Gosport Investigation

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

Staff interviewed by CHIs investigation team (see appendix D) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance advisor, Max Millet, Chief Executive (until 1.4.02) and Ian Piper Chief Executive (since 1.4.02).

Staff and patients who welcomed the CHI team on to the wards during observation work.

Detective Superintendent John James, Hampshire Constabulary

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

Executive Summary

Introductory Background

CHI has undertaken this investigation as a consequence of 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. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

The police were sufficiently concerned about the care of older people at the War Memorial Hospital, based on information gathered during their investigations, to share their concerns with CHI in August 2001.

Key Findings

In reaching the conclusions in this report, 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

To be completed with team

- Transfer arrangements for patients

To be completed with team

- Responsibility for patient care

To be completed with team

- Culture of care

To be completed with team

Key recommendations

To be completed with team

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 and levels of sedation, together with the culture in which care was provided for older people at the Gosport War Memorial Hospital. These concerns also included the responsibility for clinical care and transfer arrangements with other hospitals.

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. CHI's decision was based on 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 a chronology of events surrounding the death of one patient

provided by the trust. Discussions were also held 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 locally and 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 trust's clinical governance arrangements to support inpatient continuing care 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, consultant geriatrician, Lifespan Healthcare NHS Trust

Julie Miller, CHI Lead Investigations Manager

Maureen Morgan, Independent Consultant and former Community Trust Nurse Director

Mary Parkinson, Lay Member (Age Concern)

Jennifer Wenborne, Independent Occupational Therapist

The team was supported by:

Liz Fradd, CHI Nurse Director, lead CHI director for the investigation

Nan Newberry, CHI Senior Analyst

Kellie-Ann Rehill, CHI Investigations Coordinator

A medical notes review group established by CHI to review anonymised medical notes (see appendix E)

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 A for a list of documents reviewed).

Analysis of views received from over 34 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 B for an analysis of views received).

A five day visit by the CHI investigation team to the Gosport War Memorial Hospital when a total of 59 staff from all groups 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 Daedalus, Dryad and Sultan wards. (See appendix C for a list of all staff interviewed).

Interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (See appendix D for a list of organisations interviewed).

An independent review of anonymised clinical and nursing notes of a random sample of patients who had recently died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this specific piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendix E.

Chapter 2 – Background to the investigation

Events surrounding the CHI investigation

Police investigations

The death of a 91 year old female patient in August 1998 on Daedalus ward led to a complaint to the trust by the family regarding her care and treatment. A daughter of the patient 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, documents 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 manslaughter or any other offence.

The police investigation begun in 1998 was the subject of a complaint to the police by the patient's daughter. A further police investigation was begun in August 1999. Subsequently, in December 2000 a further file was submitted to the CPS concerning the circumstances of the patient's death. In August 2001 the CPS advised that there was

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

Local media coverage in March 2001 resulted in eleven other families raising concerns about the circumstances of their relatives' 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 in the trust in 1998.

In February 2002, 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, the UKCC the trust and the Isle of Wight, Portsmouth and East Hampshire Health Authority.

Action Taken by Professional Regulatory Bodies

General Medical Council (GMC)

The case of one doctor was considered by the Interim Orders Committee of the GMC in June 2001 and following receipt of the police expert witness reports, again in March 2002. This committee has the power to suspend or place conditions on a doctor's registration. Interim orders do not constitute a finding and can be made to protest the public pending an investigation. No suspension order has been made, the GMC are currently deciding whether to proceed further.

United Kingdom Central Council (UKCC) and after 1.4.02 Nursing and Midwifery Council (NMC)

Three nurses were referred to the UKCC's Preliminary Orders Committee in June 2001, which has the authority to ?? the cases were closed. Following receipt of further information from the police, these cases have been reopened and are under investigation by the UKCC's successor body the NMC. *(This paragraph is subject to change and update)*

Complaints to the Trust

There have been ten complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998, the period covered by the CHI investigation. Three complaints between August and November 1998 raised concerns which included the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which

triggered the initial police investigation which was not pursued through the NHS Complaints Procedure.

Action taken by Health Authority

In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people and secondly as the body through which GPs are permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered on hospital premises by GPs. As independent contractors, GPs work to a national contract to provide general medical services to NHS registered patients. GPs are not NHS employees. The health authority maintained a medical list, which allowed GPs to practice. *(RCGP view on how should have supported GP)*

The health authority was made aware, by the police, of their investigation in ???, a number of actions were taken:

(a) In June 2001, the health authority began its voluntary Local Procedure for the Identification and Support of Primary Care Medical Practitioners whose Practice is Giving Cause for Concern. This process was used in

respect of the prescribing practice of a GP who was employed by the trust as a clinical assistant. This could only consider prescribing in general practice. A Performance Steering Group, was convened in line the policy and included representation from the Community Health Council. The Steering Group found no concerns regarding the GP's prescribing in general practice. And therefore did not make a referral to the next stage of the process. *(did they talk to the trust?)*

(b) 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. The health authority contact with CHI was made at the same time the police contacted CHI. CHI then began a screening process to determine whether CHI should initiate an investigation.

© Following receipt of the police expert witness reports in February 2002, the health authority sought and received the voluntary agreement of the former clinical assistant at the Gosport War Memorial Hospital to no longer prescribe certain pain killers (opiates and benzodiazepines) in general practice.

Also in February 2002, the trust sought the voluntary, temporary agreement of the former clinical assistant to no longer admit adult patients to the Sultan (GP) ward of the Gosport War Memorial Hospital.

Action taken by NHSE South East Regional Office

The Regional Offices of the NHSE were responsible, until April 2002, for the strategic and performance management of the NHS, including trusts and health authorities. The South East Regional Office was unable to demonstrate to CHI, a robust system for monitoring trust complaints relating to the Portsmouth Healthcare NHS Trust. The Regional Office first became aware of the police investigation in ?? Serious Untoward Incident reports were completed in April and July 2001 in response to articles surrounding the death of a patient at the Gosport War Memorial Hospital in the media. *(when did RO contact HA? When did trust contact RO?)*

Chapter 3 – National and Local Context

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 that the culture and expectations of 2002 were not necessarily widespread across the NHS in 1998.

