Gosport Investigation

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

CHI believes that the use of diamorphone and the combination of medicines with a sedative effect administered to patients in 1998 was excessive and outside of accepted practice. There had been no trust policies in place to ensure the correct use of an "analgesic ladder", patients had been administered strong opiate analgesia on admission. There had been a practice of anticipatory prescribing of high dose ranges of medicines , with discretion given to nursing staff to administer as required.

The Portsmouth Healthcare NHS Trust (PHCT) failed to act on the triggers provided four years ago, in 1998, by a police investigation, a pattern of patient complaints and the trust's own pharmacy data to undertake an immediate review of prescribing practice on the wards caring for older people.

The PHCT has since, 2001 a policy in place relating to the assessment of pain. This includes guidance on appropriate prescribing. Following a review of the case notes of patients in late 2001 and early 2002, CHI believes that appropriate prescribing is now being undertaken and anticipatory prescribing is no longer happening. The trusts own review ?????

CHI found no trust system for reviewing the performance of clinical assistants and unsatisfactory supervision arrangements. CHI understands that appraisal systems for GPs acting as clinical assistants are still in their infancy within the NHS but considers that the concerns around prescribing on these wards were significant enough to have initiated such a review of practice.

There was confusion at both ward and senior management level, echoed nationally, around the terminology and expectations of the range of care offered to older people.

CHI found a well structured and motivated senior managerial team which demonstrated a strong emphasis on staff welfare and development. Good, patient quality based local performance review mechanisms were in place throughout the trust. The principles of clinical governance and reflective nursing practice had been developed to deliver improved patient care.

Chapter 1 - Terms of reference and process of the investigation

During the summer of 2001, concerns were raised with CHI about the use of some medicines, particularly analgesia and levels of sedation, and 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 and rehabilitation care 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
Dr Mary Parkinson, Retired GP and 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, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (See appendix A for a list of documents reviewed).

Analysis of views received from 36 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. A further police investigation was begun in August 1999. Subsequently, in December 2000 further information 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. The police decided to refer four of these 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, 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 is currently being reconsidered by the GMC, no interim suspension order has been made. Status of Dr Lord referral?

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 suspend nurses, 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. 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, in 1998, 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. A number of actions were taken:

(a) In June 2001, the prescribing practice of a local GP was reviewed through the health authority voluntary Local Procedure for the Identification and Support of Primary Care Medical Practitioners whose Practice is Giving Cause for Concern. No concerns were found. *(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 changes

in relation to the prescription of certain pain killers (opiates and benzodiazepines) in general practice.

Action taken by NHSE South East Regional Office

For the period of the investigation, the Regional Offices of the NHSE were responsible, 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 which would have demonstrated an awareness of local concerns. 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

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 national 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.

National standards, called Essence of Care published in 2001, provide benchmarks for assessing nursing practice against fundamental aspects of care such as nutrition, pressure sores and privacy and dignity. These have been produced by the Department of Health as an audit tool to ensure good practice and have been widely disseminated across the NHS.

Trust Background

Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust (PHCT) between April 1994 and April 2002. The hospital is situated on the Gosport peninsula and has 113 beds. Together with outpatient services and a day hospital, there are beds for older people and maternity services. 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.

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 nursing staff, premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Medical 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 trust staff was also commented on by the Local Medical Committee, UNISON and the RCN.

Local Services for Older People

Before April 2002, all services for older people in Portsmouth, including acute care, rehabilitation and continuing care were provided by the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. Acute services are based in the Queen

Alexandra and St Mary's Hospitals, part of the Portsmouth Hospitals NHS Trust. Though an unusual arrangement, precedents for this model of care did exist, in Southampton Community Trust for example. Management of all services for older people has now transferred to the East Hampshire PCT. Until August 2001, the Royal Hospital Halsar, a Ministry of Defence military hospital on the Gosport peninsula also provided acute medical care to older 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, which considered regular reports on clinical governance, complaints and risk. The division was led by a general manager, who reported to the chief executive. Divisional management at PHCT was well defined, with clear systems for reporting and monitoring. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level.

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 admitted 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 provided 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. Day to day care is provide by a staff grade doctor.
Daedalus	Trust to complete?? Patients admitted under the care of a consultant, with some care provided 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. Day to day care is provided by a staff grade doctor.
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 was staffed by PHCT staff.	As for 1998, though since April 2002, staff now employed by a PCT.

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 validated 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, appropriately admitted patients were being cared for.

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. CHI found examples of some recent patients who had been admitted with more complex needs than stipulated in the admission criteria.

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 a consultant in elderly mental health.

Terminology
CHI found considerable confusion, in written information and in interviews with staff, around the terminology describing the various levels 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 relatives in terms of their expectations of the type of care which will be received.

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 senior management team was well established and functioned, together with the trust 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.

There is lack of clarity 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.

The Department of Health should assist in the promotion of an 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. This chapter details CHI's findings following contact with patients and relatives which should be put into the context of the total number of 1725 finished consultant episode's (FCE's) for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. 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.

Stakeholder views

The term stakeholder is used by CHI to define a range of people that are affected by, or have an interest in, the services offered by an organisation. 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 with CHI were; the use of medicines, the attitude of staff, incontinence management, nutrition and fluids and use of patients' own clothing. More detail on each of these areas is included below.

Use of medicines

The use of pain relieving medicines and the use of syringe drivers to administer them was commented on by a number of relatives. One relative commented that her mother "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 "I got the feeling she had dementia and her feelings didn't count."

Incontinence Management

Continence management is an important aspect of the care of older people, the underlying objective is to promote or sustain continence as part of an holistic assessment including maintaining skin integrity (prevention of pressure sores). Where this is not possible, a range of options, including catheterisation are available and it is imparative that these are discussed with patients, relatives and carers. Some stakeholders raised concerns regarding the "automatic" 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. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes. This is an important means by which patients dignity can be maintained.

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". This concern was acknowledged by PHCT who sought an apology from the referring hospital who did not have the appropriate equipment available.

During the period of the investigation, the Hampshire Ambulance Service, who were responsible for patient transfers 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". 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 an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure 100% compliance. 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.

As a result of the review of recent case notes, CHI noted that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses did not appear to be able to make swallowing assessments, which could be delayed over weekends, for example, when speech and language staff would next be available.

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 a range a good patient experiences this could only take the form of a "snap shot" during the site visit and may not be fully representative. However, many of the positive aspects of patient care observed were confirmed by CHIs review of recent patient notes.

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 designed garden suitable for wheelchair users. The garden is paved with a variety of different textures to enable patients to practice mobility. 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.

Staff attitude

The CHI team saw patients addressed by name in a respectful and encouraging way and saw examples of staff helping patients with dressing and conducting 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. Patients who needed help

to eat and drink were given assistance. 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. Healthcare support workers told CHI that they were responsible for making a note when meals were not eaten.

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 the impact of this post has been limited.

Communication with patients and relatives

Daedalus ward have a communication book by each bed for patients and relatives to make comments about day to day care. This is a two way communication process which, for example, allows therapy staff to ask relatives for feedback on progress and enables relatives to ask for an appointment with the consultant.

Administration of medicines

CHI observed two medicine rounds, both of which were conducted in an appropriate way with two members of staff jointly identifying the patient, checking the prescription sheet with one member of staff handing out the medicines and the other overseeing the patients as medicines were taken. Medicines were safely stored on the wards in locked cupboards.

Findings

Relatives speaking to CHI had some serious 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 less positive concerns about care were raised by stakeholders to CHI

	Dryad	Daedalus	Sultan	Other	**TOTAL**
1998		8		2	**10**
1999	1	5			**6**
2000		3	3	1	**7**
2001		1		1	**2**
General				2	**2**
TOTAL	**1**	**17**	**3**	**6**	**27**

Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Deadalus, Dryad and Sultan ward.

- The ward environments and patient surroundings are good.

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

CHI was concerned regarding one aera of potential risk surrounding any inability of ward staff to undertake swallowing assessments as required to be an area of potential risk to patients whose swallowing reflex may have been affected by a stroke, for example.

Opportunities for patients to engage in daytime activities in order to encourage orientation and promote confidence are limited.

Recommendations

- That all patient complaints and comments both informal and formal, should be used at ward level to improve patient care. The PCT must ensure a mechanism is inplace to ensure that shared learning is disseminated amongst all staff caring for older people.
- That, as a priority, a performance management system is established by the PCT to ensure the early identification of any trends in all patient complaints. The performance management system should include measurements of quality and standards of care.
- Steps should be taken to ensure that relevant staff are appropriately trained to undertake swallowing

assessments, to ensure that there are no delays out of hours.

- Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities compliment therapy goals.

- The PCT must ensure that all local continence management and nutrition and hydration practices are in line with the national standards set out in the Essence of Care guidelines.

