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1 **Gosport Investigation - Proposed Framework**

2

3 *Acknowledgements*

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

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

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

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

16 Detective Superintendent John James, Hampshire Constabulary
17 The agencies listed in appendix ?? who gave their views and
18 submitted relevant documents to the investigation.

19 **Executive Summary**

20

21 *Introductory Background*

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

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1 Healthcare NHS Trust at the Gosport War Memorial Hospital.
2 This follows a number of police investigations between 1998
3 and 2001 into the potential unlawful killing of a patient in
4 1998. Based on information gathered during their
5 investigations, the police were sufficiently concerned about
6 the care of older people at the War Memorial Hospital to
7 share their concerns with CHI.

8

9 Key Findings

10 In reaching conclusions CHI has addressed whether, since
11 1998, there had been a failure of trust systems to ensure
12 good quality patient care in the following areas:

13

- 14 • Arrangements for the administration of medicines

15

16 Information provided by three expert police witness reports
17 which suggest that diamorphine, haloperidol and midazolam
18 had been prescribed in and around 1998 without sufficient
19 cause and in sufficiently high doses and combinations which
20 could adversely affect frail patients. *Though the ranges*
21 *within which these medicines were prescribed were in line*
22 *with local and national guidance?? ???*

23

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1 It is clear that great efforts have been made by the trust
2 to develop policies and procedures governing prescribing for
3 pain and the use of syringe drivers and to familiarise staff
4 with them. Palliative care guidelines are in general use
5 and expert advice is provided by palliative care specialists
6 and others with specialist input.

7

8 Data provided by the trust for 1997/98, 1998/99, 1999/00 and
9 2000/01 indicates a reduction in the usage of injectable
10 diamorphine, haloperidol and midazolam (plus fentanyl) in
11 Deadlus and Dryad and Sultan wards. CHI undertook an
12 independent review of case notes and reached

13

14 • Transfer arrangements

15

16 There is some confusion over the purpose of wards at the
17 Gosport War Memorial Hospital within the whole health
18 economy and of the criteria for admission to each ward. The
19 rehabilitation team are not involved in assessing patients
20 in the acute trust (and Haslar??) before transfer.
21 Relatives and patients had been given raised expectations on
22 discharge from the acute trust in order to ease bed
23 pressures in the acute trust, this was confirmed by staff at
24 both trusts ?? . (Could check readmission rates here).

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1 Nurses spoke of patients being increasingly dependent on
2 admission to the Gosport War Memorial Hospital in recent
3 years.

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

7

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

16

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

18

19 Most Gosport War Memorial patients are admitted following a
20 stay in one of the local acute hospitals. Patients are
21 transferred by the Hampshire Ambulance Service, who held a
22 contract with the Portsmouth Healthcare NHS Trust. Use
23 *interview notes & check any complaints from 1998 -2001.*

24

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1

- 2 • Responsibility for patient care

3

4 There was clarity in the trust regarding medical
5 accountability structures for trust employed doctors,
6 appraisal systems and personal development plans are in
7 place. All patients admitted to Dryad and Daedalus wards
8 are under the care of a consultant. Patients admitted to
9 Sultan ward are under the care of a GP on hospital premises.

10

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

18

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

23

- 24 • Culture of care

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1

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

11

12 Concern over the culture of care afforded to elderly
13 patients with dementia, who are sometimes perceived as a
14 "problem" some concern in 1998 over the use of drugs to
15 manage behaviour rather than pain. (*Liz - evidence is*
16 *police experts ?? need to link with evidence in report*)

17

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

20

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

24

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1 Trust still in denial to some extent over the complaints in
2 1998 and subsequent police involvement. Managed to convince
3 itself that they had been exonerated and still firmly
4 believe this, though some obvious contradiction over the
5 amount of work done to address the prescribing concerns.

6 Check Liz comments here??

7 The trust has annual appraisal and performance management
8 systems in place for all trust employed staff. However,
9 there are no such arrangements in place for clinical
10 assistants working less than 5/6? Sessions and contracted
11 GPs.

12

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

15

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

22

23

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1 *Key recommendations*

2

3 The prescribing ranges in use at the trust should be revised

4 ???Pharmacy safeguards?

5 Audit/monitoring???

6 Need for systems to ensure safe practice of clinical

7 assistants and GPs contracts

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

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

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

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

18 Rapid piece of work >????Clarification of discharge
19 /transfer arrangements between acute and community
20 hospitals.

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1 Chapter 1 - Terms of reference and process of the
2 investigation

3

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

9

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

16

17 The Trust provided CHI with a chronology of events
18 surrounding the death of one patient, together with an
19 outline of how the issues raised had been addressed.