The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS National Plan and the Standing Nursing and Midwifery Committee's 2001 report found care to be deficient. Amongst the concerns raised have been, an inadequate and demoralised workforce, poor care environments, lack of seamless care within the NHS and ageism. 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. This chapter explains briefly how the trust has begun to address the requirements of the NSF for Older People. *(must include)*

The Standing Nursing and Midwifery Advisory Committee's 2001 report, which focussed on nursing care for older people in acute settings nationally, found standards of care provided to older people were "mainly deficient". Fundamental aspects of nursing care, such as nutrition, fluids and the meeting of rehabilitation needs were found to be poor. Amongst the suggested reasons for this were lack of clinical leadership, inadequate training and lack of resources. National Essence of Care standards have been published by the Department of Health and widely disseminated to support measures to improve fundamental aspects of care such as nutrition, pressure sores and privacy and dignity.

Trust Background

Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust (PHCT) which was formed in 1994. The

hospital is situated on the Gosport peninsula and has ?? beds. Together with outpatient services and a day hospital, the hospital has beds for older people and maternity. The hospital does not admit patients who are acutely ill, it has neither an A&E nor intensive care facilities. 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.

The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/02 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.

According to census data, the local population is predominantly white (98.5%). The age profile is similar to that of England with the proportion of people over the age of 65 slightly higher than the England average.

Move Towards the Primary Care Trust

PHCT was dissolved on 31 March 2002. Services have been transferred to local Primary Care Trusts (PCTs), including

the Fareham and Gosport PCT which became operational, as a level four PCT, in April 2002. Arrangements have been made for various local PCTs to "host" clinical services on behalf of other organisations. This will not mean that the PCT will commission services of another PCT. The Fareham and Gosport PCT will manage the premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Staff involved in the care of older people, including those working at the Gosport War Memorial Hospital are now employed by the East Hampshire PCT. Further detail of PCT hosting arrangements can be found at appendix F

Portsmouth NHS Healthcare 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 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.

CHI heard that the Trust was well regarded in the local health community and had developed constructive links with the Health Authority and local PCGs. For example in the

lead up to the new PCT, PHCT's Director of Operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the Trust on the Development of Intermediate Care and Clinical Governance. High regard and respect for the staff of the Trust was also commented on by the Local Medical Committee.

Services for Older People

Before April 2002 all services, including acute care, for older people in Portsmouth were provided by the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. All acute services are based in the Queen Alexandra and St Mary's Hospitals, part of the Portsmouth Hospitals NHS Trust. This was an unusual arrangement, though precedents did exist, in Southampton Community Trust for example. Management of services for older people has now transferred to the East Hampshire PCT. In addition to acute care, the department also provides rehabilitation, continuing care, day hospitals and palliative care lin the community. The department works closely with the community hospitals in Fareham, Gosport (the Gosport War Memorial Hospital) and Petersfield who manage the medical and nursing care of continuing care and intermediate care at the Gosport War Memorial Hospital. Until ?? 2000, the Royal Haslar Hospital, a MoD military

hospital on the Gosport peninsula provided acute elderly care to civilians as well as military staff.

Service Performance Management

The principle tool for the performance management of the Fareham and Gosport division was the quarterly divisional review. The division is headed by a general manager, who reported to the chief executive. Divisional management at the trust was well defined, with clear systems for reporting and monitoring clinical governance, complaints and risk. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level. *Look again at elderly med division structure*

In patient services for older people at the Gosport War Memorial Hospital 1998-2002

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. In November 2000 there was a change of use of beds at the hospital to provide community rehabilitation and post acute beds as a result of local developments to develop intermediate and rehabilitation services in the community.

In 1998 four wards admited older patients at the War Memorial Hospital; Dryad, Daedalus, Sultan and Mulberry wards. This is still the case today.

Ward	1998	2002
Dryad	20? Continuing care beds. Patients admitted under the care of a consultant, with some care administered by a clinical assistant.	20 continuing care beds for frail elderly patients and slow stream rehabilitation. Patients are admitted under the care of a consultant.
Daedalus	Trust to complete?? Patients admitted under the care of a consultant, with some care administered by a clinical assistant.	24 rehabilitation beds; 8 general, 8 fast and 8 slow stream (since November 2000). Patients are admitted under the care of a consultant.
Sultan	24 GP beds with care managed by patients own GPs. Patients are not exclusively older patients, care can include rehabilitation and respite care. A ward manager, or sister, manages the ward, which is staffed by trust staff.	As for 1998

Admission criteria

Dryad and Daedalus wards

The current criteria for admission to both Dryad and Daedalus wards, are 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 and require specialist medical and nursing intervention. The

Barthel score is a recognised tool used to measure physical disability. Daedalus patients must require multidisciplinary rehabilitation for strokes and other conditions.

The case note review undertaken by CHI confirmed that the admission criteria for these two wards was being adhered to in recent months.

Sultan ward

There is a comprehensive list of admission criteria developed in 1999, all of which must be met prior to admission. The criteria states that patients must not be medically unstable and no intravenous lines must be in situ. *Check adhered to in case note review*

Elderly mental health

Though not part of the CHI investigation, older patients are also cared for on the Mulberry ward, a 40 bed assessment unit comprising of the Collingwood and Ark Royal wards. Patients admitted to this ward are under the care of an elderly mental health consultant.

Terminology

CHI found considerable confusion, in written information and in interviews with staff, around the terminology describing the various categories of care for older people, for example CHI heard of "stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care". CHI was not aware of any common criteria defining these areas in use at the trust. CHI stakeholder work confirmed that this confusion extends to patients and their relatives.

Findings

Throughout the timeframe of the CHI investigation, CHI saw evidence of strong leadership at corporate and divisional level with a shared set of values. The corporate team was well established and functioned, together with the board, as a cohesive team. The chief executive was accessible to staff and well regarded by staff both within the trust and in the local health economy. Good links had been developed with local PCGs.

CHI considers the divisional management quarterly review process to have been an appropriate method of monitoring the performance of the Fareham and Gosport division. *Alan poss expand?*

There is confusion amongst all groups of staff, which is communicated to patients and relatives, about the purpose of each of the wards caring for older people and the levels of care provided.

Recommendations

The Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by PHCT in order to take the provision of care for older people at the Gosport War Memorial Hospital forward. The PCTs should devise an appropriate performance monitoring tool to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

The findings of this investigation should be used to influence the nature of local monitoring of the National Service Framework for older people which CHI will ultimately study.

Work should be undertaken, at a national level, to establish and promote NHS wide shared understanding of the various terms used to describe levels of care for older people.

