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Gosport Investigation

Acknowledgements

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

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

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

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

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 ?? who gave their views and submitted relevant documents to the investigation.

Executive Summary

Introductory Background

CHI has undertaken this investigation based on concerns expressed by the police and others around the care and treatment of frail older people provided by the Portsmouth Healthcare NHS Trust at the Gosport War Memorial Hospital. This follows a number of police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at the War Memorial Hospital to share their concerns with CHI.

Key Findings

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

- Arrangements for the administration of medicines

Information provided by three expert police witness reports which suggest that diamorphine, haloperidol and midazolam had been prescribed in and around 1998 without

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sufficient cause and in sufficiently high doses and combinations which could adversely affect frail patients. *Though the ranges within which these medicines were prescribed were in line with local and national guidance?? ???*

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

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

- Transfer arrangements

There is some confusion over the purpose of wards at the Gosport War Memorial Hospital within the whole health economy and of the criteria for admission to each ward. The (multi-disciplinary) rehabilitation team are involved in assessing patients in the acute trust (and Haslar??) in consultation with the clinician before transfer. However, this is not the case with patients being transferred to sultan ward. Relatives and patients had been given raised expectations on discharge from the acute trust in order to ease bed pressures in the acute trust, this was confirmed by staff at both trusts ??. (Could check readmission rates here). Nurses spoke of patients being increasingly dependent on admission to the Gosport War Memorial Hospital in recent years.

Admission and discharge policy

Some degree of time lag between medical assessment in the acute setting prior to discharge and assessment on admission. Example of discharge delay can take upto 6 weeks because of lack of resources for care package but happening less often now. Other delays may be a cause of specialist equipment, transport and records.

E1 Site Interviews

Discharge arrangements are adequate, with evidence of multi disciplinary assessment and social services input. To what degree are patients supp at home CRES ??? CHI

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observed some ambiguity around setting and working towards discharge dates. Feedback from local nursing homes suggest a constructive working relationship, with nursing home staff encouraged to assess and meet patients and their families prior to discharge to nursing homes.

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

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

- Responsibility for patient care

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

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

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

- Culture of care

The culture of the trust that of the caring employer. It is unclear how the laudable strategy to develop a skilled, motivated workforce would lead to measurable improvements in patient care. User involvement???, unclear as to the priority given for patient involvement in a strategic way. The trust has, since 1999?? Been

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aware of its own demise and has worked collaboratively with staff to bring about considerable organisational change with minimum impact upon staff.

Concern over the culture of care afforded to elderly patients with dementia, who are sometimes perceived as a "problem" police expert witness reports expressed concern over the use of drugs to manage behaviour rather than pain in 1998. Multi disciplinary working in infancy though commitment exists from the staff.

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

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

Check Liz comments here??

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

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

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

Key recommendations

The prescribing ranges in use at the trust should be revised ???Pharmacy safeguards?

Audit/monitoring???

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

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How to move culture on in new trust? Staff v patients
Role of NPSA in working with trusts to establish patterns and identify risks?
Development of memorandum of understanding between CHI and all police forces detailing how to best share information and identify potential systems failures as soon as possible.
Development of national definitions of various levels of care provided to older people in order to minimise confusion and ensure that patients are cared for in the best possible environments.
Rapid piece of work >>????Clarification of discharge /transfer arrangements between acute and community hospitals.

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Chapter 1 - Terms of reference and process of the investigation

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

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

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

On 18 September 2001, CHI's Investigations and Fast Track Clinical Governance Programme Board decided to undertake an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust is responsible at the Gosport War Memorial Hospital. 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 were the reasons for CHI's decision.

Terms of reference

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

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- (i) Staffing and accountability arrangements, including out of hours.
- (ii) The guidelines and practices in place at the trust to ensure good quality care and effective performance management.
- (iii) Arrangements for the prescription, administration, review and recording of drugs.
- (iv) Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations.
- (v) Arrangements to support patients and their relatives and carers towards the end of the patients' life.
- (vi) Supervision and training arrangements in place to enable staff to provide effective care.

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

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

CHI's investigation team

Alan Carpenter, chief executive, Somerset Coast Primary Care Trust
 Anne Grosskurth, CHI Support Investigations Manger
 Dr Tony Luxton, consultant geriatrician, Lifespan Healthcare NHS Trust
 Julie Miller, CHI Lead Investigations Manager
 Maureen Morgan, Independent Consultant and former Nurse Director
 Mary Parkinson, Lay Member (Age Concern)
 Jennifer Wenborne, Independent Occupational Therapist

The team was supported by:

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

The investigation process

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The investigation consisted of five inter related parts:

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

Analysis of views received from over 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 ?? for an analysis of views received).