20

21 On 18 September 2001, CHI's Investigations and Fast Track
22 Clinical Governance Programme Board decided to undertake an
23 investigation into the management, provision and quality of
24 healthcare for which Portsmouth Healthcare NHS Trust is

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1 responsible at the Gosport War Memorial Hospital. The
2 reason behind this decision was evidence of high risk
3 activity and the likelihood that the possible findings of a
4 CHI investigation would result in lessons for the whole of
5 the NHS.

6

7 *Terms of reference*

8

9 The investigation terms of reference were informed by
10 discussions with the trust, the Isle of Wight, Portsmouth
11 and South East Hampshire Health Authority and the NHS South
12 East Regional Office to ensure that the terms of reference
13 would deliver a comprehensive report to ensure maximum
14 learning for the NHS.

15

16 The terms of reference agreed on 9 October 2001 are as
17 follows;

18

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

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1

2 (i) Staffing and accountability arrangements, including
3 out of hours.

4 (ii) The guidelines and practices in place at the trust
5 to ensure good quality care and effective
6 performance management.

7 (iii) Arrangements for the prescription, administration,
8 review and recording of drugs.

9 (iv) Communication and collaboration between the trust
10 and patients, their relatives and carers and with
11 partner organisations.

12 (v) Arrangements to support patients and their relatives
13 and carers towards the end of the patients' life.

14 (vi) Supervision and training arrangements in place to
15 enable staff to provide effective care.

16

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

20

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

24

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1 *CHI's investigation team*

2

3 Alan Carpenter, chief executive, Somerset Coast Primary Care
4 Trust

5 Anne Grosskurth, CHI Support Investigations Manger

6 Dr Tony Luxton, consulant geriatrician, Lifespan Healthcare
7 NHS Trust

8 Julie Miller, CHI Lead Investigations Manager

9 Maureen Morgan, Independent Consultant and former Nurse
10 Director

11 Mary Parkinson, Lay Member (Age Concern)

12 Jennifer Wenborne, Independent Occupational Therapist

13 The team was supported by:

14

15 Liz Fradd, CHI Nurse Director, was the lead CHI director for
16 the investigation

17 Nan Newberry, CHI Senior Analyst

18 Kellie-Ann Rehill, CHI Investigations Coordinator

19 A group convened to review anonymised medical notes (see
20 appendix ??)

21

22 *The investigation process*

23

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1 The investigation consisted of five inter related parts:

2

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

7

8 Analysis of views received from over 40?? patients,
9 relatives and friends about care received at the Gosport War
10 Memorial Hospital. Views were obtained through a range of
11 methods, including meetings, correspondence, telephone calls
12 and a short questionnaire. (See appendix ?? for an analysis
13 of views received).

14

15 A five day visit by the CHI investigation team to the
16 Gosport War Memorial Hospital when all groups of staff
17 involved in the care and treatment of older people at the
18 hospital and relevant trust management were interviewed. CHI
19 also undertook periods of observation on Daedalus, Dryad and
20 Sultan wards. (See appendix ?? for a list of all staff
21 interviewed).

22

23 Interviews with relevant agencies and other NHS
24 organisations, including those representing patients and

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1 relatives (See appendix ?? for a list of organisations
2 interviewed).

3

4 An independent review of the clinical and nursing notes of
5 patients who had recently died on Deadalus, Dryad and Sultan
6 wards.

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1 **Chapter 2 - Background to the investigation**

2

3 *Events leading up to the CHI investigation*

4

5 *Police investigations*

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

18

19 The initial police investigation was the subject of a
20 complaint by the patient's daughter and as a consequence a
21 further police investigation was begun in August 1999.
22 Subsequently, in December 2000 a further file was submitted
23 to the CPS concerning the circumstances of the patient's
24 death. In August 2001 the CPS advised that there was

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1 insufficient evidence to provide a realistic prospect of a
2 conviction against any member of staff.

3

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

15

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

21

22

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1 *GMC & UKCC*

2 The police referred one doctor to the General Medical
3 Council in ?? 2001 and four nurses to the UKCC *check*
4 */GMC/UKCC. Out come & additional referrals in 2002.*

5

6 *Complaints to the trust*

7 There were nine complaints to the trust concerning patients
8 treated on Daedalus, Dryad and Sultan wards between 1998 and
9 2001, the period of the CHI investigation. Three complaints
10 between August and November 1998 raised concerns which
11 included the use of diamorphine and levels of sedation on
12 Daedalus and Dryad wards, one of which was subsequently
13 investigated by the police. Following police involvement,
14 this complaint did not progress through the NHS Complaints
15 Procedure.