Chapter 4 – Quality of Care and the Patient Experience

Introduction

The patient's experience is at the centre of all CHIs work. The term stakeholder is used to define a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation. In the case of hospital care, it includes patients, relatives, carers, staff, unions, voluntary organisations, community health councils, social services, health authorities, GPs, primary care groups and trusts in England, local health groups in Wales. This chapter details CHI's findings following contact with patients and relatives. These findings should be put into the context of the total number of older patients admitted to the Gosport War Memorial Hospital during the period of the CHI investigation.*(include when data refined)* Detail of the methodology used to gain an insight into the patient experience and of the issues raised with CHI are contained in Appendix B.

Patient experience

CHI 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 carried out in two ways. Firstly, stakeholders were invited, through local publicity, to make contact with CHI.

The police also wrote to relatives who had expressed concern to them informing them of the CHI investigation. Views were invited in person, in writing, over the telephone and by questionnaire. A total of 36 patients and relatives contacted CHI during the investigation.

Secondly, CHI made a number of observation visits, including at night, to Daedalus, Dryad and Sultan wards during the site visit week in January 2002, some of which were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed. CHI heard from ward staff that the wards were unusually well staffed that week.

Stakeholder views

CHI heard of a range of experiences of the care of older people from those who contacted CHI, both positive and negative. The most frequently raised concerns were; the use of medicines, the attitude of staff, incontinence management, nutrition and fluids and use of patients own clothing.

Use of medicines

The use of pain relieving medicines was commented on by a number of relatives. One relative commented "she certainly was not in pain prior to transfer to the War Memorial".

Though a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI also received comments that families would have liked more information "doctors should disclose all drugs and why and what side effects are. There should be more honesty".

Attitude of staff

Comments ranged from the very positive "Everyone was so kind and caring towards him in both Deadalus and Dryad wards and "I received such kindness and help from all the staff at all times" 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."

Incontinence Management

A number of stakeholders raised concerns regarding the frequent 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". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.

Patients clothing

Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by families. "They were never in their own clothes". Relatives also thought patients being dressed in other patients clothes as a potential cross infection risk.

Transfer arrangements between local hospitals

Concern was expressed regarding the physical transfer of patients from one hospital to another. Amongst concerns were lengthy waits prior to transfer, inadequate clothing and covering such as blankets during the journey and the method used to transfer a patient "carried on nothing more than a sheet".

During the period of the investigation, the Hampshire Ambulance Service received no complaints relating to the transfer of patients to and from the Gosport War Memorial Hospital.

Nutrition and fluids

Concerns were 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 unsuitable, unappetising food and patients left to eat without assistance. A number of stakeholders commented on untouched food being cleared away without patients being given assistance to eat.

Following comments by stakeholders, CHI reviewed trust policy for nutrition and fluids. The trust conducted an audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy "Feeding People". The trust policy dated 2000 "Prevention and Management of Malnutrition" includes the designation of a lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure 100% compliance. *(check compliance in recent case notes)*. The standards state:

- all patients must have a nutritional risk assessment on admission
- Registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary.
- All staff must ensure that documented evidence supports the continuity of patient care and clinical practice.

- All clinical areas should have a nominated nutritional representative who attends training/updates and is a resource for colleagues.
- Systems should be in place to ensure that staff have the required training to implement and monitor the 'Feeding People' standards.

A second trust audit in 2000, concluded that overall the implementation of the Feeding People standards have been "very encouraging". However, there were concerns about the lack of documentation and a sense of complacency as locally written protocols had not been produced universally throughout the service.

Speech and lang & dietician input from notes review

Outcome of CHI observation work

The CHI team spent time on Dryad, Sultan and Daedalus wards throughout the week of 7 January 2002 to observe first hand the environment in which care was given and the interactions between staff and patients and between staff. Ward staff welcomed the CHI team and were friendly and open. Though CHI observed good evidence of caring and positive ward

environments, a period of observation such as this could be seen as somewhat artificial.

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 Daedalus ward has direct access to a well laid out garden suitable for wheelchair users. The garden has a variety of different textures, a thoughtful way in which to practice walking for patients. There is limited storage space in Daedalus and Dryad wards and as a result the corridors had become cluttered with equipment which was observed as problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe. Photographs of staff and there job titles were also evident on the wards, though were small and may be difficult for people to see with any visual impairment.

Staff

The CHI team saw patients addressed by name in a friendly way and saw examples of good *(how have we assessed this? – team)*patient staff interaction such as help with dressing and friendly conversations. The staff handovers observed were well conducted, held away from the main wards areas, with relevant information about patient care exchanged appropriately.

Mealtimes

Mealtimes were well organised with patients given a choice of menu 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 were not eaten. CHI did not observe any meals returned untouched.

Daytime activities

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 taking place, though some patients did eat together in the day room. Bells to call assistance were available to patients by their beds, though less accessible to patients in the day rooms. The wards do have an

activities co-ordinator, though CHI saw little evidence of any meaningful patient activity.

Patient and relative feedback

Daedalus ward had introduced a notebook system by each bed for patients and relatives to make comments about day to day care, *such as???. Double check with team.*

Confidentiality

CHI had some concern over the treatment of confidential patient information. For example, patient notes were observed in open view of other patients and visitors and information such as individual feeding regimes was taped on the doors of bays in Daedalus ward. *Double check with team*

Administration of medicines

Any evidence??

Findings

Relatives speaking to CHI had some very real concerns about the care their relatives received on Deadalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their peak in 1998. Fewer concerns

were expressed regarding the quality of care received on Sultan ward.

Table to show the wards and dates of which concerns about care were raised by stakeholders

	1998	1999	2000	2001
Daedalus	7	3	2	1
Dryad		1		
Sultan	1		3	
TOTAL	**8**	**4**	**5**	**1**

- The ward environments and physical care of patients observed by the CHI team was of good quality.

- Some notable steps had been taken to facilitate communication between patients and their relatives with ward staff.

- Though the trusts own audit of the "Feeding People" standards indicated good progress, concerns remain amongst stakeholders regarding levels of nutrition and fluids. Local guidelines have not yet been developed at the Gosport War Memorial Hospital.

- There are no local guidelines for the management of incontinence.

- Daytime activity to encourage self awareness and promote confidence available to patients is limited on all three wards.