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

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

An independent review of the anonymised clinical and nursing notes of some patients who had recently died on Deadalus, Dryad and Sultan wards between August 2001 and January 2002.

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Chapter 2 - Background to the investigation

Events surrounding the CHI investigation

Police investigations

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

The initial police investigation was the subject of a complaint by the patient's daughter and as a consequence a further police investigation was begun in August 1999. Subsequently, in December 2000 a further file was submitted to the CPS concerning the circumstances of the patient's death. In August 2001 the CPS advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

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

In February 2002, after careful consideration, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the GMC, UKCC the trust and the Portsmouth and Isle of Wight Health Authority.

(Nick - above section already checked through with police)

Tuesday, 12 January 2016

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Action Taken by Professional Regulatory Bodies

General Medical Council (GMC)

The case of one doctor was considered by the Interim Orders Committee of the GMC in June 2001. Note Dr B's case going to the IOC again on 20.3.02, the GMC are happy for CHI to refer to the June IOC if a suspension order is made on 20.3 - this sentence will have to be updated.

United Kingdom Central Council (UKCC) and after 18/03/02 1.4.02 Nursing and Midwifery Council (NMC)

Three nurses were referred to the UKCC's Preliminary Orders Committee in June 2001, the case was 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 were nine complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards between 1998 and 2001, the period of the CHI investigation. Three complaints between August and November 1998 raised concerns which included the use of diamorphine and levels of sedation on Daedalus and Dryad wards, one of which was subsequently investigated by the police. Following police involvement, the complainant did not pursue through the NHS Complaints Procedure.

Action taken by Health Authority

In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people and secondly as the body through which GPs are allowed 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. The health authority was made aware, by the police, of their investigation in ???

As independent contractors, GPs work to a national contract to provide general medical services to NHS registered patients. GPs are not NHS employees. The health authority maintained a medical list, subject to certain conditions, which allowed GPs to practice.

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In June 2001, the Isle of Wight, Portsmouth and South East Hampshire Health Authority invoked its Local Procedure for the Identification and Support of Primary Care Medical Practitioners whose Practice is Giving Cause for Concern in respect of the prescribing practice of a clinical assistant employed by the Trust in June 2001 who is a GP. The health authority Performance Steering Group, which was constituted in line with the policy and included representation from the Community Health Council, initiated a preliminary investigation and decided not to make a referral to the next stage of the process which could involve removal from the medical list, as they had no concerns regarding the GPs prescribing in general practice.

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

Following receipt of the police expert witness reports in February 2002, the health authority sought and received the voluntary agreement of the clinical assistant to no longer prescribe opiates and benzodiazepines in general practice. The trust also sought the voluntary, temporary agreement of the clinical assistant to no longer admit adult patients to the GP ward of the Gosport War Memorial Hospital.

Action taken by NHSE South East Regional Office

The Regional Offices of the NHSE are 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 system for monitoring trust complaints relating to the Portsmouth Healthcare NHS Trust. The Regional Office first became aware of the police investigation in ?? Serious Untoward Incident reports were completed in April and July 2001 in response to articles surrounding the death of a patient in the media.

Findings

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That the police appropriately raised concerns with CHI regarding the care of older patients at the Gosport War Memorial Hospital. (*Nick, can we say they should have shared info within the health community earlier, they would agree with this themselves?*)

That the trust, health authority and regional Office failed to use the intelligence available to them to identify and address a potential serious risk to patient care until 2001.

Recommendations

That CHI work with the national ??? of police forces to develop a protocol for sharing information regarding patient safety and possible systems failures as early as possible.

That as an early priority, the ?? Special Health Authority ensure that systems are in place to identify potential patient safety issues and to take appropriate action.

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Chapter 3 – National and Local Context

National context

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

The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS National Plan and the Standing Nursing and Midwifery Committee's 2001 report found care to be deficient. Amongst the concerns raised have been, an inadequate and demoralised workforce, poor care environments, lack of seamless care within the NHS and ageism. The NHS Plan's section "Dignity, Security and Independence in Old Age" published in July 2000, outlined the government's plans for the care of older people which would be detailed in a National Service Framework.