16

17 *Action taken by health authority*

18 **Define HA role**

19 The Isle of Wight, Portsmouth and South East Hampshire
20 Health Authority invoked its Local Procedure for the
21 Identification and Support of Primary Care Medical
22 Practitioners whose Practice is Giving Cause for Concern in
23 respect of the prescribing practice of a clinical assistant
24 employed by the Trust in June 2001 who is GP. The

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1 Performance Steering Group, which was constituted in line
2 with the policy and included representation from the CHC,
3 initiated a preliminary investigation and decided not to
4 make a referral to the next stage of the process as they had
5 no concerns regarding the GPs prescribing in general
6 practice.

7

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

15

16 *Action taken by NHS Executive South East*

17 The Regional Office was unable to demonstrate a system for
18 monitoring trust complaints. Serious Untoward Incident
19 define reports were completed in April and July 2001 in
20 response to articles surrounding the death of a patient in
21 the media. Need SUI policy & comment from Harriet re
22 internal investigation concerns *Issues - should the trust*
23 *have reported the police investigation into the death of Mrs*

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1 *R to RO sooner? What should have been picked up by patch*

2 *management?*

3

4 *Findings*

5 *Adequacy of HA?RO response*

6 *Mou with police.*

7

8 *Recommendations??*

9

10

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1 **Chapter 3 – National and Local Context**

2 *National context*

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

7

8 The standard of NHS care for older people has long caused
9 concern. A number of national reports have found care to be
10 deficient reference?. Amongst the concerns raised have
11 been, an inadequate and demoralised workforce, poor care
12 environments, lack of seamless care within the NHS and
13 ageism. The NHS Plan's section "Dignity, Security and
14 Independence in Old Age" published in July 2000, outlined
15 the government's plans for the care of older people which
16 would be detailed in a National Service Framework .

17

18 The National Service Framework for Older People was
19 published in March 2001 and sets standards of care of older
20 people in all care settings. It aims to ensure high quality
21 of care and treatment, regardless of age. Older people are
22 to be treated as individuals with dignity and respect. The
23 framework places special emphasis on the involvement of
24 older patient's and their relatives in the care process,

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1 including care planning. There are to be local mechanisms
2 to ensure the implementation of the framework with progress
3 expected by June 2001. (Chapter ??? highlights how the
4 Portsmouth Healthcare NHS Trust have addressed the NSF
5 targets, and CHIs role in reviewing implementation).

6

7 The Standing Nursing and Midwifery Advisory Committee's 2001
8 report, which focussed on nursing care for older people in
9 acute settings, found standards of care provided to older
10 people to be lacking check if this word used in rep & speech
11 mark. Fundamental aspects of nursing care, such as
12 nutrition, fluids and rehabilitation needs were found to be
13 poor. Amongst the suggested reasons for this were lack of
14 clinical leadership, inadequate training and lack of
15 resources.

16 Essence of care standards?? Used to address some of these
17 shortcomings

18

19

20 *Trust Background*

21 Gosport War Memorial Hospital was part of Portsmouth
22 Healthcare NHS Trust (PHCT) which was formed in 1994. PHCT
23 provided a range of community and hospital based services
24 for the people of Portsmouth, Fareham, Gosport and

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1 surrounding areas. These services included mental health
2 (adult and elderly), community paediatrics, elderly
3 medicine, learning disabilities and psychology. PHCT was
4 dissolved in March 2002. Services have been transferred to
5 local Primary Care Trusts. Elderly medicine was transferred
6 to the Fareham and Gosport PCT when it became operational in
7 April 2002. Include detail of what going where in terms of
8 service splits

9

10 Kellie - poss diagram

11

12 The trust was one of the largest community trusts in the
13 south of England and employed almost 5,000 staff. In it's
14 last year of operation check?? , the trust had a budget in
15 excess of £100 million, over 20% of income was spent on its
16 largest service, elderly medicine. All financial targets
17 were met in 2000/01.

18

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

23

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1 *Trust Strategic Management*

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

12

13 The district medicines and formulary group, the risk
14 management group and the clinical governance panel were
15 accountable to the Trust Board. Uput into context

16

17 CHI heard that the Trust was well regarded in the local
18 health economy and had developed robust links with the
19 Health Authority and local PCGs insert example of Ian
20 Piper's joint role recently & Nurse Dir check &
21 relationships with acute trust & GPs CES

22

23 *Transition to PCT*

24 Define & Summarise

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1

2 *Services for Older People*

3 Services for older people in Portsmouth were provided by the
4 department of medicine for elderly people which is managed
5 by the Portsmouth Healthcare NHS Trust. This is an unusual
6 arrangement, though precedents do exist in >?? Check with
7 Alan, The department provides acute admission,
8 rehabilitation, continuing care, day hospitals and
9 palliative care. Acute facilities are based at Queen
10 Alexandra Hospital with facilities at St Mary's Hospital
11 (both part of the local acute trust, Portsmouth Hospitals
12 NHS Trust). The department works closely with the community
13 hospitals in Fareham, Gosport (the Gosport War Memorial
14 Hospital) and Petersfield. (check Havant & Emsworth & St
15 Christophers?). Until ?? 2000, the Haslar Hospital, a
16 military hospital provided acute elderly care to civilians.

