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Gosport Investigation – Proposed Framework

Acknowledgements

CHI wishes to thank the following people for their help and co-operation with the production of this report:

The patients and relatives who contributed either in person, over the phone or in writing. CHI recognises how difficult some of these contacts were for the relatives of those who have died and is deeply grateful to them.

CHIs investigation team (see Chapter ?? paragraph ??), the clinical notes review group (see appendix ??).

Staff interviewed by CHIs investigation team (see appendix??) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, Caroline Harrington and Max Millet

Detective Superintendent John James, Hampshire Constabulary

The agencies listed in appendix ?? who gave their views and submitted relevant documents to the investigation.

Executive Summary

Introductory Background

CHI has undertaken this investigation based on concerns expressed by the police and others around the care and treatment of frail older people provided by the Portsmouth

Healthcare NHS Trust at the Gosport War Memorial Hospital. This follows a number of police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at the War Memorial Hospital to share their concerns with CHI.

Key Findings

In reaching conclusions CHI has addressed 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 medicines

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 sufficiently high doses and combinations which could adversely affect frail patients.

It is 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 staff

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

Data provided by the trust for 1998? 1999, 2000 and 2001 indicates a reduction in the usage of injectable diamorphine, haloperidol and midazolam (plus fentalyn) in Deadlus and Dryad and Sultan wards. CHI undertook an independent review of case notes and reached ……

- Transfer arrangements

There is some confusion over the purpose of wards at the Gosport War Memorial Hospital and of the appropriateness of admission to each ward. The rehabilitation team are not involved in assessing patients in the acute trust (and Haslar??) before transfer. Relatives and patients had been given raised expectations on discharge from the acute trust in order to free up beds, this was confirmed by staff at both trusts ??. . (Could check readmission rates here). Nurses spoke of patients being increasingly dependent on admission in recent years.

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

Discharge arrangements are adequate, with evidence of multi disciplinary assessment and social services input. To what degree are patients supp at home CRES ??? CHI observed some ambiguity around setting and working towards discharge dates. Feedback from local nursing homes suggest a constructive working relationship, with nursing home staff encouraged to assess and meet patients and their families prior to discharge to nursing homes.

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

- Responsibility for patient care

There is clarity in the trust regarding medical accountability structures for trust employed doctors, appraisal systems and personal development plans are in place. All patients admitted to Dryad and Deadalus wards are under the care of a consultant. Patients admitted to Sultan ward are under the care of on hospital premises.

In common with other community trusts, there were no systems in place in 1998 to supervise and appraise the performance of GPs working for the trust as clinical assistants; as contracted GPs on the Sultan ward and those GPs providing out of hours medical cover. Procedures for dealing with poor performance amongst this group of staff were and still are unclear.

Nursing accountability structures are well understood by staff and are robust. Arrangements for clinical supervision are less developed and not firmly linked to improved patient care

- Culture of care

The culture of the trust that of the caring employer. It is unclear how the laudable strategy to develop a skilled, motivated workforce would lead to measurable improvements in patient care. User involvement??? , unclear as to the priority given for patient involvement in a strategic way. The trust has, since 1999?? Been aware of its own demise and has worked collaboratively with staff to bring about considerable organisational change with minimum impact upon staff.

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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. *(Liz – evidence is police experts ?? need to link with evidence in report)*

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

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

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

Check Liz comments here??

The trust has annual appraisal and performance management systems in place for all trust employed staff. However, there are no such arrangements in place for clinical

assistants working less than 5/6? Sessions and contracted GPs.

The trust has a dedicated senior team and is a good employer with a committed workforce. Check Working lives policy??

The trust did not respond adequately to the triggers around prescribing highlighted by the police investigations and complaints of relatives. The trust should have reacted proactively to the police investigation by undertaking a thorough internal investigation of prescribing patterns and standards of care. This did not happen.

Key recommendations

Pharmacy safeguards?

Audit???

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

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How to move culture on in new trust? Staff v patients

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

Development of memorandum of understanding between CHI and all police forces detailing how to best share information and identify potential systems failures as soon as possible.

Development of national definitions of various levels of care provided to older people in order to minimise confusion and ensure that patients are cared for in the best possible environments.

Rapid piece of work >>????Clarification of transfer arrangements between acute and community hospitals.