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

Recommendations

- That all patient complaints both informal and formal, should be an item on all monthly ward meeting agendas. The service manager should coordinate shared learning amongst wards. Systems should be explored such as the notebook system used to record patient and relatives comments in use on Deadalus ward should be extended to all elderly care wards and emerging themes fed into monthly ward meetings.

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- That, as a priority a system is established by the PCT to replace the current quarterly divisional review process to ensure that the identification of any trends in all patient complaints.

- The role of the activities coordinator should be revised and strengthened through input from patients, occupational therapy and physiotherapy in order to increase daytime activities for patients.

- The PCT must work with patients and relatives to develop local guidelines for the management of incontinence and nutrition, addressing the experience of patients and carers.

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- That the PCT's Caldicott Guardian leads a review of patient confidentiality.

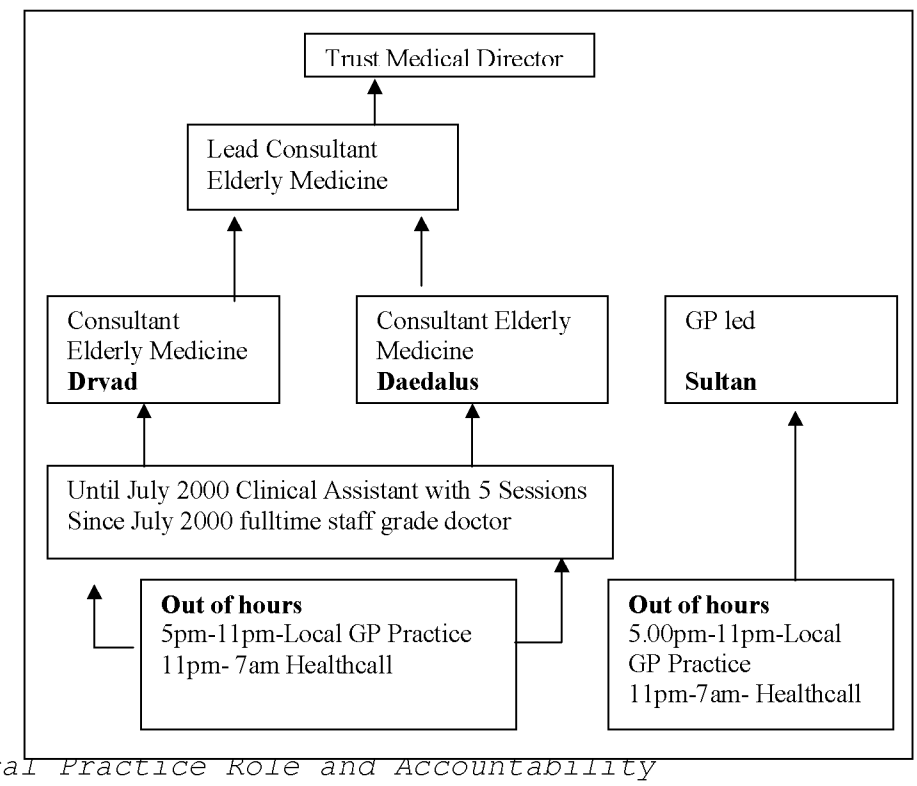
Chapter 5 – Staffing Arrangements and Accountability for Patient Care

Medical Staff Accountability

Medical accountability for the care of older people in Daedalus and Dryad wards lays with the named consultant. Currently, there is a lead consultant for Elderly Medicine who holds a two session (one session equates to half a day per week) contract for undertaking lead consultant responsibilities. The post holder does not undertake any sessions on the War Memorial site. The job description for the post, dated February 1999, outlines twelve areas for this clinician to manage and states that the post is a major challenge for "a very part time role".

In addition, *since ?* two elderly medicine consultants provide 10 sessions in total of consultant cover on Dryad and Daedalus wards. Both consultants report to the lead consultant and undertake a weekly ward round with the staff grade doctor. CHI heard that ward rounds in 198 were less frequent on Dryad ward. All patients on both wards are admitted under the care of a consultant. Junior medical support is provided by a staff grade physician employed since September 2000 who is accountable to both consultants.

CHI considers that there is potential for isolation of the staff grade doctor, due to the low levels of consultant input on Daedalus and Dryad wards and the distance of the War Memorial Hospital from the hub of the department of elderly medicine based at Queen Alexandra Hospital in Portsmouth. The trust recognised this in 2001 in the document which outlines action taken following complaints and patient based incidents " A decision was taken not to employ a locum consultant because of the risk of professional isolation and support in Gosport". *What did they do about this?*



General Practice Role and Accountability

Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation; as

clinical assistants, as the clinicians admitting and caring for patients on the the GP (Sultan) ward and as providers of out of hours medical support on each of the three wards.

Clinical Assistant Role

Clinical Assistants are GPs who hold contracts with trusts to provide, largely part time, medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years, the PHCT employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants have the same responsibilities as hospital doctors to admit and discharge patients, to prescribe medication, write in the medical record and complete death certificates.

A Clinical Assistant was employed for five sessions since 1994 until the post holder resigned in July 2000. The fees for this post when the clinical assistant was appointed in 1994 ? were £2,810 per annum for each session, per annum as set out in the job description. The job description refers only to work in the Day Hospital and does not specify to whom the post holder is responsible. Cover for annual leave and any sickness absence was the responsibility of the post holder to arrange with practice partners, with whom the trust did not have a contract for this purpose.

Do we need a paragraph outlining Dr B's growing concern over workload and a comment about the inadequate payment?

CHI is not aware of any trust systems in place to monitor or appraise the performance of the clinical assistant, nor of any formal lines of communication regarding policy development, guidelines and workload. The job description does state that the post is subject to the Terms and Conditions of Hospital Medical and Dental Staff, if identified, poor performance could have been investigated through the trust's disciplinary processes. This process was not followed in relation to any staff involved in the care of older people.*(is this true/sufficient? What is our view?)*

Sultan Ward

Medical responsibility for patients on Sultan ward lies with the admitting GP. The trust issued admitting GPs with a contract for working on trust premises, which describes very little about the GPs role. CHI was told that GPs visit their patients regularly and when requested by nursing staff. This is a common arrangement in community hospitals

throughout the NHS. GPs have no medical accountability framework within the trust.