Chapter 5 - Arrangements for the prescription, administration, review and recording of medicines

Police Inquiry and Expert Witness Reports

CHIs terms of reference for its investigation in part reflected those of the earlier inquiry by the police, whose reports were made available to the CHI team.

Though the police expert witnesses reviewed the care of five individual patients who died in 1998, general comments were also made in the reports about the clinical leadership and arrangements for the management of patients on the wards. Their examination of the use of medicines in Daedalus, Dryad and Sultan wards, caused them to express concern about three drugs, the amounts which had been prescribed, the combinations in which they were used and the method of their delivery. A summary of those comments is as follows:

- The inappropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain. It was the view of the police expert witnesses that a more reasonable response would be to prescribe a mild to moderate medicine initially with appropriate review of any pain followed up.
- The inappropriate subcutaneous combined administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death.
- An assumption by clinical staff that patients had been admitted for palliative, rather than rehabilitative care.
- There was a failure to recognise potential adverse effects of prescribed medicines by clinical staff.
- The failure of clinical managers to routinely monitor and supervise care on the ward.

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 diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. Some of the medicines used in the care of older people can be delivered by a syringe driver which delivers a continuous subcutaneous infusion (under the skin). This information has been plotted against the total number of admissions for the relevant year. The data relates only to medicines issued from the pharmacy and does not include any wastage, nor can it prove the amounts

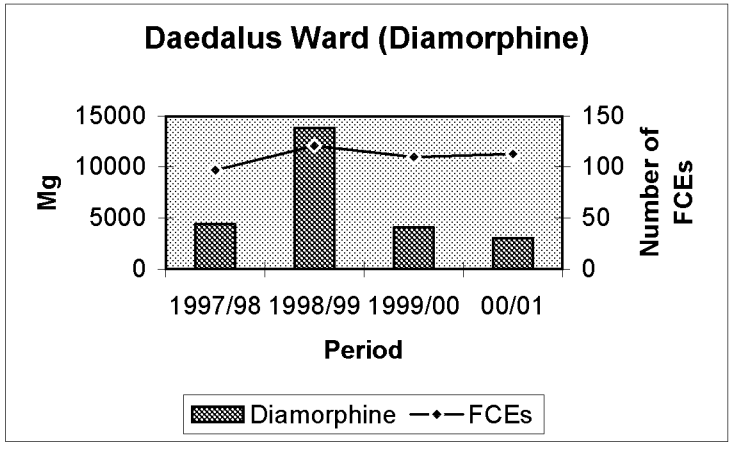
of medicines actually administered. A detailed breakdown of medicines for each ward is attached at appendix H.

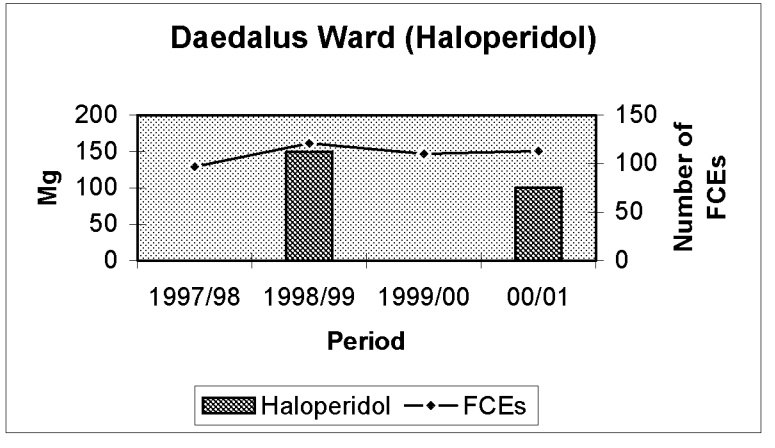
The usage of three particular medicines demonstrated below were highlighted by the experts commissioned by the police as of concern.

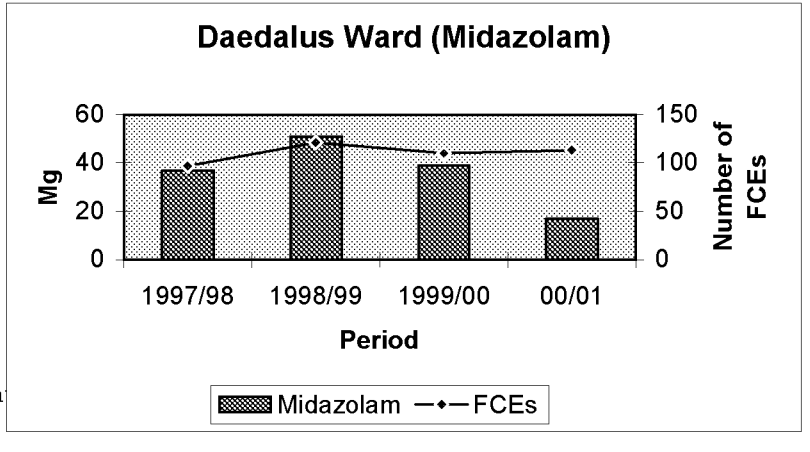
Please see next page for graphs

Graphs to show the usage of medicine 1997/98-2000/01according to the number of FCE per ward.