The National Service Framework for Older People was published in March 2001 and sets standards of care of older people in all care settings. It aims to ensure high quality of care and treatment, regardless of age. Older people are to be treated as individuals with dignity and respect. The framework places special emphasis on the involvement of older patient's and their relatives in the care process, including care planning. There are to be local mechanisms to ensure the implementation of the framework with progress expected by June 2001. Chapter ? goes on to explain how the trust has addressed the requirements of the NSF for Older People.

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

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aspects of care such as nutrition, pressure sores and privacy and dignity.

Trust Background

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

Move Towards PCT

PHCT was dissolved in March 2002. Services have been transferred to local Primary Care Trusts (PCTs). Elderly medicine was transferred to the Fareham and Gosport PCT when it became operational, as a level four PCT in April 2002.

Kellie - instead of this - I think the chart with blobs on page 13 is a bit clearer as they did it - we need to check with HA that this is the agreed configuration.

Chart Showing the Proposed Management arrangements for Clinical Services (NHS Sept 2001)

	Portsmouth City PCT	East Hampshire PCT	Proposed 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			●	
Substance Misuse	●			
Clinical Psychology	●			●
Primary Care	●			

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Counselling				
Specialist Family Planning	●			
Palliative Care		●		

The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/02 check??, the trust had a budget in excess of £100 million, over 20% of income was spent on its largest service, elderly medicine. All financial targets were met in 2000/01.

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

Trust Strategic Management

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

CHI heard that the Trust was well regarded in the local health economy and had developed robust links with the Health Authority and local PCGs. For example in the lead up to PCT status, PHCT's Director of Operations worked for two days each week for the East Hampshire PCT.

Services for Older People

Before April 2002, services for older people in Portsmouth were provided by the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust, this was an unusual arrangement, though precedents do exist in Southampton Community Trust for example. Management of this service has now transferred to the East Hampshire PCT (*check title*), The department provides acute admission, rehabilitation,

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continuing care, day hospitals and palliative care. Acute facilities are based at Queen Alexandra Hospital with facilities at St Mary's Hospital (both part of the local acute trust, Portsmouth Hospitals NHS Trust). The department works closely with the community hospitals in Fareham, Gosport (the Gosport War Memorial Hospital) and Petersfield. Until ?? 2000, the Haslar Hospital, a military hospital on the Gosport peninsula provided acute elderly care to civilians.

Service Performance Management

The principle tool for the performance management of the department of elderly medicine was the quarterly divisional review meeting, chaired by ???. The division is headed by a general manager, who reported to the chief executive. This post has been vacant since ?? 2000. Divisional management at the trust was well defined, with clear systems for monitoring clinical governance, complaints and risk. Leadership at divisional level was strong with clear accounting structures to corporate level.

In patient services for older people at the Gosport War Memorial Hospital 1998-2001

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

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

Dryad Ward

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

Daedalus Ward

24 bedded ward for continuing care (?) intermediate and slow stream rehabilitation for elderly frail patients. Admission is as for Dryad ward.

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The criteria for admission to both Dryad and Daedalus wards, are that the patient must be over 65 and be registered with a GP within the Gosport PCG. In addition, Dryad patients must have a Barthel score of under 4/20 and require specialist medical and nursing intervention. The Barthel score is a recognised tool used to measure physical disability. Daedalus patients must require multidisciplinary rehabilitation for strokes and other conditions.

Sultan Ward

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

Mulberry Ward

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

Ward	1998	2002
Dryad	Trust to complete	20 continuing care beds ? slow stream rehabilitation
Daedalus	Trust to complete	24 rehabilitation beds; 8 general, 8 fast and 8 slow stream (since November 2000)
Sultan	24 GP beds	24 GP beds

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

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Findings

The Trust had strong leadership at corporate and divisional level with a shared set of values focussed mainly on staff. The corporate team was well established and functioned, together with the board, as a team. The chief executive was accessible to staff and well regarded by NHS staff both within the trust and in the local health economy. Good links had been developed with local PCG's.

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

Recommendations

The PCT must build on the many positive aspects of leadership developed by PHCT in order to take the organisation forward.

The findings of this investigation should be used to influence national policy work under the National Service Framework which CHI has a responsibility to monitor.

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

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Chapter 4 - Quality of Care and the Patient Experience

Introduction

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

Analysts to provide through out data 1997/98 - 2000/01 here.