Chapter 1 - Terms of reference and process of the investigation

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

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

The Trust 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. The reason behind this decision was evidence of high risk activity and the likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

The investigation terms of reference were informed by discussions 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 to ensure maximum learning for the NHS.

The terms of reference agreed on 9 October 2001 are 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
Anne Grosskurth, CHI Support Investigations Manger
Dr Tony Luxton, consulant geriatrician, Lifespan Healthcare NHS Trust
Julie Miller, CHI Lead Investigations Manager
Maureen Morgan, Independent Consultant and former Nurse Director
Mary Parkinson, Lay Member (Age Concern)
Jennifer Wenborne, Independent Occupational Therapist
The team was supported by:

Liz Fradd, CHI Nurse Director, was the lead CHI director for the investigation
Nan Newberry, CHI Senior Analyst
Kellie-Ann Rehill, CHI Investigations Coordinator
A group convened to review anonymised medical notes (see appendix ??)

The investigation process

The investigation consisted of five 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 over 40 patients, relatives and friends about care received at the Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls 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. CHI also undertook periods of observation on each of the five days. (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 the clinical notes of patients who had recently died on Deadalus, Dryad and Sultan wards.

Chapter 2 – Background to the investigation

Events leading up to the CHI investigation

Police investigations

The death of a 91 year old patient in August 1998 on Deadalus ward led to a complaint to the trust by the family regarding her care and treatment. A relative contacted the police in September 1998 alleging that her mother had been unlawfully killed. A range of issues were identified (by the police) in support of the allegation. Following an investigation, papers ? were referred to the Crown Prosecution Service (CPS) in November 1998 and again in February 1999. The CPS responded formally in March 1999 indicating that in their view, there was insufficient evidence to prosecute any staff for amnslaughter or any other offence.

The initial police investigation was the subject of a complaint by the patients daughter and as a consequence a further police investigation was begun in August 1999. Susequently, in December 2000 a further file was submitted to the CPS concerning the circumstances of the patients death. In August 2001 the CPS advised that there was

insufficient evidence to provide a realistic prospect of a conviction against anyone.

Local media coverage in March 2001 resulted in eleven other families raising concerns about the circumstances of their relative's deaths in 1997 and 1998. Subsequent to the decision of the CPS in August 2001, the police decided to refer four of these other deaths for expert opinion to determine whether or not a further more extensive investigation was appropriate. Two expert reports were received in November and December 2001 which were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices used in the Trust in 1998.

After careful consideration, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the GMC, UKCC the trust and the Portsmouth and Isle of Wight Health Authority.

GMC & UKCC

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

Complaints to the trust

There were nine complaints to the trust between 1998 and 2001, the period of the CHI investigation. Three complaints between August and November 1998 raised concerns which included the use of diamorphine and levels of sedation on Deadalus and Dryad wards, one of which was subsequently investigated by the police. Following police involvement, this complaint did not progress through the NHS Complaints Procedure.

Action taken by health authority

Define HA role

The Isle of Wight, Portsmouth and South East Hampshire Health Authority invoked its Local Procedure for the Identification and Support of Primary Care Medical Practitioners whose Practice is Giving Cause for Concern in respect of the prescribing practice of a clinical assistant employed by the Trust in June 2001 who is GP. The Performance Steering Group, which was constituted in line

with the policy and included representation from the CHC, initiated a preliminary investigation and decided not to make a referral to the next stage of the process as they had no concerns regarding the GPs prescribing in general practice.

In July 2001, the Chief Executive of the Health Authority asked CHI for assistance in a local enquiry in order to re-establish public confidence in the services for older people in Gosport. As the HA contact was made around the same time as the initial contact of the police with CHI, CHI then began the investigation screening process to determine whether a CHI initiated investigation should be started.

Action taken by NHS Executive South East

The Regional Office were unable to demonstrate a system for monitoring trust complaints. Serious Untoward Incident define reports were completed in April and July 2001 in response to articles surrounding the death of a patient in the media. Need SUI policy & comment from Harriet re internal investigation concerns *Issues - should the trust have reported the police investigation into the death of Mrs R to RO sooner? What should have been picked up by patch management?*

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Trust Background

Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust (PHCT) which was formed in 1994. PHCT provided a range of community and hospital based 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 was transferred to the Fareham and Gosport PCT when it became operational in April 2002. Include detail of what going where in terms of service splits

Kellie - poss diagram

The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In it's last year of operation check?? , the trust had a budget in excess of £100 million, over 20% of income was spent on its largest service, elderly medicine. All 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.