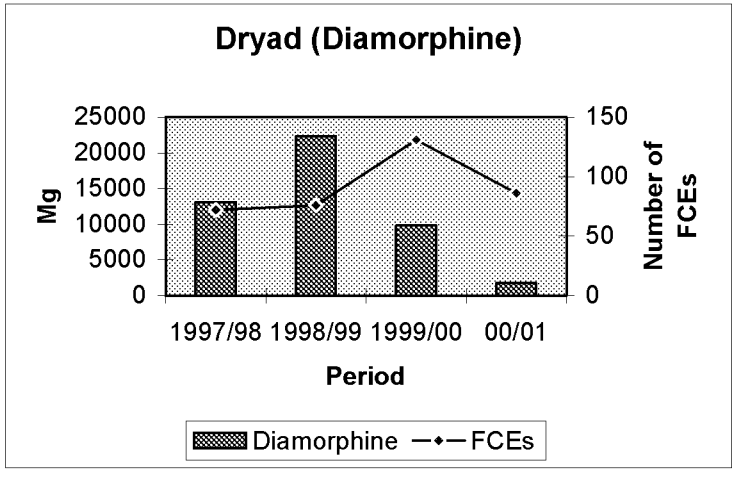
Graph 1. Daedalus

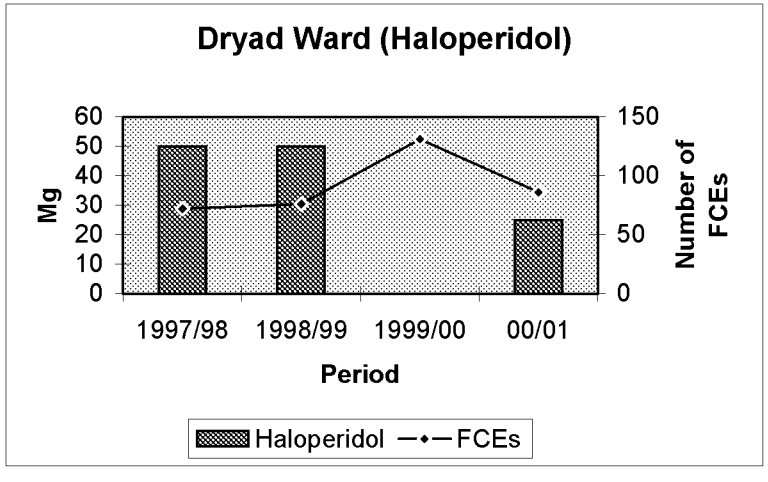


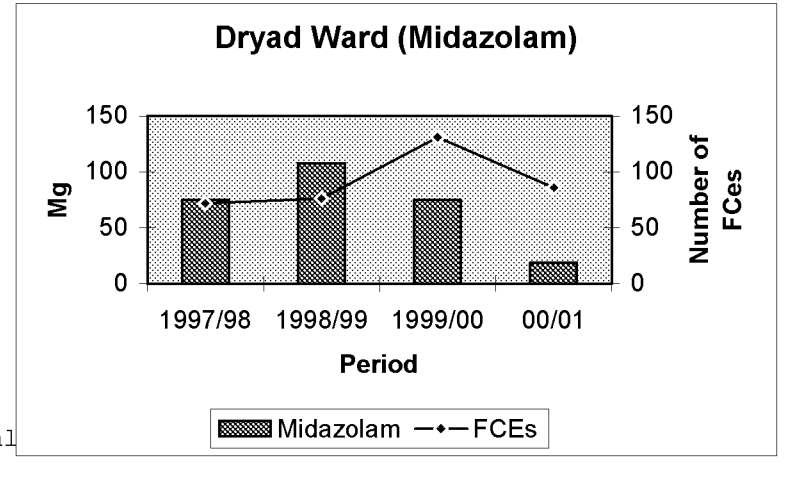




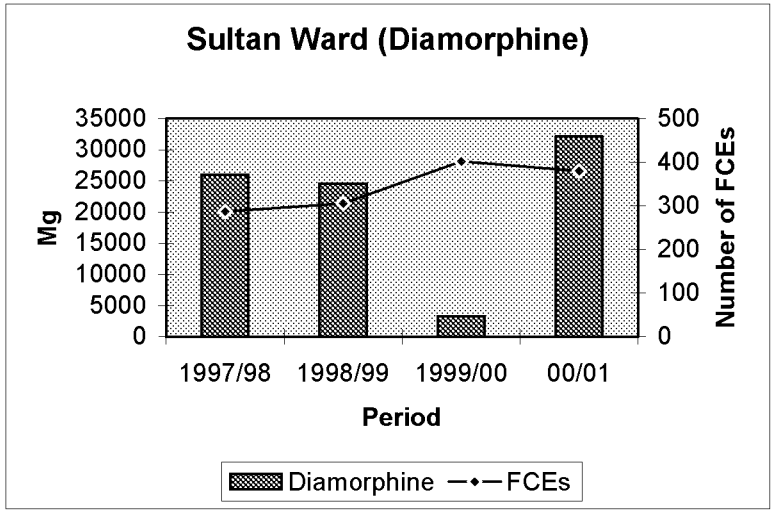
Graph 2 - Dryad

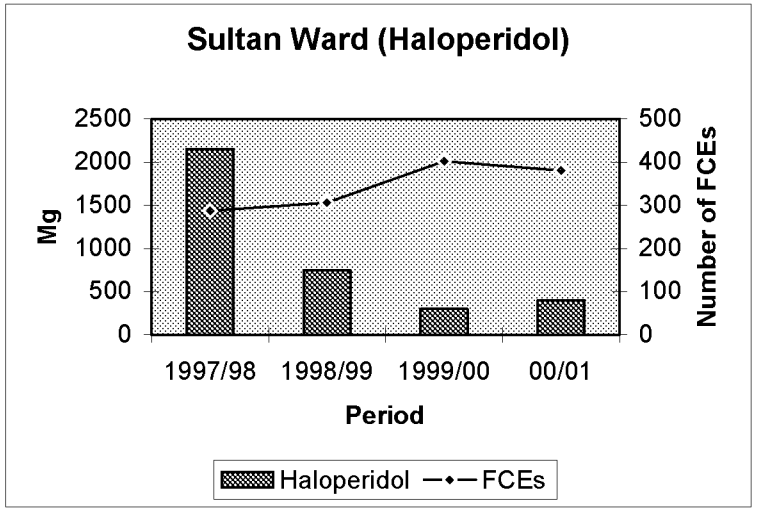


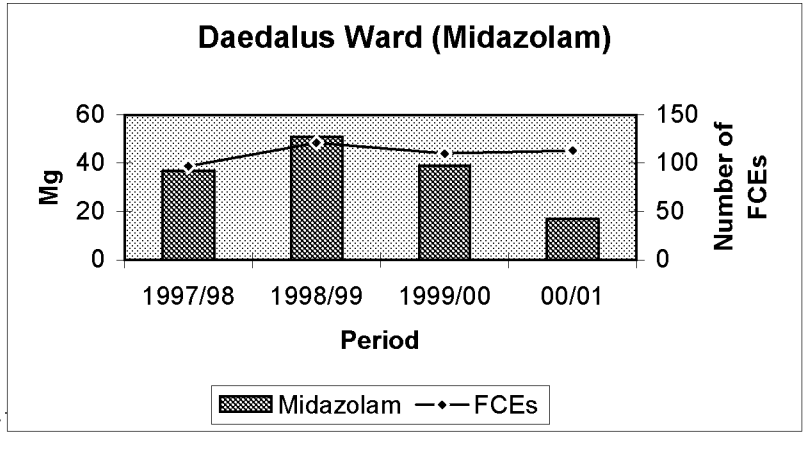




Graph 3. Sultan







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 prescriptions 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 and types 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 some nursing staff that following the introduction of the policy, it was now taking longer for some patients to become pain free and that there was a timidity amongst medical staff about prescribing 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.

Many staff interviewed referred to the "Wessex" palliative care guidelines (explained in paragraph??) which are in general use on the wards. Though the section on pain focuses on patients with cancer, there is a clear highlighted statement on the opening page of the guidelines 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.

CHIs random case note review of fifteen recent admissions concluded that the pain assistance and management policy was being adhered to. CHI was told by staff of the previous practice of anticipatory prescribing of palliative opiates. As a result of the pain and assessment policy, this practice has now stopped. 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.

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. 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. These arrangements were also confirmed by evidence found in CHIs case note review.

Administration of medication

Medication can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and under the skin via a syringe driver. Guidance for staff on prescribing via syringe drivers is contained within the Trust's policy for assessment and management of pain and

states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

Evidence from CHIs case note review demonstrated good documented examples of communication with both patients and relatives over medication and the use of syringe drivers.

Role of nurses in medicines administration

Registered nurses are regulated by the General Nursing Council, (GNC) a new statutory body which replaced the UKCC I April 2002. Registered nurses must work within their Code of Professional Conduct (UKCC June 1992), the Scope of Professional Practice (UKCC June 1992) clarified the way in which registered nurses are personally accountable for their own clinical practice and for care they provide to patients. The Standards for the Administration of Medicines (UKCC October 1992) details what is expected of nurses carrying out this important function, each nurse should have a copy of the standards.

Underpinning all of the regulations which govern nursing practice, is the requirement that nurses act in the best interest of their patients at all times. This could include challenging the prescribing of other clinical staff.

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

Review of medication

The regular ward rounds and multi-disciplinary meetings should include a review of medication by senior staff which is recorded in the patient's case notes. CHI recognises that the multi-disciplinary meeting is complex as the consultant has to process information from a variety of staff, engage in a dialogue to set and review goals and record the essence of this discussion in the case notes. The additional task of concurrently reading and amending the prescription chart, listening to the observations of staff about symptom and pain control and recording any medication changes makes the process yet more complex. Despite this, a process should be found to ensure that effective and regular reviews of patient medication take place

In November 1999, a PHCT review of the use of neuroleptic medicines, which includes tranquillisers such as haloperidol, 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 all staff on Daedalus and Dryad wards, including part-time staff and the clinical assistant. 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

The PHCT have a service level agreement with the local acute trust, Portsmouth Hospitals NHS Trust, for pharmacy services. The contract is managed locally by a grade E pharmacist and the service provided by a second pharmacist who is the lead for older peoples services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing workload. Pharmacy staff were confident the pharmacist would challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to use the trust intranet to provide a "Compendium of Drug therapy Guidelines, though CHI was told that the intranet was not generally available.

Pharmacy training to other non-pharmacy staff was regarded as "totally inadequate" and not taken seriously. There was no awareness of any training offered to clinical assistants

CHI was not aware of any trust systems which could have alerted the PHCT to any ususual or excessive patterns of prescribing, through the data to do this would have been available and was provided to CHI

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.
- *Commentary on 1997/98 – 2000/01 Pharmacy Data*
  Daedalus
  The data provided by PHCT illustrates an increase in the amount of diamorphine, haloperidol and midazolam used on Daedalus ward in 1998, the quantity of diamorphine used is most significant. The useage of all three drugs in recent years illustrates a decline, this was reinforced by trust staff interviewed by CHI and by CHIs own review of recent case notes. This should be seen against a slight rise in patient numbers.

  Dryad
  Usage of the three drugs on Dryad ward also demonstrate a decline, though this is against a decline in finished consultant episodes.

  Sultan
  Sultan ward has also experienced a rise in patient numbers, together with an increase in the use of diamorphine, haloperidol and midazolam. There has been a recent large increase in diamorphine used on the ward.

  The following graphs detail the decline in usage in specific medicines between 1998 and 2001. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998. CHI review of recent case notes confirmed that prescribing levels of diamorphine, midazolam and haloperiodol had reduced substantially.

- 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 however do not include methods of non-verbal pain assessment and rely on the patient articulating when they are in pain.

- CHI found little evidence from the expert witness reports commissioned by the police to suggest that thorough whole patient assessments were being made by multidisciplinary teams in 1998.

- Pharmacy support to the wards in 1998 was inadequate. CHI remains unconvinced that there are adequate systems in place to review and monitor prescribing at ward level.