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

Patient experience

The investigation examined in detail the experience of older patients admitted to the Gosport War Memorial Hospital between 1998 and 2001 and that of their relatives and carers. This was carried out in two ways. Firstly, stakeholders were invited, though 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. There was a range of experiences of the care of older people amongst those who spoke to CHI.

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

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Stakeholder outcomes

Concerns raised most frequently by stakeholders were; the use of medicines, the attitude of staff, incontinence management, patients clothing and nutrition and fluids. *Bracketed number will be removed in final drafts*

Use of medicines

The use of pain relieving medicines was commented on by a number of relatives. One relative commented "she certainly was not in pain prior to transfer to the War Memorial". Though a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI did receive comments that families would have liked more information (6) "doctors should disclose all drugs and why and what side effects are. There should be more honesty" (20).

Attitude of staff

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

Incontinence Management

A number of stakeholders raised concerns regarding the frequent catheterisation of patients on admission to the War Memorial. "They seem to catheterise everyone, my husband was not incontinent, the nurse said it was done mostly to save time". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.

Patients clothing

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

Transfer arrangements

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Several relatives spoke of patients being inadequately dressed and covered during the journey to the Gosport War Memorial Hospital, *insert quote*

Nutrition and fluids

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

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. Observation periods included staff handovers, mealtimes and a multidisciplinary team visit. The team also visited at night. Ward staff welcomed the CHI team and were friendly and open.

Ward environment

All wards were built during the 1991 expansion of the hospital and are modern, welcoming and bright. This view was echoed by stakeholders who were complimentary about the décor and patient surroundings. Wards were tidy, clean and fresh smelling. Day rooms are pleasant and Daedalus ward has direct access to a well laid out garden suitable for wheelchair users. The garden has a variety of different textures, a thoughtful way in which to practice walking for patients. There is limited storage space in Daedalus and Dryad wards and as a result the corridors had become cluttered with equipment which was observed as problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe. Photographs of staff were also evident, though they may be difficult to see with any visual impairment.

Staff

The CHI team saw patients addressed by name in a friendly way and saw examples of good patient staff interaction such as help with dressing and friendly

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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 options and portion size. Generally patients were assisted to eat and drink. There appeared to be sufficient staff to serve meals and to note when meals not eaten. CHI did not observe any meals returned untouched.

Daytime activities

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

Patient and relative feedback

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

Confidentiality

CHI had some concern over the confidential treatment of patient information. For example, patient notes were left open in view of the ward and information such as feeding regimes was taped on the doors of bays in Daedalus ward.

The End of Life

Casemix, complexity, expectation, rehab?? Cont care training of clinical staff
leaflets for pats/rel??

Findings

- Relatives speaking to CHI had some very real concerns about the care their relatives received on Daedalus 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 Sultan ward.
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Table to shows the wards and dates concerns about care were raised by stakeholders
(patients/relatives/friends/users)

	1998	1999	2000	2001
Daedalus	4	1	2	1
Dryad	1			
Sultan	1		1	
Not sure	1 1 (d/D)	1 (d/D)	1	

d/D means either
Dyrad or Daedalus..

Need totals and to decide which wards

- The ward environments and physical care of patients observed by the CHI team was of good quality.
- daytime activity to encourage self awareness and promote confidence available to patients is limited on all three wards.
- Some evidence of poor practice regarding patient confidentiality was observed.
-

Recommendations

- That all patient complaints, informal and formal, which express any of the issues referred to above should be an item on all monthly ward meeting agendas. The service manager should coordinate shared learning amongst wards.
- That the system adopted by the PCT to replace the quarterly divisional review process, ensures that the identification of trends in patient complaints is a priority.
-
- That all systems such as the notebook system used to record patient and relatives comments in use on Deadalus ward be extended to all elderly care wards and emerging themes fed into monthly ward meetings.
- That increased daytime activities be made available to patients. The role of the activities coordinator should be revised and strengthened with patient, occupational therapy and physiotherapy input.
- That the wards review, with the assistance of the PCT's Caldicott Guardian, steps to ensure that patient confidentiality is maintained.