17

18 Divisional management at the trust was well defined, with
19 clear systems for monitoring clinical governance, complaints
20 and risk. Leadership at divisional level was strong with
21 clear accounting structures to corporate level. *Comment on*
22 *service performance management at service level?*

23

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

8

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

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

13

14 Dryad Ward

15 20 bedded continuing care ward for frail elderly patients
16 who are admitted under the care of a consultant from the
17 department of elderly medicine. Admission is by GP referral
18 to elderly medicine consultants based in the local acute
19 trust.

20

21 Deadalus Ward

22 Confirm beds useage in 1998 24 bedded ward for continuing
23 care (?) intermediate and slow stream rehabilitation for
24 elderly frail patients. Admission is as for Dryad ward.

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1

2 Sultan Ward

3 Has 24 beds for adult patients whose care is managed by
4 their own GP. Patients in this ward are not exclusively
5 older patients. This care includes respite, rehabilitation,
6 intermediate and palliative care. A sister, employed by the
7 trust manages the ward, which is staffed by trust nurses.
8 Admission is arranged by the GP directly with ward staff
9 admission prevention measure?? .

10

11 Mulberry Ward

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

15

16 The criteria for admission onto both Dryad and Daedalus
17 wards, were that the patient must be over 65 and be
18 registered with a GP within the Gosport PCG. In addition,
19 Dryad patients must have a Barthel score of under 4/20. The
20 Barthel score is a recognised ?????? (*Which means?*) and
21 dependency levels?? require specialist medical and nursing
22 intervention. Daedalus patients must require
23 multidisciplinary rehabilitation for strokes and other
24 conditions.

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1

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

2

3 CHI found confusion around the terminology describing the
4 various categories of care for older people, for example CHI
5 heard of "stroke rehab, slow stream rehab, very slow stream
6 rehab, intermediate and continuing care". CHI is not aware
7 of any common criteria defining these areas in use at the
8 trust.

9

10 *Findings*

11 The Trust has strong leadership at corporate and divisional
12 level with a shared set of values focussed mainly on staff.
13 The corporate team was well established and functioned,
14 together with the board, as a team. The chief executive was

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1 accessible to staff and well regarded by NHS staff both
2 within the trust and in the local health economy. Good
3 linked had been developed with local PCG's etc

4

5

6 There is confusion amongst all groups of staff and therefore
7 communicated to patients and relatives about the different
8 levels of care provided by the wards under investigation.

9

10 *Recommendations*

11 How does the PCT carry forward competent leadership style?

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

15

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1 **Chapter 3 - Quality of Care and the Patient Experience**

2 *Introduction*

3 The patient's experience is at the heart of all CHIs work.
4 The term stakeholder is used to describe any person or
5 organisation one who has experience of or an interest in the
6 care of patients. This can range from patients and their
7 relatives to hospital staff and local GPs. This chapter
8 details CHIs findings following contact with patients and
9 relatives. These findings must be put into the context of
10 the total number of older patients admitted to the Gosport
11 War Memorial Hospital during the period of the CHI
12 investigation.

13

14 Trust ?? to provide data

15

16 Detail of the methodology used to gain an insight into the
17 patient experience and of the issues raised with CHI are
18 contained in Appendix ??.

19

20

21 **Patient experience**

22 The investigation examined in detail the experience of older
23 patients admitted to the Gosport War Memorial Hospital
24 between 1998 and 2001 and that of their relatives and

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1 carers. This was carried out in two ways. Firstly,
2 stakeholders were invited, through local publicity, to make
3 contact with CHI. The police also wrote to relatives who had
4 expressed concern to them informing them of the CHI
5 investigation. Views were invited in person, in writing,
6 over the telephone and by questionnaire. Over 40?? Patients
7 and relatives contacted CHI towards the end of 2001. There
8 was a range of experiences of the care of older people
9 amongst those who spoke to CHI.

10

11 Secondly, CHI made a number of observation visits to
12 Daedalus, Dryad and Sultan wards during the site visit week
13 in January 2002. Mealtimes, staff handovers, & ??? were
14 oobserved. The wards were also observed during the night.
15 Ward staff did comment during this week that the wards were
16 especially well staffed that week. Check evidence?