Recommendations

- The PCT should review the provision of pharmacy services to Dryad, Deadalus and Sultan wards, taking into account the change in casemix and useage of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.
- The PCT must review the introduction of IT in maintaining records of prescribing.
- The PCT, in conjunction with the Pharmacy department, must ensure that all relevant staff are trained in the prescription, administration, review and recording of medicines

Chapter 6 - Staffing Arrangements and Responsiblity for Patient Care

Responsibility for Patient Care

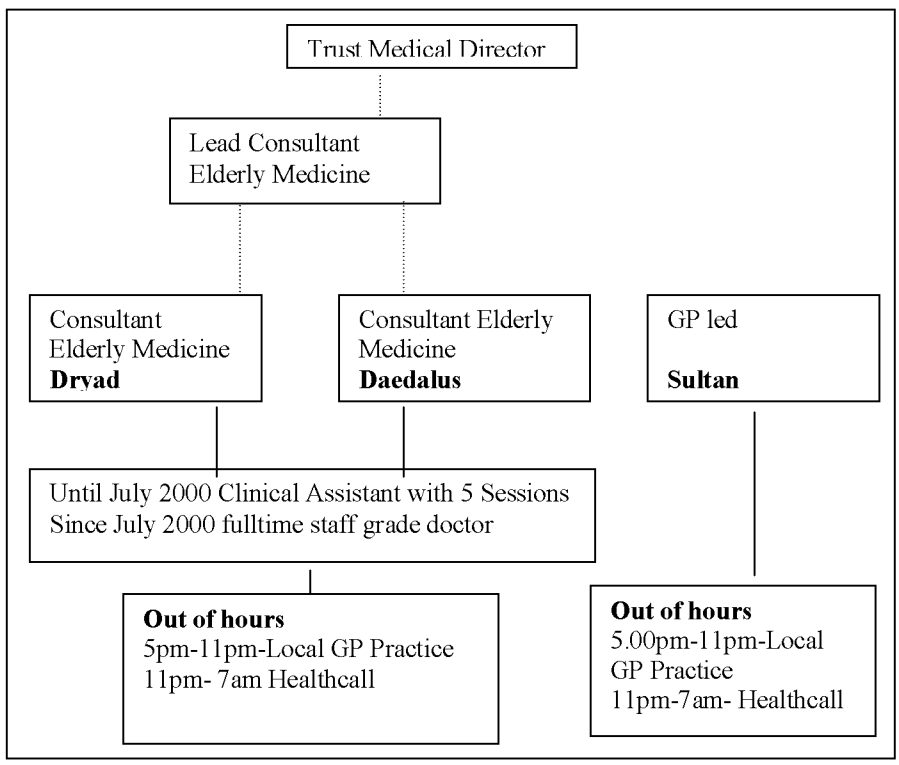
Patient care at the Gosport War Memorial for the period of the CHI investigation was provided by a consultant led team on Daedlus and Dryad wards. The complex needs of this vulnerable group of patients are best met by a multi-disciplinary, multi-professional team of appropriately trained staff. This ensures that the total needs of the patient are joined together in a care plan, discussed with the patient and their relatives and carers, which reflects the individual needs of each patient and is understood by every member of the team. Solid care planning such as this would ensure that all care decisions, such as prescribing, were jointly owned by all members of the team, including the lead consultant.

Medical Responsibility

For the period covered by the CHI investigation and currently, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. All patients on both wards are admitted under the care of a consultant. Since 1999, there has been 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. These responsibilities include overall management of the department and the development of departmental objectives. The lead clinician is not responsible for the clinical practice of individual doctors. The post holder does not undertake any sessions on the War Memorial site. The job description for the post, outlines twelve functions and states that the post is a major challenge for "a very part time role".

In addition, since 2000 *(check with trust)* two elderly medicine consultants provide 10 sessions in total of consultant cover on Dryad and Daedalus wards. Since September 2000, day to day medical support is provided by a staff grade physician who is supervised by both consultants. Before this, additional medical support was provided by a Clinical Assistant until July 2000. Both consultants undertake a weekly ward round with the staff grade doctor. In 1998, there had been a fortnightly ward round on Daedalus ward, CHI heard that ward rounds were less frequent than this on Dryad ward.

CHI considers that the staff grade post is a pivotal, potentially isolated post, due to the distance of the War Memorial Hospital from the hub of the department of elderly medicine based at Queen Alexandra Hospital and the difficulty in attending departmental meetings. The trust recognised this as an issue 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 to cover the wards because of the risk of professional isolation and support in Gosport".



* .....

This line indicates managerial accountability and not clinical

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 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 are employed and paid by 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. PHCT employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants work as part of a consultant led team have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

Between 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states that the clinical assistant is accountable to "named consultant physicians in geriatric medicine". 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. 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. Any concerns over the performance of any clinical assistant could have been pursued through the Trust disciplinary proceedings. CHI could find no evidence to suggest that this option was explored.

CHI is not aware of any trust systems in place to monitor or appraise the performance of the clinical assistant, this lack of monitoring is still common practice within the NHS. CHI could find no evidence of any system put in place by consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, to supervise the practice of the clinical assistant. This includes any review of prescribing. CHI could also find no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions.

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 clearly states "you will take full clinical responsibility for the patients under your care". 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 accountablity framework within the trust.

GPs managing their own patients on Sultan ward could be subject to the Health Authority's 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. Again, this arrangement is common throughout the NHS.

Out of Hours Cover Provided by GPs

Between the hours of 9.00am and 5.00pm on weekdays, 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 after which nursing staff call on either the patients' practice or Healthcall, a local deputising service for medical input between 11.00pm and 7.00am. *(check 7am-9am gap with trust)* Some 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 trust system to report long waits. The Healthcall contract is managed by a local practice. *(check contract)*

Nurses expressed concern over Healthcall GPs reluctance to "interfere" with admitting GPs prescribing on Sultan and Dryad wards.

In an urgent situation, out of hours, staff on all wards call 999 for assistance.

Appraisal of Hospital Medical Staff

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.

Nursing Responsibility

All qualified nurses are personally and legally accountable for their own clinical practice. Their managers are responsible for implementing systems and environments which promote high nursing quality care.

Ward nurses on each ward are managed by a G grade clinical manager, who reports to a senior, H grade nurse. This nurse covers the three wards caring for older people, and was managed by the general manager for the Fareham and Gosport division. The general manager reported to both the director of nursing and the operations director. An accountability structure such as this is not unusual in a community hospital. The director of nursing was ultimately accountable for the standard of nursing practice within the hospital.

Nursing supervision

Clinical supervision for nurses was recommended by the UKCC in 1996, and again in the national nursing strategy, Making a Difference, in 1999. It is a system through which qualified nurses can maintain life-long development and enhancement of their professional skills through reflection, exploration of practice and identification of issues that need to be addressed. There are a range of models, but in the main, three are used: clinical supervision with an expert; one to one supervision and group supervision. Clinical supervision is not a managerial activity, but provides an opportunity to reflect and improve on practice in a non-judgemental environment. Clinical Supervision is a key factor in professional self-regulation.

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 the 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.

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 ward 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.

Team working

Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. 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 by hospital staff as good, though not always available.

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 though were hopeful of more progress.

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.

Physiotherapy

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 at St James Hospital. Each ward has a nurse with lead nutrition responsibilities to offer advice to colleagues on request.

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 and 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 nursing 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 to CHI 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 and high sickness levels. Concerns were raised formally with the trust 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.

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 and dementia. Staff demonstrated to CHI 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 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.

Staff welfare

The trust developed, since its creation in 1994, 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"

Findings

- There are 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. CHI was concerned regarding the potential for professional isolation of the staff grade doctor.

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

  The PCHT did not have any systems in place to monitor and appraise the performance of clinical assistants. The clinical assistant working on Daedalus and Dryad wards was allowed to practice without adequate supervision arrangements. It was not made clear to CHI how GPs working as clinical assistants and admitting patients to Sultan wards are included in the development of trust procedures 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 as the service developed.

- The PHCT should be congratulated for its progress towards a culture of reflective nursing practice.

- 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 patient dependency.

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 continue to work with colleagues to ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

- The PCT should ensure that recent arrangements to ensure strong, long term, nursing leadership on Dryad ward continue.

Chapter 7 – Lessons Learnt from Complaints

CHI to check with HSC if they are looking at Mrs D (daughter Mrs R – before publication)
A total of 129 complaints were made regarding the division of elderly medicine since 1.4.97. 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 at the Gosport War Memorial Hospital during the same period.

Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. One recent complaint concerned admission arrangements in Sultan ward. Three complaints in the last five months of 1998 expressed concern regarding levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients was considered by the police expert witnesses. (findings summarised on page ??)

External review of complaints
One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical advisor found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 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 an acceptable range.

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. *(evidence of a review?)* A leaflet for patients detailing the various stages of the complaints procedure was produced, 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. This leaflet was not freely available on the wards.

Both the trust and the local CHC described a good working relationship. The CHC however regretted that their resources had, since November 2000, prevented them from offering the level of advice and active support 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 mentioned above, which is sent to complainants earlier in the process. Audit standards for complaints handling are good with at least 80% of complainants satisfied with complaint handling and 100% of complainants resolved within national performance targets. *(CHI check date)* 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.