GPs managing their own patients on Sultan ward could be subject to the Health Authorities voluntary process for dealing with doctors whose performance is giving cause for concern. However, this procedure can only be used in regard to their work as a GP, and not any contracted work performed in the trust as a clinical assistant or as a GP on Sultan ward. Again, this arrangement is common throughout the NHS. *Are we sure? Any BMA/RCGP guidance?*

Out of Hours Cover Provided by GPs

Between the hours of 9.00am and 5.00pm hospital doctors employed by the trust 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 5.00pm to 11.00pm (*to whom are they responsible?)* after which nursing staff call on Healthcall, a local deputising service for medical input between 11.00pm and 7.00am. *check 7am-9am gap* Staff interviewed by CHI on all wards expressed concern regarding long waits for the Healthcall service. It was suggested that waiting times for Healthcall to attend to a patient could sometimes take between 3-5 hours. However, evidence provided by Healthcall

contradicts this. There is no system to report long waits. The Healthcall contract is managed by the Director of Personnel and does not include any performance standards *(still to see contract)*

There was also concern over Healthcall GPs reluctance to "interfere" with admitting GPs prescribing on Sultan wards. This was also evident on Dryad ward where staff commented on out of hours GPs declining to interfere with established pain management care *(discuss with BT)* which could include strong analgesics. *(confirm with case note review)*

In an emergency situation, staff on all wards call 999 for assistance

Hampshire Ambulance Service Trust
Emergency Incidents Origniating at Gosport War Memorial Hospital
Reference period :- 01/04/2000 to 28/02/2002 (23 months)
Note. The current system has only been operational from mid March 2000

Ward/department Distribution	Number
Daedalus Ward	11
Dryad Ward	2
Sultan Ward	28

Hampshire Ambulance Service NHS Trust 2002

Insert commentary on table with team

Medical Supervision

Since, April 2000, all NHS employers have been contractually required to carry out annual appraisals, covering both clinical and non-clinical aspects of their jobs.

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. *How do the GPs fit in here? Dr B exempt as left June 2000.*

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. This post was created in November 2000. 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. An accountability structure such as this is not unusual in a community hospital.

?chart here to explain structure

Nursing supervision

Insert definition from MP??

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 being to ensure that staff had access to good systems of clinical support to enhance their practice. As part of the Trust's 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 long term 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.

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 wards, with less clear arrangements on Dryad ward which may be due to long term senior ward staff sickness. *(do we mean ward meetings here or supervision meetings?)*

Allied Health Professional Structures

Allied Health Professionals (AHP's) are a group of staff which include occupational therapists, dieticians, speech and language therapists and physiotherapists. The occupational therapy structure is in transition from a traditional site based service to staff providing defined clinical specialty (e.g. stroke rehabilitation) in the locality. All referrals are received centrally. Staff explained that this system enables the use of specialist clinical skills and ensures continuity of care of patients, as one occupational therapist follows the patient throughout hospital admission(s) and at home. Occupational therapists talking to CHI described a good supervision structure, with supervision contracts and performance development plans in place.

Physiotherapist Structure

Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right

through to home treatment. Physiotherapists illustrated good levels of training and supervision and involvement in multi-disciplinary team meetings on Daedalus ward.

Speech and Language Therapists

Speech and language therapists also reported participation in multi-disciplinary team meetings on Daedalus ward. Examples were given to CHI of well developed in service training opportunities and professional development such as discussion groups and clinical observation groups.

Dietetics

The staffing structure consist of one full time dietician (based ??) Each ward has a nurse with lead nutrition responsibilities to offer advice to colleagues on request. *Training to support this role??*

Workforce and service planning

In preparation for the change of use of beds in Dryad and Daedalus wards in November 2000, from continuing care to intermediate care, the Trust undertook an undated resource requirement analysis. This identified three risk issues;

(i) consultant cover

(ii) medical risk with change in client group and the likelihood of more patients requiring specialist intervention. The trust believed that the introduction of automated defibrillators would go some way to resolve this. The paper also spoke of "the need for clear protocols….within which medical cover can be obtained out of hours".

(iii) the trust identified a course for qualified staff, ALERT, a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration.

Despite this preparation, several members of staff expressed concern regarding the complex needs of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages, with high sickness levels. *check evidence here*. Concerns were raised formally by the clinical assistant in early 2000 around the increased workload and complexity of patients, which were acknowledged by the Medical Director, though CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix.

Staff welfare

The trust developed an approach of being a caring employer, demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy which has won national recognition. The hospital was awarded Investors in People status in 1998. Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship.

However, 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. Trust managers told CHI of their encouragement of staff to use the trust's counselling service and of organised support sessions for staff. Not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, "I don't feel I've had the support I should have had before and during the investigation-others feel the same"

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, an occupational therapist. No junior staff were present. Access to social work input was described as patchy *(check evidence)* All professions keep separate patient notes. Both physiotherapists and speech and language therapists spoke of involvement in multi disciplinary team meetings.

Arrangements for multi-disciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multi-disciplinary goal setting for patients, such as targets working towards making a cup of tea, though they wished to see more development.

Social Services (one further interview planned)

Joint planning arrangements, involvement in discharge planning. Community Enabling Scheme. Good OT relationships, joint visits. Senior OT due to be seconded to social services for two days per week to enhance joint working and continuity of care. MDT meetings – often not have input from social services – little continuity. Funding assessment and care package delays.

Access to specialist advice

Older patients are admitted to Gosport War Memorial Hospital with a wide variety of physical and mental health conditions such as strokes, cancers, dementia and Alzheimers. Staff demonstrated good examples of systems in place to access expert opinion and support. There are supportive links with palliative care consultants, consultant psychiatrists and oncologists. The lead consultant for elderly mental health reported close links with the three wards, with patients either given support on the ward or transfer to an elderly mental health bed. There are plans for a nursing rotation programme between the elderly medicine and elderly mental health wards.

A joint palliative care booklet, published jointly in 1998 with PHCT, the Portsmouth Hospitals NHS Trust and a local hospice have published a palliative care booklet which staff are aware of and use. The booklet includes a number of guidelines on clinical management, including symptom management, psychological and spiritual care and bereavement. Staff spoke of strong links with the Rowans hospice and MacMillian nurses. Nurses gave recent examples of joint training with the hospice in the use of syringe drivers.

CHIs audit of recent case notes indicated that robust systems are in place for both specialist medical advice and therapeutic support.