17

18 Concerns raised most frequently by stakeholders were; the
19 use of medicines, the attitude of staff, incontinence
20 management, patients clothing and nutrition and fluids.

21

22 *Use of medicines*

23 The use of pain relieving medicines was commented on by a
24 number of relatives. One asked the question, "Why weren't

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1 milder analgesics given before administration of
2 diamorphine?". ??pos use a more general comment?? (6)
3 "doctors should disclose all drugs and why and what side
4 effects are. There should be more honesty" (20).

5

6 *Attitude of staff*

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

15

16 *Incontinence Management*

17 A number of stakeholders raised concerns regarding the
18 frequent catheterisation of patients on admission to the War
19 Memorial. "They seem to catheterise everyone, my husband
20 was not incontinent, the nurse said it was done mostly to
21 save time".Uplus comment about help with commode?

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1

2 *Patients clothing*

3 Many relatives were distressed about patients who were not
4 dressed in their own clothes, even when labelled clothes had
5 been provided by families. "They were never in their own
6 clothes". More evidence ??

7

8

9 *Nutrition and fluids*

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

17

18 *Outcome of CHI observation work*

19 The CHI team spent time on Dryad, Sultan and Daedalus wards
20 throughout the week of 7 January 2002 to observe first hand
21 the environment in which care was given and the interactions
22 between staff and patients and between staff. Observation
23 periods included staff handovers, mealtimes and a
24 multidisciplinary team visit. The team also visited at

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1 night. Ward staff welcomed the CHI team and were friendly
2 and open. Have we said all this twice?

3

4 *Ward environment*

5 All wards were built during the 1991 expansion of the
6 hospital and are modern, welcoming and bright. This view
7 was echoed by stakeholders who were complimentary about the
8 décor and patient surroundings. Wards were tidy, clean and
9 fresh smelling. Day rooms are pleasant and Daedalus ward
10 has direct access to a well laid out garden suitable for
11 wheelchair users. The garden has a variety of different
12 textures, a thoughtful way in which to practice walking for
13 patients. There is limited storage space in Daedalus and
14 Dryad wards and as a result the corridors had become
15 cluttered with equipment which was observed as problematic
16 for patients using walking aids. Daedalus ward has an
17 attractive, separate single room for independent living
18 assessment with its own sink and wardrobe.

19

20 *Staff*

21 The CHI team saw patients addressed by name in a friendly
22 way and saw examples of good patient staff interaction such
23 as help with dressing and friendly conversations. The staff
24 handovers observed were well conducted, held away from the

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1 main wards areas, with relevant information about patient
2 care exchanged appropriately.

3

4 *Mealtimes*

5 Mealtimes were well organised with patients given a choice
6 of options and portion size. Generally patients were
7 assisted to eat and drink. There appeared to be sufficient
8 staff to serve meals and to note when meals not eaten. CHI
9 did not observe any meals returned untouched.

10

11 *Daytime activities*

12

13 Patients are able to watch the television in day rooms,
14 where there are large print books, puzzles and current
15 newspapers. The CHI team saw little evidence of social
16 activities, though some patients did eat together in the day
17 room. Bells to call assistance were available to patients
18 by their beds, though less accessible to patients in the day
19 rooms. The wards do have an activities co-ordinator, though
20 CHI saw little evidence of any meaningful patient activity.

21

22 *Patient and relative feedback*

23 Daedalus ward had introduced a notebook system by each bed
24 for patients and relatives to make comments????? Need more
25 info

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1

2 *Confidentiality*

3 CHI had some concern over the confidential treatment of patient information. For
4 example, patient notes were left open in view of the ward and information such as
5 feeding and medicine regimes was evident on the doors of side rooms?? Which ward –
6 Jen?

7 *Findings*

8 - Relatives speaking to CHI had some very real concerns
9 about the care their relatives received on Deadalus and
10 Dryad wards, check dates of these largely around 1998 –
11 2000??. Fewer concerns were expressed regarding Sultan
12 ward.

13 - The ward environments and physical care of patients
14 observed was of good quality.

15 - daytime activity, such as ???? available to patients
16 is limited

17 - The ward environments and physical, nursing care of
18 patients observed was of good quality.

19 - Some evidence of poor practice regarding patient
20 confidentiality was observed.

