returned. The responses were mainly of a positive nature. Some of the comments from open questions are as follows:

- **Value of the report** – all the comments were positive except one that stated it was bad value as it promoted a

negative image of a hospital that provides excellent care. This respondent also felt that the staff needed support and sympathy, not blame. One person felt that patients would feel safer and more secure since the report was published.

- **The way the patient experience was incorporated in the report** – there were varied thoughts. Two respondents felt that their comments were noted, although one commented that the 'good' was not shown equal to the 'bad'. One person commented that concerns were not accountable in the report, that they entered the process at a late stage and were told that CHI didn't need any more information as they couldn't look at individual cases. This person also said that they could not express concerns effectively over the telephone.

Suggestions to improve the process for stakeholders

- CHI's work should be publicised more widely, with leaflets in local & national papers & TV (especially for deaf).
- All Trust workers should be informed of CHI's role in the NHS.
- It should be made clearer to relatives what exactly CHI does and what they can expect from a CHI investigation.
- The venue could be further away from the hospital as it holds bad memories.
- Large interview (3:1) can cause intimidation, 1:1 or 2:1 would be better

General comments

- CHI should have reassessed the police input following SI John James' removal from the case
- Part of CHI's remit should be to refer individuals back to the police or GMC
- Report should not be the end, CHI should do unannounced visits to check uptake of new policies & procedures
- A committee of people from all sections could form a best-value group where all items could be discussed and reported
- Pleased with treatment and experience
- Possibly too much information in the report, useful to CHI and health experts but too much for a lay person
- General lack of communication among staff and between hospitals needs t be resolved and between staff and relatives as well

- Still have lack of trust in hospital's treatment
- Positive, helpful outcome, professional, unfailingly courteous team from CHI.
- The report is too long and it would have been helpful to have a short document containing key points and findings.
- Stakeholders should meet prior to CHI visit to discuss and see if there are any general patterns in occurrences
- The hospital was given too much notice of the investigation & so were too prepared
- There is no-where else to turn as CHI can't investigate the death's themselves. Investigation helps improve for future but fails in addressing questions of the past.

PP to fill in number questionnaires were circulated to external agencies and 1 was returned. In the main comments were positive, although the respondent did comment they disagreed that working relationships between their communications team and the CHI communication team was good. They thought that clear links should be identified early on in the process which would ensure the smooth running of actions.
General comments were that CHI's working relationship with the police made it difficult for the Regional Office to act appropriately or to be fully aware of any consequences.

- ***Trust staff*** (detailed analysis appendix B)

Of the **PP to insert number** questionnaires circulated, 34 were returned.

Of all the comments received, those from trust staff were the least positive. For example, with regard to information provided before interview, 15 agreed they received adequate information from CHI before their interview, 9 felt they did not. In response to the question about the final report containing no surprises six individuals disagreed with this statement, but 21 agreed.

There are several concerns noted from trust staff the key ones of which I have grouped into the headings below:

Interview questions

- Interviewer "put words in my mouth"
- Questions at one point appeared to be steered towards possible negligence of Clinical Assistant

- Felt team pursued pre-determined, narrow-minded line of questioning. Did not open up questioning in response to information staff member interviewed was providing
- Gave answers and information only by force of determination – was not encouraged
- Interviewers made me feel relaxed with their questioning approach
- Advance knowledge of specifics of questioning would have been helpful rather than cramming on everything that might be covered
- Appropriate handling by interviewers, thoughtful questioning and attentive to comments

Information provided

- Would have liked more practical information before interview – e.g. number of interviewers, range of skills in CHI team, whether it was possible to have a record of what was said etc.
- Clarity about purpose of investigation. Felt team unsure of its role and/or found it difficult to adhere to ToR
- More information prior to interview. Instead had to talk to colleagues already interviewed to gain greater understanding of what would be involved and required. Would have felt ill-prepared had he/she not spoken to others first.

Knowledge of interviewers

- Lack of knowledge among interviewers should have been from pharmacy background
- One of the interviewers should have been from a pharmacy background

On the other hand there was a much more positive response about the manner of team members, e.g. made people feel relaxed and were thoughtful and sympathetic. 21 people agreed that the site visit went well.

Recommendations made:

- Where Directors have moved on/retired, they receive draft copy to comment on
- Fact & opinion kept clearly separate
- Where CHI frames a recommendation as an opinion, this is made clear

- ***Investigating team members*** (appendix C)

All 5 team members returned the questionnaire and responded very positively about their experience of being an investigator. The team strongly agreed that they functioned well during the investigation, were well briefed before the visit, had the appropriate skills needed and their experience of being involved in the investigation was positive.

The team praised the investigation manager's approach and efforts to make all team members feel equal and were thankful for the opportunity to participate.

Recommendations:

- Earlier access to patient records
- During the site visit, investigation team had information from police and expert witnesses that the trust did not. This does not assist in promoting openness and honesty
- More time needed, but understand people will always feel there is not enough time

- ***Investigation manager*** (appendix D)

PP to insert comments once got from Julie.

- ***Investigations Programme Board*** (appendix E)

Of the 5 questionnaires circulated, 1 was returned.

The respondent felt that the ToR was relevant and clear, the report structure, layout and content were good and it was easy to understand. It was felt that the report failed to meet the expectation of being able to clearly say why patients had died. It was also felt that CHI has learnt the importance of clinical reports and the importance of getting to the story and asking the relevant questions. It was also felt that the final handling of the press could have been better.

Proposed next steps

10. Many very positive comments have been made in this evaluation. However, it is important to ensure that areas of concern raised are considered in more detail and taken forward appropriately.

The investigation team are currently working on a paper about the developing framework for investigations and the following issues will be considered as part of this project:

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Recommendations

14. The Programme Board is asked to NOTE the contents of this report and to APPROVE the proposed next steps.