Nicky Pendleton, Portsmouth Health Authority (22/11/01)

* General manager pf elderly medicine at GWM trust during investigation period (1992-2000); has recently moved to a role in performance management at the health authority

* When with GWM, she would have regular meetings with the health authority; however discussion tended to focus on activity figures (ie bed occupancy, FCEs)

* Any discussion of quality of care to patients at GWM were relatively superficial and about physical facilities and environment

* 'we were quite frustrated as we wanted to discuss outcomes of care and the views of patients'; however those issues weren't the agenda for health authorities at the time

* in early 90s when Nicky started working ther, the trust was very spread out and fragmented (St Mary's, QA. GWM); there was separate nurse manager for each site: 'it was very difficult to achieve commonality among different hospitals'; allocation of patients to different hospitals depended on acuity of illness and prospects for recovery and rehabilitation; 'retrievable' patients were sent to GWM

* stroke service introduced in 92; average age of patients at GWM in her time was 82

* Dryad & Daedalus: they had 8 or 9 stroke beds for 'slow stream stroke patients'

* Continence was used as predictor of outcome and was considered a reliable indicator: if a patient could achieve 7 full days of continence, full recovery would be predicted, all others were classified as 'slow streamers'

* With advent of clinical governance, arrangements were set up for different area of elderly care in Portsmouth/Gosport: continuing care, acute care, strokes

* When at Gosport, Nicky spent 'a lot of time on communications with relatives'

* A consultant was in the lead for multi-disciplinary group working on elderly wards (sister in charge, nurse from each ward, AHPs from different services)

* Protocols for cot sides developed in late 90s (need to check date): it was a good example of pulling together all staff involved in elderly care

* Trust's elderly care acute team took responsibility for problems with medication

* NP feels that GP wards (including Sultan) 'sometimes left out of the loop'

* GP beds often 'misused' for non-clinical care (especially respite: GPs would place elderly patients on wards when family on holiday); Sultan beds also often used for younger patients with chronic progressive conditions like MS: there were no real care

plans for such patients

* 99/2000: new money for intermediate care: each PCG allocated set number of beds

* in some areas, like Petersfield, very good procedure for dealing with GPs
* GWM would not accept patients for step down from acute hospitals unless patient capable of moving from bed to chair - they later abandoned this policy reluctantly

* Majority of patients from acute care moved to GWM came from Haslar or St Mary's; seldom referred by geriatrician until intermediate care policy intro'd and more liaison between GWM and Haslar consultants

* Daedalus was designated 'geriatricians' ward for patients referred by consultants; Dryad designated continuing care ward

* Patients on the two wards were separated into two groups: 1) those not likely to recover and 2) patients thought to have reasonable chance of recovery and rehab

* Staff at GWM had difficult time in coping with arrival of greater number of acutely ill patients with serious mobility problems; found it difficult to get patients up and moving around; some of the staff were not used to being assertive with patients

* Just before she let GWM, there was a big drive to improve nursing skills; training in auto-defibrillators, Alert course (to train nurses to recognise when patients were at risk of dying); all nurses and GPs sent on courses; NP believes Alert training had a very positive impact on staff; many felt much more confident about dealing with seriously ill patients

* NP only able to comment on complaints handling as it was dealt with at Petersfield where she later worked: common theme emerging from complaints during her time at trust behaviour and attitude of staff, impact of changeover, discontinuity in nursing car

* 'We used such complaints to develop changes in procedure. One good example was always moving patients to the same wards when they came back to GWM. Complaints were anonymised and we took the learning points out of them and circulated them to all staff on the wards'; where relevant, sent learning points to staff at Gosport but NP not sure how that information was used there (simply sent info to general manager at GWM); would try to share good practice around the trust whenever possible

* in her role as Health Authority officer responsible for elderly care, NP would visit general manager if she heard that GWM wards having problems to pass concerns on to them

* there were apparently 2 or 3 critical incidents at Queen Alexandra re the administration of drugs and the maintenance of drug charts

* most of the work in the drugs area done by the acute group but had trust wide relevance

* NP particularly concerned about potential for drug administration errors on GP wards

like Sultan

* Nurse prescribing: list of drugs and treatments allowed to be administered by nurses maintained on elderly wards by Jan Peach the lead nurse and reviewed annually by Dr Dowd (lead consultant in elderly care)

* 'all nurses would know on continuing care ward what they were allowed to prescribe'

* dangerous & controlled drugs: NP says very robust policy in acute sector . People treat this area very seriously. I was reassured by how strict and robust procedures were and how seriously staff responded to misdemeanours.' When based at Petersfield, NP herself suspended a nurse for failing to follow protocol

* NP started in 3/01 as health authority lead on NSF for elderly; responsible for leading strategy on elderly care in a cross-district way

* In that role, she monitors activity and instigates developmental work to remedy problems identified in monitoring (eg current work in reducing delayed discharges)
* HA has set up a district-wide screening group underpinned by multi-disciplinary local implementation teams; much work at same time in consulting service users and carers

* 6 district wide implementation teams: strokes; falls; equipment; single assessment process; pharmacy and prescribing; older people and mental health problems each locality sends rep to each team

* we're attempting to join up a very complex set of targets for NSF and local modernisation review -it's about improving practive to national standards rather than criticising local services

* Fareham & Gosport have produced very good written material; also produced very good gap analysis for stroke service with action plan for change; not as good on falls; they were one of the first localities to start user and carer involvement work; only locality with community implementation strategy

* HA board know about and, in some cases, are involved in NSF for older people; at health authority level, some of the non-exec directors actively involved ; ' I have no reason to think board members are any less active in Fareham and Gosport

* very active discussion about use of rehab beds in Sultan by GP board directors at GWM

* HiMP: belongs to primary care group and trusts; must report annually on how they plan to improve care of elderly in their area; that plan must be linked to NSF, LMR and SaFF targets

* Top priority in elderly care in acute sector is to prevent bed blockages and reduce delayed discharges

* Fareham & Gosport have worked as a virtual PCT for over a year (NP describes it as a 'very well done exercise'); F&G implementation group includes all key stakeholders with robust framework underpinned by clear targets - eg number of rehab beds needed); identified nurse deficiency and charted plans for addressing it

* Evert bit of local health economy is overspent (but same is true of whole region)

* Feels that Portsmouth has been short-changed in allocation of resources

* Monthly meeting of all leads from each health authority and social service authorities; Regional office policy leads: meetings consist of policy update and report back on local activity' each member of this group liaises with colleagues in rest of region about local proposals to ensure consistency- very effective network

* Have had successful discussions with Ian Philp (older people's czar)

* 'we're trying to promote a culture in which older people can complain'