21 -

22 *Recommendations (suggestions?)*

23

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

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- 1 - That the system adopted by the Primary Care Trust to
2 replace the quarterly divisional review process,
3 ensures that the identification of trends in patient
4 complaints is a priority. (pos in complaints chapter??)
5
- 6 - That all systems such as the notebook system used to
7 record patient comments in use on DeaDalus ward be
8 extended to all elderly wards and emerging themes fed
9 into monthly ward meetings.
10
- 11 - That increased daytime activities be made available to
12 patients. The role of the activities coordinator
13 should be revised and strengthened with patien,
14 occupational therapy and physiotherapy input.
15
- 16 - That the wards review, with the assistance of the
17 Caldicott Guardian, steps to ensure that patient
18 confidentiality is maintained.
19

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1 **Chapter 4 - Staffing Accountability and Supervision**

2

3 *Medical Staff Accountability*

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

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

18

19 *General Practice Role and Accountability*

20 Clinical Assistant post - to be completed.

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

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1 *partners - never had contract with the trust.* No apparent
2 lines of communication with GPs regarding workload,
3 guidelines and policy development.

4

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

11

12 *Medical Supervision*

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

19

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

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

3

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

11

12 *? isolation of staff grade doctor by day?*

13 *Nursing Accountability*

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

23

24 *?chart here to explain structure*

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1

2 *Nursing supervision*

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

22

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

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

8

9 *Accountability and supervision of therapists*

10 To be added with Jen

11

12 *Workforce and service planning*

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

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

4

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

8

9 *Staff welfare*

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

14

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

22

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1 *Out of hours arrangements*

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

17

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

21

22 *Night skill mix review - see file*

23

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1 *Team working*

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

10

11 There are no multi-disciplinary team meetings on Dryad and
12 Sultan wards. ?CHI found no evidence of a service lead for
13 multi-disciplinary working. Therapy staff reported some
14 progress towards multi-disciplinary goal setting for
15 patients though wished to see more development.

16 Systems are in place to access expert psychiatric opinion.

17 There are good and supportive links with consultant
18 psychiatrists. The lead consultant for elderly mental
19 health reported close links with the three wards with
20 patients either given support on the ward or transfer to an
21 elderly mental health bed. *Any nursing links - joint*
22 *training?* There was also evidence of dietician, podiatry and
23 dentistry input.

24

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1 The trust has recently appointed a nurse consultant in
2 stroke services

3

4 *Findings*

5

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

12

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

18

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

21

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

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1 - There is no real driver for multi disciplinary team
2 working, though Daedalus ward has made significant
3 progress.

4

5 *Recommendations (just ideas)*

6

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

11

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

15

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

19

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

24

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

5

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1 **Chapter 5 - Guidelines and Practices**

2

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

8

9 *Refer to HAS standards, Essence of Care, NSF*

10 *Outline drivers for change*

11 *Outline process for writing/agreeing policy*

12

13 Policies looked at in relation to the TOR;

14

15 Patient transfer

16 Lack of OT input

17

18 DNR

19 Users and local groups were consulted on a leaflet
20 explaining "decision making around resuscitation"

21

22 Palliative care

23 Guidelines in place and good evidence of comprehension -
24 good links with local hospice the Rowans.

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1

2 Nutrition and fluids

3 Leaflet produced on catering services which outlines
4 provision of meals and includes a feedback form.

5

6 Medical records

7 Continence

8 Consent

9 Control of infection - MRSA

10 Rehabilitation

11 Continuing care

12

13 *Findings*

14

15 *Recommendations*

16

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

3

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

9

10 *Insert table of pharmacy data*

11

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

19

20 *Assessment and management of pain*

21 The Trust's policy for the assessment and management of pain
22 was introduced in April 2001 and is due for review in 2003.

23 The stated purpose of the document was to identify
24 mechanisms to ensure that all patients have early and

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

5

6 - The prescription must be written by medical staff
7 following diagnosis of type(s) of pain and be
8 appropriate given the current circumstances of the
9 patient.

10 - If the prescription states that medication is to be
11 administered by continuous infusion (syringe driver)
12 the rationale for this decision must be clearly
13 documented.

14 - All prescription sheets for drugs administered via a
15 syringe driver must be written on a prescription sheet
16 designed for this purpose.

17

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

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

6

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

10

11 *Prescription writing policy*

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

18

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

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

3

4 CHI was told of the practice of prior prescription of
5 palliating opiates. Policy has now changed (*which one &*
6 *when?*) CHI understands that one of the drivers for this
7 policy was the staff grade physician appointed in September
8 2000, who expressed concern over the range of anticipatory
9 doses prescribed on the wards, based on knowledge gained
10 elsewhere. CHI's case note review confirmed that anticipatory
11 prescribing no longer occurs. (*confirm true for out of hours*
12 *& Sultan too*)

13

14 *Administration - use of syringe drivers*

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

23 *Role of nurses & HCSW - checking of competencies?*

24

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

9

10 *Review of medication*

11 In November 1999, a review of neuroleptic drugs within
12 trust elderly care continuing care wards concluded that
13 neuroleptic drugs were not being over prescribed. The same
14 review revealed that the weekly medical review of medication
15 was not necessarily recorded in the medical notes. This was
16 re-audited in January 2000, when it was concluded that ???