Trust Strategic Management

The Trust Board consisted of a Chair, 5 Non-Executive Directors, the Chief Executive and the executive directors of operations, medicine, nursing and finance, together with the personnel director. The Board met five times a year in public, with five alternate strategic briefings which were not open to the public. The trust was organised into 6 divisions, two of which are relevant to this investigation. The Fareham and Gosport Division which managed the Gosport War Memorial Hospital and the Department of Elderly Medicine.

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

The Trust was well regarded in the local health economy and has developed robust links with the Health Authority and local PCGs insert example of Ian Piper's joint role

recently & Nurse Dir check & relationships with acute trust & GPs CES

Transition to PCT

Services for Older People

Services for older people in Portsmouth were provided by the department of medicine for elderly people which is managed by the Portsmouth Healthcare NHS Trust. The department provides acute admission, rehabilitation, continuing care, day hospitals and palliative care. Acute facilities are 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 & St Christophers?). Until ?? 2000, the Haslar Hospital, a military hospital provided acute elderly care to civilians.

Divisional management at the trust was well defined, with clear systems for monitoring clinical governance, complaints and risk. Leadership at divisional level was strong with

clear accounting structures to corporate level. *Comment on service performance management at service level?*

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

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 consultants from the department of elderly medicine. Admission is arranged following a GP referral to elderly medicine consultants based at the acute hospitals (Day Hospital).

Deadalus Ward

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

Sultan Ward

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

Mulberry Ward

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

The criteria for admission onto both Dryad and Deadalus wards, were 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 (*Which means?*) and require specialist medical and nursing

intervention. Deadalus patients must require multidisciplinary rehabilitation for strokes and other conditions.

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

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

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 the culture and expectations of 2002 may not have been the norm in 1998.

The standard of NHS care for older people has 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 involvement of older patient's and their relatives 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. (Chapter ??? 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 lacking. Fundamental aspects of nursing care, such as nutrition, fluids and rehabilitation needs were found to be poor. Amongst the suggested reasons for this were lack of clinical leadership, inadequate training and lack of resources.

Findings

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

There is confusion around the categories of care.

Recommendations

How does the PCT carry forward competent leadership style?

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

Chapter 3 – Quality and the Patient Experience

Patient experience

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

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

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

Use of drugs

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

Attitude of staff

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

Continence

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

Patients clothing

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

Nutrition and fluids

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

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

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

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

Ward environment

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

Staff

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

Mealtimes

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

Patient experience

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

Findings

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

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

Recommendations (suggestions?)

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

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

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

Chapter 4 – Staffing Accountability and Supervision

Medical Staff Accountability

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

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

General Practice Role and Accountability

Clinical Assistant post – to be completed.

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

partners – never had contract with the trust. No apparent lines of communication with GPs regarding workload, guidelines and policy development.

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

Medical Supervision

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

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

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

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

? isolation of staff grade doctor by day?

Nursing Accountability

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

?chart here to explain structure

Nursing supervision

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

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

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

Accountability and supervision of therapists

To be added with Jen

Workforce and service planning

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

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

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

Staff welfare

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

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

Out of hours arrangements

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

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

Night skill mix review – see file

Team working

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

There are no multi-disciplinary team meetings on Dryad and Sultan wards. ?CHI found no evidence of a service lead for multi-disciplinary working. Therapy staff reported some progress towards multi-disciplinary goal setting for patients though wished to see more development.
Systems are in place to access expert psychiatric opinion. There are good and supportive links with consultant psychiatrists. The lead consultant for elderly mental health reported close links with the three wards with patients either given support on the ward or tranfer to an elderly mental health bed. *Any nursing links - joint training?* There was also evidence of dietician, podiatry and dentistry input.

The trust has recently appointed a nurse consultant in stroke services

Findings

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

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

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

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

- There is no real driver for multi disciplinary team working, though Deadalus ward has made significant progress.

Recommendations (just ideas)

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

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

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

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

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

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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, NSF
Outline drivers for change
Outline process for writing/agreeing policy

Policies looked at in relation to the TOR;

Patient transfer
Lack of OT input

DNR
Users and local groups were consulted on a leaflet explaining "decision making around resusitation"

Palliative care
Guidelines in place and good evidence of comprehension – good links with local hospice the Rowans.