Findings

- The trust now has clear accountability and supervisory arrangements in place for trust doctors, nurses and AHP staff. Currently, there is effective nursing leadership on Daedalus and Sultan wards, this is less evident on Dryad ward. The trust has a well developed supervision and appraisal systems for all directly employed staff. CHI was concerned that the position of the staff grade doctor could be seen as professionally isolated.

- Systems are now in place to ensure that appropriate specialist medical and therapeutic advice is available for patients. Some progress has been made towards multi-disciplinary team working which should be developed.

The trust did not have any systems in place to monitor and appraise the performance of the clinical assistant working on Daedalus and Dryad wards. The clinical assistant was allowed to practice without adequate supervision arrangements. There remains a lack of

clarity regarding the medical accountability of GPs admitting to the Sultan ward and those providing out of hours cover. CHI was unclear how such GPs are included in the development of trust policy and clinical governance arrangements.

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

- The trust should be congratulated for it progress towards a culture of reflective nursing practice, though it was unclear how this was intended to directly improve patient care.

- The trust had a strong staff focus, with some notable examples of good practice. Despite this, CHI found evidence to suggest that not all staff were adequately supported during the police and other recent investigations.

- Out of hours medical cover for the three wards out of hours is inadequate and does not reflect current levels

of dependency. *Tie in with commentary on 999 evidence with team??*

Recommendations

- National guidelines for employing trusts and for GPs working as clinical assistants and those admitting patients to for GPs working on GP led wards should be developed by the Royal College of general Practitioners.

- The provision of out of hours medical cover should be reviewed. Should a contact be agreed with a deputising service, advice must be taken from the British Medical Association and PCT staff to ensure a shared philosophy of care, adequate payment, waiting time standards and a disciplinary framework are included in the contract.

- The new PCT responsible for the provision of care of older people should undertake a case-mix review of patients admitted to Dryad, Daedalus and Sultan wards to determine if higher dependency patients are being admitted and if so, to address any increased care needs and potential risks to good quality patient care.

- The findings of such a case-mix review should be used to inform a review of the provision of out of hours medical cover.

The PCT should ensure that arrangements are made to ensure strong, long term, nursing leadership on Dryad ward.

Chapter 6 - Arrangements for the prescription, administration, review and recording of medicines

Medicine useage

In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamporphine, fentanyl patches, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Diamorphine is a controlled drug. This information has been plotted against the total number of admissions for the relevant year. The detailed breakdown of medicines for each ward is attached at appendix H. Some of the medicines used in the care of older people can be delivered by a syringe driver which delivers a continuous subcutaneous infusion.

Police expert witness reports describe the excessive use of these medicines.

This is where we need to insert a summary of police witness findings

CHI was told that concerns had been expressed to a ward sister by nurses?? *Check evidence v carefully* on Dryad ward

in ?? regarding the amount of morphine given to patients, the range of prescription and the use of syringe drivers. These concerns were not followed through outside of the ward. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998.

Commentary on case note review findings

Assessment and management of pain

The Trust's policy for the assessment and management of pain was introduced in April 2001 in collaboration with Portsmouth Hospitals NHS Trust 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 rationale 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 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 evaluate 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 by nursing staff that following the introduction of the policy, it was now taking longer for patients to be made pain free and that there was a timidity amongst medical staff about using diamorphine. Nurses also spoke of a reluctance of some patients to take pain relief. CHIs case note review concluded that two of the fifteen patients reviewed were not prescribed adequate pain relief for part of their stay in hospital. *Is this in line with any identified national trend?*

CHIs review of random case note review of recent admissions concluded that the pain assistance and management policy was being adhered to. We also need to check in medical notes review if there are mechanisms in place to distinguish discomfort from pain??

Other prescribing guidelines in use

Many staff interviewed referred to the "Wessex" palliative care guidelines (explained in paragraph??) which are in general use on the ward. Though the section on pain only refers to patients with cancer, there is a clear highlighted statement on the opening page which states that "All pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold".

The guidelines are comprehensive and include detail, in line with British National Formulary recommendations, *(need to check)* on the use, dosage, and side effects of drugs commonly used in a palliative care environment. *(Tony – do we need to describe the ranges and make a comment as to whether this was adhered to in 1998 & in recent notes?)*

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 medicines.

The policy also covers a section on verbal orders. Telephone orders for single doses of medicines can be accepted over the telephone by a registered nurse if the doctor is unable to attend the ward. According to UKCC guidelines (October 2000), this is only acceptable where the, "the medication has been previously prescribed and the prescriber is unable to issue a new prescription. Where changes to the dose are considered necessary, the use of information technology (such as fax or e-mail) is the preferred method. The UKCC suggests a maximum of 24 hours, in which a new prescription confirming the changes should be provided. In any event, the changes must have been authorised before the new dosage is administered. "CHI understands that arrangements such as these are common practice in GP led wards and work 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 anticipatory prescribing of palliative opiates. As a result of the pain and assessment policy, this practice has now stopped *(confirm with case note review)* CHI understands that one of the people who initiated this change of practice was the staff grade physician appointed in September 2000, who had expressed concern over the range of anticipatory doses prescribed on the wards, based on knowledge gained elsewhere.

Administration of medication

Medication can be administered in a number of ways, orally in tablet form, by injection and via a syringe driver *(check out terminology with team).* 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. *Confirm with evidence from case note review being adhered to*

Role of nurses in medicines administration

Registered Nurses are accountable for their own practice in the administration of medicines and have a professional responsibility to adhere to the Code of Professional Conduct (UKCC June 1992), The Scope of Professional Practice (UKCC

June 1992) and to the Standards for the Administration of Medicines (UKCC October 1992).

Members of the CHI team were present on a ward during a medicine round and found….