17 *CHIs review of clinical notes saw evidence to suggest??*

18

19 *Findings*

20

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

24

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

8

9

10 *Recommendations*

11

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

16

17

18

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1 **Chapter 7 - Communication**

2

3 *Patients*

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

14

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

21

22 *Relatives and carers*

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

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1

2 *Staff*

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

7

8 *Primary care*

9 Interfaces with existing PCGs, GPs, GPs on Sultan ward

10

11 *Acute trust/Haslar*

12 In general - transfer issues will need to be picked up
13 elsewhere.

14

15 *Social Services*

16 Joint planning arrangements, involvement in discharge
17 planning. Community Enabling Scheme. Good OT relationships,
18 joint visits. Head OT due to be seconded to social services
19 for two days per week to enhance joint working.

20

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

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1

2 *Nursing homes*

3 Positive stakeholder feedback from top three local nursing
4 homes.

5 *Examples of good joint working*

6 *Findings*

7

8 *Recommendations*

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

11

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1 **Chapter 8 - End of Life**

2

3 Casemix issues, increasing acuity of patients and impact.

4 Expectation issues at referring hospital. Unclear use of

5 term rehabilitation, what does continuing care mean?

6 Definition of terms.

7

8 *Specialist input*

9 Staff demonstrated good knowledge regarding how to access

10 expert palliative care advice, both from a palliative care

11 consultant (*is he from acute trust?*) and the local hospice.

12 CHI heard evidence of some joint training with the hospice

13 on the use of syringe drivers for example.

14

15 *How patient care is delivered?*

16 Staff are aware of a palliative care guidelines book

17 (*Wessex? what's this??*) which is available on the wards

18

19 *How are clinical staff trained?*

20

21 *How are relatives supported?*

22 The Trust has provided a range of leaflets guiding relatives

23 through the practicalities after a death. The patient

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

3

4 *DNR*

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

8

9 *How does the trust support staff?*

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

13

14 *Cultural and spiritual needs*

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

19 *Findings*

20

21 *Recommendations*

22

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1

2 **Chapter 9 - Complaints**

3

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

21

22 (Initials must be removed in later drafts)

23

24

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1 August 1998 Complaint 1 (MRS R)
2 Care and treatment on Deadalus ward (concerns
3 subsequently raised with police regarding use
4 of pain relief)
5
6 October 1998 Complaint 2 (MR C)
7 Use of syringe driver to deliver diamorphine
8 on Dryad ward.
9
10 November 1998 Complaint 3 (MRS P)
11 Medical and nursing care. Diamorphine usage
12 on Dryad ward.
13 This complaint was reviewed by the Health
14 Service Commissioner
15
16 December 1999 Complaint 4 (MR S)
17 Quality of nursing care on Deadalus.
18
19 January 2000 Complaint 5 (MRS D)
20 Clinical care, including use of sedation and
21 communication with family on Dryad ward.
22 This complaint was reviewed by an Independent
23 Review Panel
24

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1 June 2000 Complaint 6 (MRS G)
2 Nursing care and pain relief of Dryad ward.
3
4 June 2000 Complaint 7 (MR R)
5 Nursing care and communication on Sultan ward
6
7 August 2000 Complaint 8 (MRS W)
8 Care received on Sultan ward
9
10 May 2001 Complaint 9 (MRS H)
11 Transfer arrangements from acute hospital to
12 Sultan ward.

13

14 *Complaint Handling*

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

24

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

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

20

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

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

10

11 *Trust Learning*

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

22

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

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

5

6 - Piloting of pain management charts and prescribing
7 guidance approved in May 2001.

8 - The appointment of a staff grade doctor in September
9 2000.

10 - One additional consultant session in ??(is this true?)

11 - Increase in consultants ward round from fortnightly to
12 weekly from February 1999.

13 - Nursing documentation now clearly identifies prime
14 family contacts and next-of-kin information.

15 - All conversations with families are now documented,
16 supported by training.

17

18 *Monitoring and Trend Identification*

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

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

5

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

14

15 *Findings*

16

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

21

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

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1 patterns of concern and failure highlighted by formal
2 complaints.

3

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

7

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

10

11 *Recommendations*

12

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

16

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

20

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

24

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1 - Increased pharmacy safeguards?