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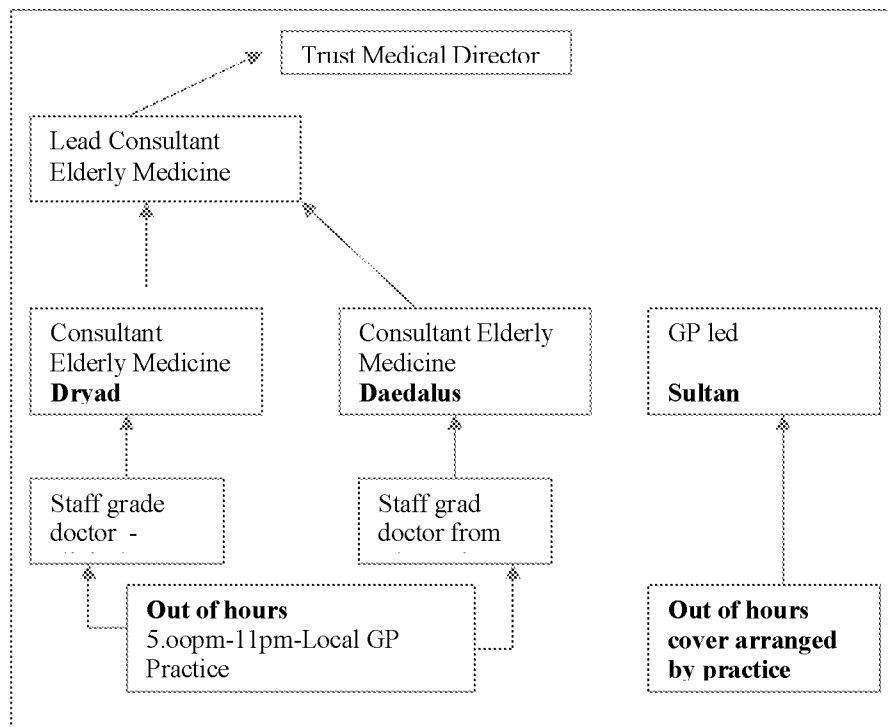
Chapter 5 - Staffing Accountability and Responsibility for Patient Care

Medical Staff Accountability

Medical accountability for the care of older people in Daedalus and Dryad wards lies ultimately with the Medical Director. There is a senior consultant for Elderly Medicine who holds a two session contract for undertaking lead consultant responsibilities. The post holder does not undertake any session on the War Memorial site. The job description (Feb 1999) for this post dates February 1999 outlines twelve areas for this clinician to manage and states that the post is a major challenge for "a very part time role".

DJ Interview

In addition, two consultants provide 10 sessions in total of consultant cover on Dryad and Daedalus wards. Both consultants report to the lead consultant and undertake a weekly ward round with the staff grade doctor. All patients on both wards are admitted under the care of a consultant. Junior medical support is provided by a staff grade physician employed since September 2000. CHI learnt that in 1998 the lead consultant held a fortnightly ward round on Daedalus ward, this increased in ?? to weekly.



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General Practice Role and Accountability

Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation; as Clinical Assistants, as the clinicians admitting and caring for patients on the the GP (Sultan) ward and as providers of out of hours medical support on each of the three wards.

Clinical Assistant Role

Clinical Assistants are GPs who are contracted to hospitals to provide, largely part time, medical support on hospital wards. Clinical Assistants have been a feature of community hospitals for a number of year, the PHCT employ a number of such GPs. Clinical Assistants have the same responsibilities as hospital doctors to admit and discharge patients, to prescribe medication, write in the medical record and complete death certificates. A Clinical Assistant was employed for five sessions for the period of this investigation under the post holder resigned in July 2000. The fees for this service when the Clinical Assistant was appointed in 1994 ? were £2,810 per session, per annum as set out in the job description. The job description refers only to work in the Day Hospital and does not specify to whom the post holder is responsible. Cover for six weeks annual leave and any sickness absence was the responsibility of the post holder to arrange with the clinical assistants practice partners.

A covering specification of medical services provided by retained medical officer Tony ????

Need to see jane b's notes

CHI is not aware of any systems in place to monitor the performance of the clinical assistant, nor of any formal lines of communication regarding policy development, guidelines and workload. The performance of the clinical assistant was not appraised. The job description does state that the post is subject to the Terms and Conditions of Hospital Medical and Dental Staff.

Sultan Ward

Medical responsibility for patients on Sultan ward lies with the admitting GP. The trust issued admitting GPs with a contract to enable them to admit patients onto the Sultan ward. These contracts are standard throughout the trust and clearly state " As a member of the staff of this hospital, you will take full clinical

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responsibility for the patients under your care". The documents also make it explicit that the agreed disciplinary procedure is that of the trust. CHI was told by PCHT staff and GPs 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 lines of clinical responsibility into the medical staffing arrangements of the trust.