Once the police became involved in the initial complaint in 1998, the trust ceased internal investigation processes. CHI found no evidence in board agendas 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 doctor involved in the care of this patient wrote to the trust's quality manager expressing concern that she discovered by chance three months later that a complaint had been made. Neither that doctor nor portering staff involved in the transfer of the patient were asked for statements during the initial trust investigation.

Trust Learning Regarding Prescribing

The trust did not connect the police investigation, the review of the Health Service Commissioner, the Independent

Review Panel and the trust's own pharmacy data, 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.

Action was however taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter??). In addition, CHI learnt that external clinical advice sought by PHCT in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mgs to 200mgs a day was poor practice and "could indeed lead to a serious problem". The comment was made that the patient had been given doses ranging from 20mg to 40mg per day.

PHCT correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mgs a day. CHI understands this to be the "Wessex guidelines". Further correspondence in October 1999, indicated that a doctor working on the wards asked for a trust position policy on the prescribing of opiates in community hospitals. This was not addressed until April 2001, when the joint PHCT and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain was introduced.

Other Trust Lessons

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 the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999.
- The appointment of a staff grade doctor in September 2000 to increase medical cover following the resignation of the clinical assistant.
- 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. CHIs review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff.

Comments were recorded in this workshop which were echoed by staff interviewed by CHI, such as; the difficultly in building a rapport with relatives when patients die a few days after transfer, the rising expectations of relatives, and the lack of control Gosport War Memorial staff have over information provided to patients and relatives prior to transfer.

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 played a key role in this. Until the dissplution of PHCT, actions were 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. This has improved the quality of complaint responses.

The PHCT offered specific training in complaints handling, customer care and loss, death and bereavement, which many, though not all, staff interviewed by CHI were aware of and had attended.

The Trust had a well defined and respected line management structure through which staff are confident emerging themes from complaints would now be identified.

Findings

- PHCT did not use the issues raised through complaints made between 1998 and 2001 and an ongoing police investigation as a trigger for an internal review of prescribing within the Gosport War Memorial Hospital.

- PHCT did effect changes in patient care, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

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

- That there has been some, though not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

Recommendations

That CHI work with the Association of Chief 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 Chief 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 ensure 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 PHCT quarterly performance management 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. Any new training programmes should be developed with staff, patients and relatives to ensure that current concerns and the particular needs of the bereaved are addressed.

Chapter 8 - Communication

This 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. 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 was not collected. 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. CHI could find no evidence to suggest that the findings from patient surveys are shared across the trust.

Communication Towards the End of Life

Staff 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 Communication

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 by the Fareham and Gosport PCT to facilitate communication with staff.

Transfer into the community

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. These positive views were echoed by district nurses.

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.

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 improve communication with older patients and their relatives and carers.

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 directors 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 February 2000. The Medical Director and

Clinical Governance Manager attended Divisional Review meetings and reported key issues back to the Clinical Governance Panel.

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 had an operational policy for "Recording and Reviewing Risk Events" introduced in 1994. 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 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.

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 about 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

CHI heard of no demonstrable examples during interviews with staff of positive changes in patient care as a result of clinical audit outcomes. Despite a great deal of work on revising and creating policies to support good prescribing, there has been no planned audit of outcome.

Need to include outcome of trust recent prescribing audit here.

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.

APPENDIX A

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1. **Audit of standards of oral hygiene within the stroke service,** November 1999 – April 2000. (undated)

2. **Re-Audit evaluation of compliance with revised handling assessment guidelines,** Portsmouth Healthcare NHS Trust, June 1998 - November 1998.

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4. **Guidelines, Practices and performance management.** Portsmouth Healthcare NHS Trust, (undated)

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14. **Community Hospitals, Guidelines for confirmation of death,** Portsmouth Healthcare NHS Trust, Policy date May 1998 Review date May 1999.

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17. **Clinical audit of painful shoulder guidelines,** Portsmouth Healthcare NHS Trust, September 1996 – March 1996.

18. **Ortho-Geriatric development group, East Hampshire & Portsmouth City Primary Care Trusts, Fareham & Gosport Primary care groups, Portsmouth Hospitals NHS Trust, Portsmouth Healthcare NHS Trust** Ben Gillett, 23 November 2001.

19. **Memorandum re: Guidelines for admission to Daedalus Ward from Dr A Lord,** Portsmouth Healthcare NHS Trust, 4 October 2000.

20. **Clinical policy, Admission and discharge policy,** Portsmouth Healthcare NHS Trust, September 2000.

21. **Patient flows,** 24 October 2001.

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24. **Discharge summary form, Guidance notes for completion,** Portsmouth Healthcare NHS Trust, 21 November 2001.

25. **Audit of patient records, December 1997 – July 1998.** (undated)

26. **Audit of nutritional standards, October 1997 – April 1998.** Portsmouth Healthcare NHS Trust, (undated)

27. **Guidelines, Practices and Performance Management, Falls Policy Development.** Portsmouth Healthcare NHS Trust,

28. **Stepping Stones, How the Need for Stepping Stones came about.** Portsmouth Healthcare NHS Trust (Undated)

29. **Procedure for the Initial Management of Medical Emergencies in Gosport War Memorial Hospital,** Portsmouth Healthcare NHS Trust, 15 January 2001.

30. **Policy for Psychiatric Involvement,** Toni Scammell, Senior Nurse,, Portsmouth Healthcare NHS Trust November 2001.

31. **Trust Corporate Policies, Guidance for Staff,** Portsmouth Healthcare NHS Trust Revised August 2000.

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33. **Corporate Policy, Policy for Prevention and Management of Malnutrition within Trust Residential and Hospital Services,** Portsmouth Healthcare NHS Trust, November 2000.

34. **Clinical Policy, Policy for the Prevention and Management of Pressure Ulcers,** Portsmouth Healthcare NHS Trust, May 2001.

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36. **Personnel Policy, Whistleblowing,** Portsmouth Healthcare NHS Trust, February 2001.

37. **Operational Policy, Risk Management Policy,** Portsmouth Healthcare NHS Trust, January 2001.

38. **Corporate Policy, Recording and Reviewing Risk Events,** Portsmouth Healthcare NHS Trust, **May 2001.**

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5. **Clinical Policy, Control and Administration of Medicines by Nursing Staff,** Portsmouth Healthcare NHS Trust, January 1997.

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11. **Scoresheet – Medicines Management Standard, 2001/02.** Portsmouth Healthcare NHS Trust,

12. **Organisational Controls Standards, Action Plan, 2000/01.** Portsmouth Healthcare NHS Trust,

13. **Trust Board, 16 October 2000.**

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14. **Summary medicines use 1997/1998 to 2000/2001,** Portsmouth Hospitals NHS Trust Pharmacy Service, (undated)
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Information Centre, Department of Trade and Industry - Avoiding slips, trips and broken hips, Department of Trade and Industry - Step up to Safety April 2000, Help the Aged - Fight the Flu 2001 - 2002 Edition, Gosport Action (GVA) Befriending Services, The Royal society for the Prevention of Accidents (ROSPA) - Falls: How to Avoid them and How to Cope, Getting the most from your NHS - Your guide to the NHS (NHS) March 2001.

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2. **Proposal for Portsmouth Healthcare NHS Trust, The Provision of an Employee Assistance Programme for Portsmouth Healthcare NHS Trust, 16 March 2000.**

3. **Portsmouth Healthcare NHS Trust, Employee Assistance Programme Annual Report 1 May 2000 to 30 April 2001,** Coutts Corecare - July 2001.

4. **Agreement for Provision of Services of Employee Advisory Resource Limited (EAR), 1 February 1997.**

5. **Letter to Jill Sadler from Sally Keeling (Employee Assistance Programme Consultant) Re: Employee Assistance Programme Three Months usage report, 15 June 2000.**

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8. Talking with Dying Patients, Doc 3.

9. Loss Death and Bereavement.

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3. Training programme 2002.