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Nutrition and fluids

Leaflet produced on catering services which outlines provision of maels and includes a feedback form.

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

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

Insert table of pharmacy data

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

Assessment and management of pain

The Trust's policy for the assessment and management of pain was introduced in April 2001 and is due for review in 2003. The stated purpose of the document was to identify mechanisms to ensure that all patients have early and

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

- The prescription must be written by medical staff following diagnosis of type(s) of pain and be appropriate given the current circumstances of the patient.
- If the prescription states that medication is to be administered by continuous infusion (syringe driver) the rational for this decision must be clearly documented.
- All prescription sheets for drugs administered via a syringe driver must be written on a prescription sheet designed for this purpose.

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

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

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

Prescription writing policy

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

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

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

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

Administration - use of syringe drivers

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

Role if nurses & HCSW - checking of competencies?

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

Review of medication

In November 1999, a review of neuroleptic drugs within trust elderly care continuing care wards concluded that neuroleptic drugs were not being over prescribed. The same review revealed that the weekly medical review of medication was not necessarily recorded in the medical notes. This was re-audited in January 2000, when it was concluded that ??? *CHIs review of clinical notes saw evidence to suggest??*

Findings

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

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

Recommendations

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

Chapter 7 - Communication

Patients

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

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

Relatives and carers

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

Staff

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

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. Community Enabling Scheme. Good OT relationships, joint visits. Head OT due to be seconded to social services for two days per week to enhance joint working.

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

Nursing homes

Positive stakeholder feedback from top three local nursing homes.

Examples of good joint working

Findings

Recommendations

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

27/08/15

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

Staff demonstrated good knowledge regarding how to access expert palliative care advice, both from a palliative care consultant *(is he from acute trust?)* and the local hospice. CHI heard evidence of some joint training with the hospice on the use of syringe drivers for example.

How patient care is delivered?

Staff are aware of a palliative care guidelines book *(Wessex? what's this??)* which is available on the wards

How are clinical staff trained?

How are relatives supported?

The Trust has provided a range of leaflets guiding relatives through the practicalities after a death. The patient

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

DNR

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

How does the trust support staff?

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

Cultural and spiritual needs

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

Findings

Recommendations

Chapter 9 – Complaints

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

(Initials must be removed in later drafts)

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. Diamorphine usage on Dryad ward.
This complaint was reviewed by the Health Service Commissioner

December 1999 Complaint 4 (MR S)
Quality of nursing care on Deadalus.

January 2000 Complaint 5 (MRS D)
Clinical care, including use of sedation and communication with family on Dryad ward.
This complaint was reviewed by an Independent Review Panel

June 2000 Complaint 6 (MRS G)
Nursing care and pain relief of Dryad ward.

June 2000 Complaint 7 (MR R)
Nursing care and communication on Sultan ward

August 2000 Complaint 8 (MRS W)
Care received on Sultan ward

May 2001 Complaint 9 (MRS H)
Transfer arrangements from acute hospital to Sultan ward.

Complaint Handling

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

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

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

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

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

Trust Learning

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

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

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

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

Monitoring and Trend Identification

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

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

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

Findings

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

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

patterns of concern and failure highlighted by formal complaints.

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

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

Recommendations

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

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

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

- Increased pharmacy safeguards?

Chapter 10 – Clinical Governance

Introduction

Clinical governance is a framework of systems and processes which NHS organisations establish to deliver high quality patient care. CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems support continuing and rehabilitative inpatient care of older people at the Gosport War Memorial Hospital. 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 by the Department of Health in NHS a First Class Service. In September 1998 a paper outlining how the trust planned to develop a framework for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff

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

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

reported risks. 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??

Complete with team

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??*

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

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

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

ClinicalAudit

Needs to be completed.

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

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.

Findings

- That the Trust has responded well to the clinical governance agenda and has a robust framework in place with strong corporate leadership.
- That understanding of clinical risk was not universal.

Recommendation

- That the PCT fully embrace the developments made and direction set by the Trust.
- That all staff groups be required to complete risk and incident reports and training put in place to reinforce.
- That the clinical governance panel regularly identify and monitor trends revealed by risk reports and ensure appropriate action taken.

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