Medical Supervision

Define consultant appraisal??

Since, ?? there has been a system for the annual appraisal of all doctors employed by the trust, including those on locum contracts. All doctors interviewed by CHI, including the medical director who works 5 sessions in the department of elderly medicine, have regular appraisals. Those appraising the work of other doctors have been trained to do so. CHI found no evidence of appraisal arrangements for GPs working as clinical assistants.

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

CHI had some concerns regarding the potential for isolation of the staff grade doctor, due to the level of consultant input on Daedalus and Dryad wards and the distance of the War Memorial Hospital from the hub of the department of elderly medicine. The trust recognised this in 2001 in the document which outlines action taken following complaints and patient based incidents " A decision was taken not to employ a locum consultant because of the risk of professional isolation and support in Gosport".

Nursing Accountability

Nurses are accountable to a clinical manager (G Grade) who is accountable to a senior nurse (H Grade). The senior nurse has responsibilities for continuing care and rehabilitation across both wards, the post was created in November 2000 with the aim of the postholder acting as a role model and nursing leader. The senior nurse is accountable to the elderly service manager who reports to the general manager for the Fareham and Gosport division. The general manager is then

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responsible jointly to the director of nursing and the operational director. An accountability structure such as this would not be unusual in a community hospital.

Responsibility of Direstor of nursing ???-
development/monitoring??
?chart here to explain structure

Nursing supervision

Definition from Maureen ??The Trust has been working to adopt a model of clinical supervision for nurses for a number of years and received initial assistance from the Royal College of Nurses to develop processes. The Trust focus had been on reflective practice, the overall aim to ensure that staff had access to good systems of clinical support to enhance their practice. As part of the Trusts Clinical Nursing Development Programme which ran between January 1999 and December 2000, nurses were identified to facilitate the development of leadership skills in order to lead the development of clinical supervision and reflective practice. Two members of staff attended this programme, though one has retired and one left the trust.

CHI was also told of the trusts Gerontological Nursing Programme, which began in September 2001. All F and G grade nurses are participating. The programme is geared towards the principles of individual care and reflection. The trust believed that this programme (...see nurse dir comments)

Though CHI was impressed by the very credible efforts made by the trust, with the input of the Royal College of Nurses, CHI was unclear how the strategic impact of the introduction of clinical supervision and reflective practice was being measured in terms of improved quality of care for patients. The trust have acknowledged that the main barriers to clinical supervision have been the availability of appropriate supervisors and protected time.

Many of the nurses interviewed valued the principles of reflective practice as a way in which to improve their own skills and care of patients. The H grade senior nurse coordinator post appointed in November 2000 was a specific trust response to an acknowledged lack of nursing leadership at the Gosport War Memorial Hospital. Regular clinical supervision meetings are held on Sultan

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and Daedalus ward, with less clear arrangements on Dryad ward which may be due senior ward staff sickness.

Allied Health Professional Structures

Allied Health Professionals (AHP's) are a group of staff which include occupational therapists, physiotherapists and pharmacists. The Trust's 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, at Haslar??. 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

Physiotherapists are based within the Hospital they have well equipped gym room with cubicles plus separate are of cubicles containing a variety of electrical equipment, traction small room used for gynaecology, urology and private consultation with patients/relatives to ensure privacy. The Physiotherapist deals will the patient from admission right through to home treatment. This type of follow through is also facilitated by the STEP-DOWN groups organised within the community. These groups meet once a month. The type of patient have usually suffered a stroke but many also have orthopaedic conditions that need attention too. The treatment can be provided individually or in groups depending on the patients and the family are also involved in the care plan.

Physiotherapist are in involved in Multi-disciplinary team meetings on Daedalus which also involve OTS, and SLT.

Generally it there is a good level of training and SUPERVISION????

Speech and Language Therapists

Speech and Language Therapists deal with disvager/swallowing and speech therapy. There are clinics in the Rehabilitation Department on a sessional basis within inpatients and outpatients. Referrals are accepted from Doctors, Nurses and other therapists. The Speech and Languauge Therapist attend Multi Disciplinary Team meetings on Daedalus on Monday and Thursday based on patients.