4. Annual Physiotherapy Conference – 14 November 2001 St Mary's Hospital, Provisional Programme.

5. Physiotherapy Service, continuing Professional Development Programme, Workshops 2002. NHS (Undated)

6. Frontline, Course and Conferences, 17 October 2001.

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8. Occupational Therapy Service – Supervision Manual. Portsmouth Healthcare NHS Trust

9. Certificate of Attendance. Portsmouth Healthcare NHS Trust

10. Supervisor Support Group Meeting – 8 November 2001, PIDC?? Cosham.

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12. Training and Development in Community Hospitals (Gosport War Memorial Hospital, St Christophers Hospital, Emsworth Victoria Cottage Hospital, Petersfield Community Hospital, Havant War Memorial Hospital) **Workshops – Practice Development Facilitators.**

13. **Fareham & Gosport Induction Programme, 9 November 2001.** Portsmouth Healthcare NHS Trust

14. **Competence Record and Development for Qualified Nurses 1998 – 2001, Sultan.**

15. **Competence Record and Development for Qualified Nurses 1998 – 2001, Dryad.**

16. **Competence Record and Development for Qualified Nurses 1998 – 2001, Daedalus.**

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18. *Missing – Post registration Propectus*

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20. **Training and development for Nursing Staff in Portsmouth Healthcare NHS Trust Community Hospitals relating to intermediate care, 12 February 2001.**

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25. **Procedural Statement – Individual Performance Review, March 1995.**

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30. **An evaluation of Clinical Supervision Activity in Nursing throughout Portsmouth Healthcare NHS Trust, Mary Golden (Clinical Practice Development Coordinator)** Portsmouth Healthcare NHS Trust, December 1999.

31. **Policy Statement – Training and Education, April 2001.**

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3. **Portsmouth Healthcare NHS Trust, Letter to – Mr W from Max Millett Chief Executive, 8 January 1999.**

4. **Complaint Mrs R. Letter to Margaret Tozer from Max Millet (Chief Executive).** Portsmouth Healthcare NHS Trust, Gosport War Memorial Police Investigation, Chronological Sequence of Events.

5. **Ombudsman Investigation Mrs P.**

6. **Independent Review Panel Mrs D.**

7. **Your Views Matter, Making comments or complaints about our services.** Portsmouth Healthcare NHS Trust

8. **Corporate Policy, Handling Patient Related Complaints**, Portsmouth Healthcare NHS Trust, January 2000.

(L) Documents relating to Portsmouth Healthcare NHS Trust: Complaints – Volume I

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2. **Handling Complaints Course Facilitators Notes** 21 May 1999, Aim of Session, Complaints Scenario – Mr Smith and the CPN??, Behaviour Styles, Finished Files. Portsmouth Healthcare NHS Trust

3. **Complaints – re: Mrs R & Mrs P,** local resolution, background Papers (minus correspondence). Independent review, background papers (minus correspondence). Correspondence at local resolution and independent review. Correspondence with Ombudsman, 25 May 2000 & 16 February 2001. Ombudsman Report, 22 March 2001. Action log and background re: Ombudsman.

(L) Documents relating to Portsmouth Healthcare NHS Trust: Complaints – Volume II

1. **Mrs D –** Local Resolution, background papers (minus correspondence). Independent review panel papers (including local resolution correspondence). Correspondence with Mrs R and Max Millett during independent review process, 12 July 2000. Independent review panel, agenda 22 May 2001. Independent review panel report and trust action plan, produced 10 August 2001. Independent review panel notes from Hearing /Interviews. Correspondence with Ombudsman, 12 October 2001.

2. **Complaint:- Mrs W. & Portsmouth Healthcare NHS Trust (undated)**

3. **Complaint:- Mr C. & Portsmouth Healthcare NHS Trust (undated)**

4. **Complaint:- Mr S. & Portsmouth Healthcare NHS Trust (undated)**

5. **Mr/Mrs?? B/G report June 2000.**

6. **Complaint:- Mr R. & Portsmouth Healthcare NHS Trust, (undated)**

7. Complaint:- **Mrs H. & Portsmouth Healthcare NHS Trust, (undated)**

8. **Patient leaflets,** Your views matter. How the Health Service Ombudsman can help you April 1996. Your views matter. Making comments or complaints about our services. Complaints, listening acting improving. Portsmouth Healthcare NHS Trust (Undated)

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10. **Bleep holder policy review, 15 May 2001.**

11. **Gosport War Memorial Hospital, Patients survey information and action plan,** Portsmouth Healthcare NHS Trust, **October 2001.**

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3. *General Rehabilitation Clinical Governance Group, minutes of meeting 6 September 2001.*

4. *Day Hospital Clinical Governance meeting, 9 October 2001.*

5. *Stroke Service Clinical Governance meeting, minutes of meeting 12 October 2001.*

6. *Continuing Care Clinical Governance Group, minutes of meeting 7 November 2001.* ***Portsmouth Healthcare NHS Trust***

7. *Community Hospitals Clinical Leadership Programme Update, 19 November 2001.* ***Portsmouth Healthcare NHS Trust***

8. *Practice Development Programme,* ***Portsmouth Healthcare NHS Trust, March 1999.***

9. *Third Quarter quality/clinical governance report, Community Hospitals Service Lead Group,* ***Portsmouth Healthcare NHS Trust, January 2000.***

10. *Community Hospitals Clinical Governance Baseline Assessment Action Plan, September 1999.*

11. *Notes of a Community Hospital Service Lead Group Meeting,* ***Portsmouth Healthcare NHS Trust, 26 May 2000.***

12. *Mandatory training by contract group, November 2000.*

13. **Clinical Governance Development Plan 2001/2002.** Portsmouth Healthcare NHS Trust

14. **Clinical Governance – Annual Report – 1999/2000.** Portsmouth Healthcare NHS Trust

15. **Clinical Governance: Minimum Expectations of NHS Trust and Primary Care Trusts from April 2000. Action Plan – Review March 2001.** Portsmouth Healthcare NHS Trust

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17. **Risk Management Strategy 2000 – 2003.** Portsmouth Healthcare NHS Trust

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2. *South East Region, Clinical Governance and Clinical Quality Assurance, The Baseline Assessment Framework,* ***NHS Executive – 1999.***

3. *Clinical Governance, District Audit 1998/1999.* ***Portsmouth Healthcare NHS Trust***

4. *Clinical Governance Baseline Assessment, Trust Wide Report, 1999.* ***Portsmouth Healthcare NHS Trust***

5. *Trust Clinical Governance Panel, Meeting held 16 May 2001.* ***Portsmouth Healthcare NHS Trust***

6. *Memorandum, Implementation of clinical governance, 11 June 1999.* ***Portsmouth Healthcare NHS Trust***

7. *Risk Management Strategy, 1999/2002.* ***Portsmouth Healthcare NHS Trust***

8. *.Risk Management Strategy, 1998/2001.*

NEW EVIDENCE

9. *Clinical governance development plan,* ***Portsmouth Healthcare NHS Trust, 2001/2002***

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Documents relating to Portsmouth Healthcare NHS Trust: Staffing and Accountability - Volume I

2. **Department of medicine for elderly people, Job description, Service manager** Portsmouth Healthcare NHS Trust ,22 November 2001.

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5. **University of Portsmouth, Clinical nursing governance in a department of elderly medicine: an exploration of key issues and proposals for future development,** Eileen Thomas, Portsmouth Healthcare NHS Trust, May 2000.

6. **A review of nursing in the department of elderly mental health,** Eileen Thomas, Portsmouth Healthcare NHS Trust, July 2001.

7. **One year on: aspects of clinical nursing governance in the department of elderly medicine,** Eileen Thomas, Portsmouth Healthcare NHS Trust, September 2001.

8. **Operational policy, bank/overtime/agency, Fareham and Gosport community hospitals and elderly mental health,** Portsmouth Healthcare NHS Trust, 1 May 2001.

9. **Department of medicine for elderly people, Full time staff grade physician.** Portsmouth Healthcare NHS Trust

10. **Portsmouth Healthcare NHS Trust, Department of medicine for elderly people, Essential information for medical staff, Mastercopy.** (undated)
11. **Department of medicine for elderly people, Full time staff grade physician.** Portsmouth Healthcare NHS Trust,

12. **Development of intermediate care and rehabilitation services within the Gosport locality.** Portsmouth Healthcare NHS Trust, (undated)

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2. **Audit of detection of depression in elderly rehabilitation patients, January - November 1998.** Portsmouth Healthcare NHS Trust (undated)

NEW EVIDENCE

3. **Stepping stones - self help group for patients and carers.** Shirley Dunleavy, Team leader in Physiology, (undated)

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1. **Audit of Neuroleptic Prescribing in Elderly Medicine,** Portsmouth Healthcare NHS Trust, Nov 98 - July 99.

Documents relating to Portsmouth Healthcare NHS Trust: Communication

Documents relating to Portsmouth Healthcare NHS Trust: End of Life

Documents relating to Portsmouth Healthcare NHS Trust: Supervision and Training – Volume I

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3. **Department of Medicine for Elderly People – Friday Lunchtime Journal Club, 1999 - 2001.**

4. **Portsmouth Healthcare NHS Trust, Memo – 19 October 2001, Clinical Assistant Teaching Elderly Medicine, Osteoporosis & Falls – 14 November 2001.**

NEW EVIDENCE

5. **Science Committee day conference – palliative care for older people: can we improve its scientific basis?** The Association of Palliative Medicine of Great Britain and Ireland, November 2001

Documents relating to Portsmouth Healthcare NHS Trust: Complaints

Documents relating to Portsmouth Healthcare NHS Trust: Clinical Governance – Volume I

APPENDIX B

Views from patients and relatives/friends

1. Methods of obtaining views

i. The investigation sought to establish the views of people who had experience of services for older people at the Gosport War Memorial Hospital.