2

3

4

5

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1 **Chapter 10 - Clinical Governance**

2

3 *Introduction*

4 Clinical governance is a framework of systems and processes
5 which NHS organisations establish to deliver high quality
6 patient care. CHI has not conducted a clinical governance
7 review of the Portsmouth Healthcare NHS Trust but has looked
8 at how trust clinical governance systems support continuing
9 and rehabilitative inpatient care of older people at the
10 Gosport War Memorial Hospital. This chapter sets out the
11 framework and structure adopted by the trust between 1998
12 and 2002 to deliver the clinical governance agenda and
13 details those areas most relevant to this terms of
14 reference; risk management including medicines management
15 and the systems in place to allow to staff to raise
16 concerns.

17

18 *Summary*

19 The trust reacted swiftly and appropriately to the
20 principles of clinical governance outlined by the Department
21 of Health in NHS a First Class Service. In September 1998 a
22 paper outlining how the trust planned to develop a framework
23 for clinical governance was shared widely across the trust
24 and aimed to include as many staff as possible. Most staff

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

5

6 District Audit carried out an audit of the trust's clinical
7 governance arrangements in 1998/99. The report, dated
8 December 1999, states that the Trust had fully complied with
9 requirements to establish a framework for clinical
10 governance. The report also referred to the Trust's
11 document "Improving Quality - steps towards a First Class
12 Service" was of a high standard and reflected a sound
13 understanding of clinical governance and quality assurance.

14

15 Whilst commenting favourably on the framework, the District
16 Audit Review also noted the following:

17

18 - The process for gathering user views needed to be more
19 focussed and the process strengthened.

20

21 - The clinical governance loop needed to be closed in
22 some areas to ensure that strategy, policy and
23 procedure resulted in changed/improved practice.

24 Published protocols were not always implemented by

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1 staff; results of clinical audit were not always
2 implemented and re-audited; lessons learnt from
3 complaints and incidents not always used to change
4 practice and that R&D did not always lead to change in
5 practice.

6

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

10

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

17

18 Outcome of this????

19

20 *Structure*

21 The Medical Director took lead responsibility for clinical
22 governance. A Clinical Governance Panel was established as a
23 sub committee of the Trust Board, chaired by the Medical
24 Director. The Clinical Governance Panel was supported a

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1 Clinical Governance Reference Group, whose membership
2 included representatives from each clinical service,
3 professional group, non-executive directors and the chair of
4 the Community Health Council. Five key themes were
5 identified for action at the groups first meeting in October
6 1999: continuing professional development, clinical audit,
7 evidence based practice, patient and user involvement and
8 clinical risk management

9

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

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

22

23 *Risk management*

24 Definition?????

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

13

14 The Trust has an operational policy for "Recording and
15 Reviewing Risk Events". New reporting forms were introduced
16 in April 2000 following a review of the assessment systems
17 for clinical and non-clinical risk. The same trust policy is
18 used to report clinical, non-clinical and accidents. All
19 events are recorded in the Trust's Risk Event Database. The
20 procedure states that this reporting system should also be
21 used for near misses and all drug and medication errors.

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

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1 reported risks. CHI was told on a number of occasions, that
2 risk forms were regularly completed by wards in the event of
3 staff shortages. This is not one of the Trust's Risk Event
4 Definitions.

5

6 *Risk in Elderly Medicine??*

7 *Complete with team*

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

11

12 *Raising concerns*

13 The Trust has had a Whistleblowing policy in place since
14 1998 (*check as version I have is dated Nov 2001*) The policy
15 sets out the process staff should follow if they wish to
16 raise a concern about the care or safety of a patient in the
17 event of other procedures having failed or being exhausted.

18 *???? M - is it good practice to include a NED??*

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

22

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

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

8

9 *Clinical Audit*

10 *Needs to be completed.*

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

15

16 *How structures will be taken forward by the PCT?*

17

18 The Clinical Governance Development Plan for 2001/02 states
19 that the focus for risk management in 2000/01 was the safe
20 transfer of services to successor organisations, with the
21 active involvement of PCTs and PCGs in the Trust's Risk
22 Management Group. Meetings have been held with each
23 successor organisation to agree future arrangements for such

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1 areas as; risk event reporting, health and safety, infection
2 control and medicines management.

3

4 *Findings*

5

6 - That the Trust has responded well to the clinical
7 governance agenda and has a robust framework in place
8 with strong corporate leadership.

9 - That understanding of clinical risk was not universal.

10

11 *Recommendation*

12

13 - That the PCT fully embrace the developments made and
14 direction set by the Trust.

15 - That all staff groups be required to complete risk and
16 incident reports and training put in place to
17 reinforce.

18 - That the clinical governance panel regularly identify
19 and monitor trends revealed by risk reports and ensure
20 appropriate action taken.

21

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