The Speech and Language Therapist appear to have good supervision and training. Training consists of:

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- in-service training schemes, continued professional development- clinical casework and discussion groups very two months.
- Discussion groups to talk about problems
- Clinical observation groups, evaluation conducted
- Clinical co-ordinates meet twice a year. Meet with mismanagement at Gosport to talk about standards

Dietetics

The staffing structure consist of one full time dietician and then each unit should have a lead nutrition person. The Lead Nutrition person has been nominated and should attend training/updates and acts as a source for colleagues. The Lead Nutrition persons meet every 6 months. As part of training all staff will attend a Diet Course which will enable them to recognise any deterioration in a patient should this event arise. Assistance in feeding is also provided by the HCSW. Patients that are dependent have their food habits documented on a chart which is reviewed every 48hours. Systems should also be in place to ensure that staff have the required training to implement and monitor the " Feeding People" standards.

Relative and patient care is also involved in dietary needs and the Community Enablement Service acts as an interface between hospitals and communities.

Workforce and service planning

? { In preparation for the change of use of beds in Dryad and Deadalus wards in November 2000, from November 1999 to April 2000 the Trust undertook a skill mix review which identified a possible increase of specialist intervention, such as as a risk. Plans were put in place to increase consultant staffing by prior to Jan 2001 and to train qualified nursing staff to address the need to develop skills in relation to assessment of changes/deterioration in patients conditions, Eg alert course (a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration) No additional therapy support was identified or provided. Despite this, several members of staff expressed their concern regarding the complexity of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages and high sickness levels.check evidence here This change of use of beds at the Gosport War Memorial Hospital with the resulting

Development
of Int Care
and Rehab
services
within
Gosport
Locality

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increased complexity of patients was in line with national policy ???? Concerns were raised formally by the Clinical Assistant in early 2000 around the increased workload and complexity of patients, these were acknowledged by the Medical Director in ??, though there was no systematic attempt to review or seek solutions. ADD IN DR B'S OTHER LETTERS what was reason for no action ?? Ian Reids notes

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

Staff welfare

The trust developed as a caring employee this is demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy. Domestic abuse policy- used as a benchmark around the country extend???????? Add in award winning from who?? Improving working lives standards??

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 the use of the trust's counselling service and of organised support sessions for staff. Though not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, some staff during the interviews suggested that, " Junior staff have not received as much support" or "I don't feel I've had the support I should have had before and during the investigation-others feel the same"

Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship. The RCN have an ???

Out of hours arrangements

Between the hours of 9 - 5, 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 ?? to 11.00pm after which nursing staff call on Healthcall, a local deputising service for medical input between 11pm and 7.00am. Staff interviewed by CHI on all wards expressed concern

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regarding frequent 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

There is no system to report long waits. The healthcall contract with the trust ??? performance standards, It was also recorded that monitoring and management would be done by the General Manager and Personnel Director (E6 pg 41) *Any conflict with Dr Beasley's info??*

There was also concern over Healthcall GPs reluctance to "interfere" with admitting GPs prescribing on Sultan wards. This was also evident on Dryad ward where staff commented on out of hours GPs declining to interfere with established pain management care this would include strong analgesics.

In an emergency situation, nursing staff call 999 for assistance and possible transfer to the local A&E department. The need to call 999 is because the GWMH does not have the facility to provide intensive care in the event of a medical emergency whereupon, the patient becomes critically ill which could eventually lead to organ failure. In an Acute hospital the patient would be transferred to an Intensive care unit. But in the community hospital where an intensive care unit is absent, staff are trained to recognise acute life threatening events through ALERT course training and then to initiate basic life support and use an automated external defibrillator, if necessary, to maintain a patient's life. If further advanced life support is required this will be provided by the Paramedic Ambulance Services for Community Hospitals. Basic Life Support is provided by CPR training and Automated External Defibrillator (AED) is provided by training which is also mandatory.

<p>Training and development for Nursing staff in PHCT Community Hospitals relating to intermediate care</p>

On Sultan ward, out of hours cover is provided by the patients GPs practice on-call arrangements I thought they also used Healthcall??. Emergency cover is provided through the 999 service.

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

Night skill mix review - see file

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Team working

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

There are no multi-disciplinary team meetings on Dryad and Sultan wards. Therapy staff reported some progress towards multi-disciplinary goal setting for patients, such as targets for ??? Jen? though wished to see more development. How would they influence this??

Expert opinion

Older patients are admitted to Gosport War Memorial Hospital with a wide variety of conditions such as dementia, cancers and ??? Staff demonstrated good examples of systems in place to access expert opinion. 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. There are also strong links with a local hospice and MacMillan nurses. The local hospice have published a palliative care booklet ???, which staff are aware of and use. Nurses gave an example of joint training with the hospice in the use of syringe drivers. CHI was also told of specialist of dietetic, chiropody and dentistry support for patients.