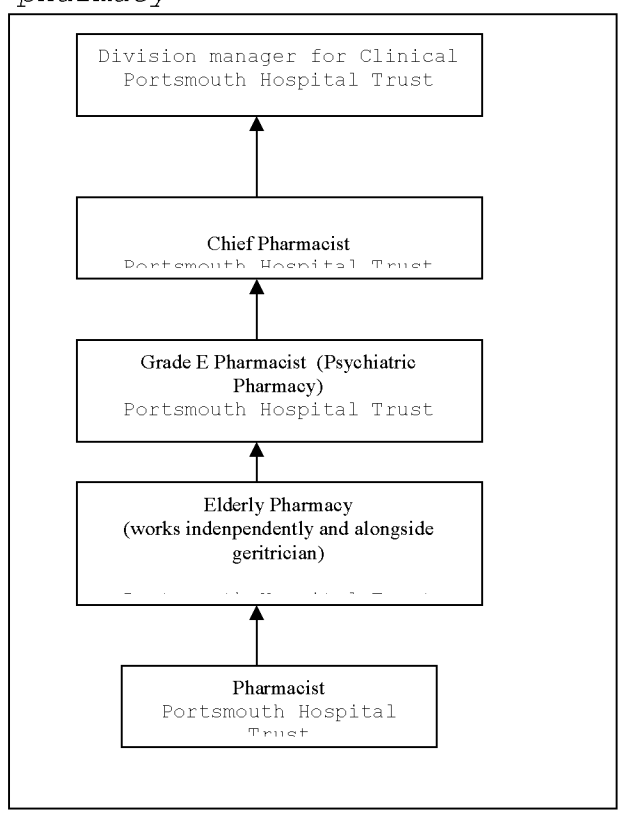
Information provided by the Trust indicates that two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five nurses had also completed a drugs competencies course. No qualified nurses from either Dryad or Deadalus ward had taken part in either course between 1998 and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

Review of medication

In November 1999, a review of the use of neuroleptic medicines, which are major tranquillisers such as haloperidol *(does this include midazolam?)*, within all trust elderly care continuing care wards concluded that neuroleptic medicines were not being over prescribed. The same review revealed that "the weekly medical review of medication was not necessarily recorded in the medical notes". The findings of this audit and the accompanying

action plan, which included guidance on completing the prescription chart correctly, was circulated to the clinical assistant and Dryad and Daedalus wards. A copy was not sent to Sultan ward. There was a re-audit in January 2000, when it was concluded that ??? (*trust asked for copy)*

Structure of pharmacy



Findings

- CHI has serious concerns regarding the quantity, combination and lack of review of medicines prescribed to older people on Dryad and Deadalus wards in 1997/98. This is based on the findings of police expert witnesses and pharmacy data provided for the wards.

- Concerns raised by staff regarding the amounts of drugs administered via syringe driver in 1998 did not lead to any prescribing review of change in practice.??

- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Though the palliative care "Wessex" guidelines refer to non-physical symptoms of pain, the polices themselves do not include methods of non-verbal pain assessment and rely on the patient articulating when they are in pain.

- Pharmacy support to the wards in 1998 - ?? was inadequate. The inavailability of electronic pharmacy data could compromise the trust's ability to monitor prescription of medicines.

Recommendations (these need more work with team and case note review group)

- Role of pharmacy?
- Adequacy of syringe driver policy?

Chapter 7 - Communication

The chapter considers how the trust communicated with and established relationships with its patients and relatives, its staff and the wider NHS.

Patients, Relatives and Carers

The trust has an undated "User Involvement in Service Development Framework", which sets out the principles behind effective user involvement within the national policy framework. It is unclear from the framework who was responsible for taking the work forward and within what timeframe. The framework states that each service should have formal links with local user support groups. CHI was not aware of any such links within the elderly medicine service at Gosport War Memorial Hospital. Given the dissolution of the Trust, a decision was taken not to establish a trust wide Patient Advocacy and Liaison Service (PALS), a requirement of the NHS National Plan. However, work was started by the trust to look at a possible future PALS structure for the PCT.

The Health Advisory Service 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". CHI saw a number of separate information leaflets provided for patients and relatives during the site visit.

The trust uses patient surveys as part of its patient involvement framework. This was also one of the action points arising from a complaints workshop in February 2001. Surveys are given to patients on discharge, the response rate is not known. Issues raised by patients in completed surveys are addressed by action plans discussed at clinical managers meetings. Ward specific action plans are distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, thermometers were purchased by the ward to address the problem. *Are surveys reported to the Board/are finding shared across the trust?*

Communication Towards the End of Life

Staff again spoke of the "Wessex" palliative care guidelines in use on the wards which talks about breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute

sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure at Portsmouth Hospitals NHS Trust hospital, Queen Alexandra and St Mary's Hospitals to discharge patients too quickly to the Gosport War Memorial Hospital. Staff were aware of more medically unstable patients being transferred in recent years.

Staff

Most staff interviewed by CHI spoke of good internal communications, and were well informed about the transfer of services to PCTs. The trust used newsletters to inform staff of key developments. An intranet is being developed to facilitate communication with staff.

Nursing homes

CHI talked to staff from the nursing homes which most frequently receive patients from the Gosport War Memorial Hospital. Nursing home staff spoke of good, collaborative relationships with ward staff. Patients admitted into local nursing homes recently, were thought by staff to have been well cared for at the Gosport War Memorial Hospital. No concerns were raised with CHI regarding skin integrity (pressure sores) and nutritional status for example.

Findings

- CHI found evidence of good communication within the trust, both with staff and partner organisations in the local health community.

- CHI found a strong theoretical commitment to patient and user involvement which was not always demonstrated by the actual engagement of patients and users to influence strategic development and change.

Recommendations

- The PCTs must find ways to continue the staff communication developments made by the PHCT.

- Within the framework of the new PALS, as a priority, the PCT should consult with user groups, and consider reviewing specialist advice from national support groups, to determine the best way to communicate with older patients and their relatives and carers.

Chapter 8 – Complaints

A total of 129 complaints were made regarding elderly medicine since 1.4.97 (*need to ask trust to provide from 1.1.98)*. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra Hospitals. In addition, CHI was told that over four hundred letters of thanks had been received by the three wards during the same period.

The trust forwarded details of the ten complaints made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards since 1998. A number of the complaints raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death. Three such concerns were raised in the last five months of 1998. The clinical care surrounding Complaints 1 and 2 were also considered by the expert witnesses commissioned by the police.

Complaint 3 was referred to the Health Services Commissioner (Ombudsman) whose medical advisor found the choice of pain relieving drugs appropriate in terms of medicines, doses and administration. Complaint 5 was referred to an Independent

Review Panel (IRP), which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Though the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

The trust's 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. Insert *comment on acceptability of that range from notes review group??*

(Initials must be removed in later drafts)

August 1998 Complaint 1 (MRS R)
Care and treatment on Daedalus ward (concerns subsequently raised with police regarding use of pain relief). This complaint was pursued through the NHS complaints procedure.

October 1998 Complaint 2 (MR C)
Use of syringe driver to deliver diamorphine to a patient on Dryad ward.

