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. Similarly, some patients are being admitted to continuing care who may be suitable for rehabilitation and discharge to nursing home. Little liaison between acute wards and GWM about transfer of patients, who are often moved at short notice.

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. Increasing problem of bed blockages at GWM due to greater scarcity of nursing homes in local area.

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. Good working arrangements between three wards investigated and GWM elderly psychiatric ward and clinicians. However, limited scope for moving demented patients into that ward due to its high bed occupancy.

Multi disciplinary working in infancy though commitment exists from the staff. Limited team working between doctors and other staff.

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

Trust still in denial to some extent over the complaints in 1998 and subsequent police involvement. Managed to convfince 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. However, some indication that trust has made efforts to improve its approach to dealing with relatives and carers, and to learning from complaints.

Key conclusions

Key recommendations

Chapter 1 - Terms of reference and process of the investigation

Outline of why decided to undertake the investigation

- Concerns raised
- How decision was reached

Terms of reference

CHIs team

The investigation process

Chapter 2 – Background to the investigation

National context
Many changes within the NHS and elderly services since 1998. Important to note that the culture and expectations of 2002 may not have been the norm in 1998.

Number of issues raised around standards of care for older people, culminating in the National Service Framework in 2001. Aims to equalise standards of care across the NHS, enlarging the workforce, improving the care environment and eliminating ageism.

Eg HAS 2000 "Not Because They Are Old";
British Geriatric Society "Seamless Care – Obstacles and Solutions"
HAS "Standards for Health and Social Care for Older People
The National Plan 2000.

Trust context
Demographic background
General background to the trust
Description of services
Organisation of the trust
- board level
- service level (including patient flow)
- changes in casemix since 1998

Strategic direction and planning
Health economy partnerships
Patient public partnerships

PCT transfer arrangements
Impact on trust

Impact on elderly services

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

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

Structure in place to support clinical governance, against seven pillars

Risk management

Raising concerns

How structures will be taken forward by the PCT?