CHI sought to obtain views about the service through a range of methods. People were invited to;

- Meet with members of the investigation team
- Fill in a short questionnaire
- Write to the investigation team
- Contact by telephone or email

ii. In November 2001 information was distributed about the CHI investigation at Gosport War Memorial Hospital to Stakeholders, Voluntary Organisations and Statutory Stakeholders. This information included posters advertising stakeholder events, information leaflets about the investigation, questionnaires and general CHI information leaflets. Press releases were issued in local newspapers and radio stations. The Hampshire police force were asked to forward CHI contact details to families who had previously expressed their concerns to them.

The written information was distributed to a large group of potential stakeholders. In total 36 Stakeholders and 59 Voluntary organisations will have received the above information. These people ranged from:

- **Voluntary organisations**- e.g. Motor Neurone Disease, Alzheimer Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- Statutory stakeholder- Portsmouth and SE Hampshire Community Health Council, Isle of Wight, Portsmouth and SE Hampshire Health Authority, Local Medical Council, Members of Parliament, Nursing Homes and Social Services, Local Primary Care Trusts and Primary Care Groups.

- **Stakeholders** who had contacted CHI-patients, relatives/carers/friends.

2. Stakeholder Responses

i. As a result of the mail out of information in November 2001, CHI have received the following responses from patients, relatives/carers/friends and voluntary organisations

Letters	Questionnaires	Telephone Interviews	*Stakeholder Interviews
7	1	10	16

*Stakeholders were counted according to the number of attendees and not based on number of interviews

ii. A number of people who contacted CHI did so using more than one method. In these cases any other form of submitted evidence, was incorporated as part of the Stakeholders contact.

3. Analysis of views received:

During the CHI investigation the stakeholder evidence highlighted both positive and negative views about patient care. The following analysis illustrated both types of experiences of patients/friends and relatives.

Positive Experiences

CHI received 9 letters from stakeholders commenting on the satisfaction of the care that the patients received and highlighting the excellent level of care and kindness demonstrated by the staff and how much the staff were appreciated. This was also supported by the many letters of thanks and donations received by the Gosport War Memorial Hospital.

Table to show the most frequent positive views of patient and relative/friend experiences

View	Frequency of responses
Staff Attitude	5
Environment	5
Other one of comments included: Access to Services, Transfer, Prescribing, End of Life arrangements, Communication and Complaints.	

The overall analysis of the stakeholder comments indicated that staff attitude and the environment were most highly commended. Examples of staff attitude included comments such as, "One lovely nurse on Dryad went to say hello to every patient even before she got her coat off" and "As a whole the ward was lovely and the there was no complaints against the staff". The environment was described as being tidy and clean with good décor. Another comment recognised the wards attention to maintaining patient dignity with curtains been drawn reducing attention to the patient. A Stakeholder also commented on the positive experience they had when dealing with the trust concerning a complaint they had issued.

Negative Experiences

However, there were a number of frequent emerging negative experiences of patients/friends and relatives that were shared with CHI by stakeholders.

Table to show the most frequent negative views of patient and relative/friend experiences

View	Frequency of responses
Communication with relatives/carers/friends	14
Patient transfer	10
Nutrition and fluids	11
Prescription of medicines	9
Continence management, catheritisation	4,4

Staff attitude	8
End of Life, Communication with: patients	
patients	4
	6
relatives/carers/friends	
Humanity of care i.e. access to buzzer, clothes	5,3

The table above highlights some of the more common negative views from the stakeholder responses, which are associated with the concerns, which have triggered the Investigation and are incorporated into the term of reference.

The specifics of the term of reference which stakeholders have commented on are:

- **The guidelines and practices in place at the trust to ensure good quality care and effective performance management**

- Patient Transfer: -
  Three of the contacts commented on the complexity of the patient's health before and during the transfer, "Patients should be physically fit to transfer", "Family felt if they knew how ill their father was they would not have moved him from Queen Alexander Hospital" and "Hospital claimed that the patient is in very serious pain following their transfer from Queen Alexander Hospital" Two contacts mentioned the time that it took to transfer the patient and a further two highlighted the in appropriate method of transporting the patient, such as being carried " on a sheet, with no poles- like a sack of potatoes" or being transferred, " naked from the waist down apart from a piece of padding".

- Nutrition and fluids: -
  Four of the contacts highlighted a lack of help in feeding patients. Three contacts commented on how dehydrated the patients appeared and others generally commented on the lack of positive communication between the relative/carer and the staff to overcome the relative/carer's concern about the level of nutrition and fluids.

- Humanity of care: -

The stakeholders commented consistently on incontinence management, the attitude of staff, proximity of bells and management of patients' clothes.

- Incontinence management- four stakeholders felt that there was limited help with patients that needed to use the toilet, "asked on three separate occasions but did not receive help" and "never able to reach emergency button so the patient wet herself "
- Attitude of staff- eight stakeholders commented on staff attitude mentioning waiting times for staff to respond, " waited 40 minutes for the nurse to come" other comments included, "basic care lacking in last few days e.g. moistening of mouth, clean pillows" and "main concern is culture on the ward especially manner of staff with patients and relatives". However, other stakeholders also observed some nurses being excellent and caring.
- Provision of bells – Five stakeholders observed that the bells were often out of the patients reach.
- Management of Clothing- 3 stakeholders commented, "that the patients were never in their own clothes" and that "one patient rarely had a cover on their legs"

- **Arrangements for the prescription, administration, review and recording of drugs**

- Prescribing: -
  The majority of concerns were around the prescribing of diamorphine. Other concerns centred on those authorised to prescribe the medication to the patient, which was communicated to the relatives/carer.

- **Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations.**

- Communication with relatives/carers: -
  Five interviews indicated a lack of staff contact with the relatives/carers about the condition of the patient and the patient's care plan. Other interviews commented on how some of the staff were not approachable. One interview referred to the

absence of lay terms to describe a patient's condition, making it difficult to understand the patient's status of health.

- **Arrangements to support patents and their relatives and carers towards the end of the patient's life.**

  - End of life patients, relatives /carers: - Stakeholders mainly felt that there was a lack of communication from the staff after their relative had died, this was feedback to CHI through comments such as, "no doctors entered room in last days of the patient's life", " family received no support from GWMH staff after told them that the patient would die".

i. Three of the contacts had made complaints. Of these all were dissatisfied about the trust response. They felt that the complaints were not dealt with appropriately.

APPENDIX C

Portsmouth Healthcare Trust staff and non-executive directors interviewed by CHI

CHI is grateful to Caroline Harrington for scheduling interviews.

- Wood, Andy, Finance Director,
- Wilson, Angela, Senior Staff Nurse,
- Tubbitt, Anita, Senior Staff Nurse,
- Monk, Anne, Chairman,
- Haste, Anne, Clinical Manager,
- Robinson, Barbara, Deputy General Manager,
- Melrose, Barbara, Complaints,
- Hooper, Bill, Project Director,
- Phillips, Catherine, Speech & Language Therapist,
- Joice, Chris, ,
- Lee, David, Complaints Convenor & Non Executive Director
- Barker, Debbie, Staff Nurse,
- Law, Diane, Patient Affairs Manager,
- Yikona, Dr, Staff Grade Physician,
- Ravindrance, Dr, Consultant,
- Qureshi, Dr, Consultant,
- Lord, Dr Althea, Lead Consultant,
- Jarrett, Dr David, Lead Consultant,
- Banks, Dr Vicki, Lead Consultant,
- Thomas, Eileen, Nursing Director,
- Cameron, Fiona, General Manager,
- Walker, Fiona, Senior Staff Nurse,
- Hamblin, Gill, Senior Staff Nurse,
- Day, Ginny, Senior Staff Nurse,
- Langdale, Helen, Health Care Social Worker,
- Reid, Ian, Medical Director,
- Piper, Ian, Operational Director,
- Neville, J, ,
- Hair, James, Chaplain,
- Peach, Jan, Service Manager,
- Williams, Jane, Nurse Consultant,
- Parvin, Jane, Senior Personnel Manager,

- Watling, Jeff, Chief Pharmacist,
- Clasby, Jerry, Senior Nurse,
- O'Dell, Jo, Practice Development Facilitator,
- Dunleavy, Jo, Staff Nurse,
- Taylor, Jo, Senior Nurse,
- Lock, Joan, ,
- Jones, Julie, Corporate Risk Advisor,
- Mann, Katie, Senior Staff Nurse,
- Humphrey, Lesley, Quality Manager,
- Peagram, Lin, Physio Assistant,
- Woods, Linda, Staff Nurse,
- Barrett, Lynn, Staff Nurse,
- Wigfall, Margaret, Night Enrolled Nurse,
- Thorpe, Maria, Health Care Social Worker,
- Barker, Marilyn, Enrolled Nurse,
- Millett, Max, Chief Executive,
- Loney, Mick, Porter,
- Wilkins, Pat, Senior Staff Nurse,
- Carroll, Patrick, Occupational Therapist,
- Goode, Pauline, Health Care Social Worker,
- Wells, Penny, District Nurse,
- King, Peter, Personnel Director,
- Beed, Phillip, Clinical Manager,
- Crane, Rosemary, Senior Dietician,
- Brind, Shelly, Occupational Therapist,
- Hallman, Shirley, ,
- Dunleavy, Shirley, Physiotherapist,
- King, Steve, Clinical Risk Advisor,
- Nelson, Sue, ,
- Jones, Teresa, Ward Clerk,
- Douglas, Tina, Staff Nurse,
- Lawrence, Vanessa, Senior Nurse Coordinator,
- Pease, Yong, Staff Nurse,
- Clarke, Sally, Patient Transport Manager,

APPENDIX D

Meetings with external agencies with an involvement in Elderly care at the Gosport War Memorial Hospital.