November 1998 Complaint 3 (MRS P)
Quality of medical and nursing care and diamorphine usage on Dryad ward. This complaint was reviewed by the Health Service Commissioner as outlined above.

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

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

June 2000 Complaint 6 (MRS G)
Nursing care and pain relief given to a patient on Dryad ward.

June 2000 Complaint 7 (MR R)
Nursing care and communication with family (*check*)on Sultan ward

August 2000 Complaint 8 (MRS W)
Quality of care received by a patient 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. (*has it been reviewed?)* A leaflet for patients detailing the various stages of the complaints procedure was produced, though this was 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 November 2000, prevented them from offering the level of advice and active support services to trust complainants they would have wished.

CHI found that letters to complainants in response to their complaints did 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 were responded to by the Chief Executive. Staff interviewed by CHI valued the Chief Executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services. *Check what board/divisional review process aware of?*

Once the police became involved in Complaint 1, the trust ceased internal investigation processes. CHI found no evidence in board agendas to suggest that the trust board were formally made aware of police involvement. One senior trust manager told CHI that the trust would have commissioned an internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not need to preclude an internal clinical investigation. The GP Clinical Assistant involved in the care of this patient wrote to the trust's quality manager expressing concern that she only discovered Complaint 1 had been made by chance three months later. Neither the Clinical Assistant nor portering staff involved

in the transfer of the patient were asked for statements during the initial trust investigation of this complaint.

Trust Learning

Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter??), though 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 connect the police investigation, the review of the Health Service Commissioner and the Independent Review Panel, 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 issues 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 since the series of complaints in 1998 are as follows:

- An increase in consultants ward round on Daedalus ward, from fortnightly to weekly from February 1999.

- The appointment of a staff grade doctor in September 2000.
- Piloting of pain management charts and prescribing guidance approved in May 2001. Nursing documentation is currently under review, with nurse input.
- One additional consultant session in ?? following a district wide initiative with local PCGs around intermediate care.
- Nursing documentation now clearly identifies prime family contacts and next-of-kin information to ensure appropriate communication with relatives.
- All conversations with families are now documented in the medical record.

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.

Findings

- The trust did not use the issues raised by complaints made between 1998 and 2001 as a trigger for any internal review of prescribing within the Gosport War Memorial Hospital.
- The trust had a robust system, through the Divisional Review process, supported by the clinical governance framework, to identify and address patterns of concern and potential failure to ensure high quality patient care
-
- Changes to increase the level of medical input on Daedalus and Dryad wards have been effected. Changes to improve and record communication with relatives have been made by the trust as a direct result of patient complaints.

- Systems are not yet in place to ensure that the impact of these changes have been robustly monitored and reviewed.

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

- Whole issue of difficult complainants???take forward with team.

Recommendations

That CHI work with the Association of Police Officers to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible. CHI will also work with the Association of Police Officers to develop police awareness of the NHS and its management and accountability structures.

That CHI work with the National Patients Safety Agency to produce guidelines for the NHS to ensure that information which could signal potential patient safety issues are identified as soon as possible.

- That any trends demonstrating serious concern, within individual NHS organisations, which emerge from the prescription of any medicines be referred immediately to the National Patients Safety Agency.

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

- That the relevant PCT, through it's appraisal and personal development planning process, ensures that all staff working on these three wards, who have not attended customer care and complaints training events do so.

- Increased pharmacy safeguards?

Chapter 9 – Clinical Governance

Introduction

Clinical governance is about making sure that health services have systems in place to provide patients with high standards of care. The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems support the delivery of continuing and rehabilitative inpatient care for 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 the terms of reference for this investigation; risk management including medicines management and the systems in place to enable staff to raise concerns.

Summary

The trust reacted swiftly to the principles of clinical governance outlined by the Department of Health in NHS a First Class Service by devising an appropriate framework. In September 1998 a paper outlining how the trust planned to develop a system for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff interviewed by CHI were aware of the principles of clinical governance and were able to demonstrate how it related to them in their individual roles. Understanding of some specific aspects, particularly risk management and audit was patchy.

Clinical Governance Structures

The Medical Director took lead responsibility for clinical governance and chaired the Clinical Governance Panel, a sub committee of the Trust Board. The Clinical Governance Panel was supported by a Clinical Governance Reference Group, whose membership included representatives from each clinical service, professional group, non-executive direjctors and the chair of the Community Health Council. Each clinical service also had its own Clinical Governance Committee. This structure had been designed to enable each service to take clinical governance forward into whichever PCT it found

itself in after April 2002. The trust used the divisional review process to monitor clinical governance developments.

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" which was described as "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 should 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 regarding 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 to be inserted????*

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 attended 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 South East Regional Office in March 2001 (*RO have not sent their response)*

Risk management

A Risk Management group was established by the Trust in ?? to develop and oversee the implementation of the 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 achieved the Clinical Negligence Scheme for Trusts (CNST) level 1 in 1999, a decision was taken by the Trust, due to pending dissolution in 2002, not to pursue the level 2 standard.

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 (CAREKEY). The procedure states that this reporting system should also be used for near misses and medication errors. Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, though CHI was less confident that medical staff 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.

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.

Systems for reporting medication errors and near misses

To be completed with team.

Raising concerns

The Trust has a Whistleblowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. 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. NHS guidance requires systems to enable concerns to be raised outside of the usual management chain. The trust policy informs staff that they can use the Whistleblowing process when staff have concerns "that cannot be resolved be resolved by the appropriate procedure".

Most staff interviewed were clear of how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. There was less certainty around the existence of the Trust's Whistleblowing Policy.

Clinical Audit

Needs to be completed.

CHI heard of no demonstrable examples during interviews with staff of positive changes in patient care as a result of clinical audit outcomes. *Check, was falls policy an outcome?* Despite a great deal of work on revising and

creating policies to support good prescribing, there has been no planned audit of outcome.

Findings

- That the trust has responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

- That although a robust system is in place to record risk events, understanding of clinical risk was not universal. The trust did have a Whistleblowing policy in place. However, this did not make it explicitly clear that staff could raise concerns outside of the usual management channels if they felt unable to raise concerns in this way.

Recommendations

- That the relevant PCT fully embrace the clinical governance developments made and direction set by the Trust.

- That all staff groups be required to complete risk and incident reports. Training must be put in place to

reinforce the need for rigorous risk management. 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 considers a revision of the Whistleblowing policy to make it clear that concerns may be raised outside of normal management channels.

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