- **Haslar Hospital**

  Sam Page, Bed Manager

- **Portsmouth Hospital Trust**

  Gill Angus, Clinical Discharge Coordinator
  Wendy Peckham, Discharge Planner for Medicine, St Mary's Hospital
  Clare Bownass, Ward Sister, St Mary's Hospital
  Sonia Baryschpolec, Staff Nurse, St Mary's Hospital

- **Hampshire Ambulance Services**

  Alan Lyford, Patient Transport Service Manager

- **Isle of Wight, Portsmouth & South East Hampshire Health Authority**

  Dr Peter Olde, Director of Public Health
  Penny Humphries, Chief Executive
  Nicky Pendleton, Progamme Lead for Elderly Care Servces

- **NHS Executive- East Regional Office**

  Mike Gill,

-
- **St Mary's Hospital**

- **Portsmouth and South East Hampshire Community Health Council**

  Joyce Knight,
  Margaret Lovell, Chief Officer
  Christine Wilks,

- **Hampshire Constabulary**

  DSI. John James

- **Social Services- Portsmouth Social Services Department for Older People**

Sarah Mitchell, Assisstant Director
Tony Warns,
Helen Loren,

- **Alverstoke House Nursing and Residential Care Home**

  Rose Cook,

- **Glen Heathers Nursing and Residential Care Home**

  John Perkins,

Other

- **League of Friends**

  Mary Tyrell, Chair

- **Motor Neuron Association**

  Mrs Fitzpatrick

- MP
- PCT
- PCG
- Local Medical Council
- GWMH Medical Committee
- RCN
- Unison

APPENDIX E

Medical case note review

Terms of Reference for the Medical Notes Review Group to Support the CHI Investigation at Gosport War Memorial Hospital

Purpose
The Group has been established to review the clinical notes of a random selection of recently deceased older patients at the Gosport War Memorial Hospital in order to inform the CHI investigation. With reference to CHIs investigation terms of reference and the expert witness reports prepared for the police by Dr Munday and Professor Ford, this review will address the following:

(i) The prescription, administration, review and recording of drugs.
(ii) The use and application of the Trust's policies on the Assessment & Management of Pain, Prescription Writing and Administration of IV Drugs.
(iii) The quality of nursing care towards the end of life.
(iv) The recorded cause of death.

Method
The Group will review 15 anonymised clinical notes supplied by the Trust, followed by a one day meeting at CHI in order to produce a written report to inform the CHI investigation. The Group will reach its conclusions by March 31st 2002 at the latest.

Membership
Dr Tony Luxton, Geriatrician – Lifespan NHS Trust (CHI doctor team member & chair of Group)
Maureen Morgan, Independent Management Consultant (CHI nurse member)
Professor Gary Ford, Professor of Pharmacology of Old Age, University of Newcastle and Freeman Hospital
Dr Keith Munday, Consultant Geriatrician, Frimley Park Hospital
Annette Goulden, Deputy Directior Of Nursing, Trent Regional Office and formerly Department of Health Nursing Officer for elderly care

Dr Luxton and Maureen Morgan have been seconded to CHI for their work with CHI on this investigation, similar arrangements will apply to Professor Ford, Dr Munday Annette Goulden with regard to expenses, confidentiality etc. The Group will be supported by Julie Miller CHI Investigation Manager, who will produce a report based on the Group's work.

Findings of Group
The findings of the Group will be shared with:

(i) the CHI Gosport investigation team
(ii) CHI's Nurse Director and Medical Director and other CHI staff as appropriate
(iii) The Trust
(iv) Relatives of the deceased (facilitated by the Trust) if requested, on an individual basis

The Group's findings will not be published in full in the investigation report, though a summary will be included. The final report of the Group will be subject to the usual rules of disclosure applying to CHI investigation reports.

APPENDIX F

An explanation of the dissolution of services into the new Primary Care Trusts.

Arrangements for hosting clinical services

	Portsmouth City PCT	East Hampshire PCT	Fareham & Gosport PCT	West Hampshire NHS TRust
Elderly medicine		●		
Elderly mental health		●		
Community paediatrics	●			
Adult mental health services	● For Portsmouth City Patients			● For Hampshire Patients
Learning disability services			●	
Subsatnce misuse	●			
Clinical pyschology	●			●
Primary care counselling	●			
Specialist family planning	●			
Palliative care		●		

(**Local Health, Local Decisions, Consultant Document September 2001**, South East Regional Office of the NHS Executive: Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

APPENDIX G

Table illustrating the Throughput in the Gosport War Memorial Hospital wards Sultan, Dryad and Daedalus.

Table . Throughput data 1997/98 - 2000/01

Financial Year	Ward	FCEs	Spells
1997/98	Daedalus	97	27?
1997/98	Dryad	72	19?
1997/98	Sultan	287	106?
	GWMH	**456**	**152?**
1998/99	Daedalus	121	119
1998/99	Dryad	76	75
1998/99	Sultan	306	298
	GWMH	**503**	**492**
1999/00	Daedalus	110	110
1999/00	Dryad	131	130
1999/00	Sultan	402	383
	GWMH	**643**	**623**
2000/01	Daedalus	113	110
2000/01	Dryad	86	84
2000/01	Sultan	380	361
	GWMH	**579**	**555**

*** Daedalus and Daedalus Stroke have been added together.**

Further work needed on presentation of data and commentary.(1997/98 data incomplete to date)

APPENDIX H

Breakdown of Medication in Dryad , Sultan and Daedalus wards at the Gosport War Memorial Hospital.

Summary of Medicine Useage 1997/98-2000/01 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine Injection	**Daedauls**	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total	**5mg**	**5**	**6**	**10**	**0**	**19**
Diamorphine Syringe	**Sultan**	5mg	1	0	10	0	0
	Total	**5mg**	**1**	**0**	**10**	**0**	**0**
Diamorphine Injection	**Daedalus**	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	87	38	24	35
	Total	**10mg**	**5**	**128**	**127**	**107**	**74**
Diamorphine Syringe	**Dryad**	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total	**10mg**	**1**	**0**	**37**	**0**	**0**
Diamorphine Injection	**Daedalus**	30mg	5	16	27	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	43	14	31
	Total	30mg	5	117	121	69	42
Diamorphine Syringe	**Dryad**	30mg	1	0	5	0	0
	Total	**30mg**	**1**	**0**	**5**	**0**	**0**

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine Injection	**Daedalus**	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total	100mg	5	34	51	3	0
Diamorphine Injection	**Daedalus**	500mg	5	0	1	0	0
	Dryad	500mg	5	0	2	0	4
	Sultan	500mg	5	1	1	0	4
	Total	**500mg**	**5**	**1**	**4**	**0**	**0**
Haloperidol Injection	**Daedalus**	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
	Sultan	5mg/5ml	10	43	15	6	0
	Total	**5mg/5ml**	**10**	**44**	**19**	**6**	**0**
Drug	**Ward**	**Dose**	**Pack**	**97/98**	**98/99**	**99/00**	**00/01**
Haloperidol Injection	**Daedalus**	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
	Sultan	5mg/5ml	5	0	0	0	16
	Total	**5mg/5ml**	**5**	**0**	**0**	**0**	**21**
Midazolam	**Daedalus**	10mg/2ml	10	37	51	39	17
	Dryad	10mg/2ml	10	75	108	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total	**10mg/2ml**	**10**	**133**	**168**	**116**	**47**

(Summary of Medicine Useage 1997/98-2000/01 (Mar 2002), Portsmouth Hospitals Trust , Pharmacy Service)

APPENDIX I

Glossary