The trust has recently appointed a nurse consultant in stroke services Expand impact/monitoring of role??

Findings

- The trust has a well developed supervision and appraisal systems for all directly employed staff. The principles of reflective practice are becoming embedded in the culture of care. No such systems were evident for the employment of clinical assistants and GPs working on the Sultan ward.

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- The Trust has a strong staff focus, with some notable examples of good practice.
-
- Following national guidance, there was a planned approach to the service development which brought about the change of use of beds in 2000. The increasing dependency of care required by patients and resulting pressure on the service, whilst recognised, was neither monitored nor reviewed by the trust.
-
- Out of hours medical cover for the three wards out of hours is inadequate and does not reflect current levels of dependency. 999 evidence??
- Some progress has been made towards multi-disciplinary team working which should be developed NSF?? Standards
- There are clear accountability and supervisory arrangements in place for trust doctors, nurses and AHP staff. Currently, there is effective clinical leadership on the three wards.
Recommendations (just ideas)
- The Royal College of GPs should develop national guidelines for trusts and for GPs employed as clinical assistants and for GPs working on GP led wards.
- The Trust should urgently review its use of clinical assistants with the aim of establishing an appraisal and supervision system in line with that for other trust staff.
- The 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 trust should undertake a case-mix review of patients admitted to Dryad, Daedalus and Sultan wards to determine and address higher dependency patients are being admitted.

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Chapter 6 – Guidelines and Practices

CHIs remit is to investigate the adequacy of systems to support good patient care. CHI looked at specific policies from a range in use at the trust and has assessed their impact on patient care.

*Refer to HAS standards, Essence of Care, NSF
Outline drivers for change
Outline process for writing/agreeing policy*

- In relation to the implementation of the National Service Framework for Older people the IOW Portsmouth and SE Hampshire health Authority created a District –wide Implementation Team. This team included representatives from voluntary organisation and the general public from the Fareham and Gosport District. This group has met twice and agreed a term of reference and local priorities for action in line with National Service Framework timescales. The IOW, SE Hampshire Health Authority Joint Investment Plan for Older People 2001-2002 includes local intentions for implementation of the NSF and the relevant early milestones to be achieved. At the Gosport and Fareham Division the progress of implementation at more specifically the Gosport War Memorial Hospital has included:
 - Community Enablement Service
 - Conversion of 24 continuing care beds to provide additional geriatric rehabilitation beds
 - Incorporating existing policy into generic Transfer document
 - Falls Policy
 - Stroke Policy
 - Alert Policy
 - User and Carer experience - 'User involvement in service development: framework' (Portsmouth Healthcare Trust Nov 2001)

IOW, Posrtmouth and SE hants health HA Progress report
--

Additional Information IOW SE Hanmp Joint Investment Plan 201-2202

Policies looked at in relation to the TOR;

Patient transfer
Lack of OT input

DNR

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

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Palliative care

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

Nutrition and fluids

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

As part of a five year strategy towards developing a "Feeding People Policy" for Portsmouth Healthcare NHS Trust an audit of minimum nutritional standards was undertaken between October 1997 and March 1998. As a result of this audit the "Feeding People Working Group" developed the following standards, based on DOH guidelines. Two of the main findings were the need for a Lead Nutrition Person in each clinical area. This Lead Nutrition Person would also be involved in organising training programmes for staff and improved documentation to ensure 100% compliance. A framework was also established through the "Policy for Prevention and Management of Malnutrition with Trust Residential and Hospital Services". The Policy states:

- all patients must have a nutritional risk assessment on admission
- Registered nurses must plan, implement and oversee nutritional care and refer to appropriate professional as necessary.
- All clinical areas should have a nominated nutritional representative who attends training/updates and is a source for colleagues.
- Systems should be in place to ensure that staff have the required training to implement and monitor the 'Feeding People' Standards.

The "Feeding People" Standards are as follows:

- | |
|---|
| <ul style="list-style-type: none"> ○ Patients to be weighed within 48 hrs of admission and at least monthly thereafter. ○ Any significant weight loss or gain to be reported to medical staff and recorded in notes ○ All patients to have nutritional assessment on admission ○ There is a designated member of staff responsible for nutrition on every unit ○ Those who need help will get help from staff at meal times ○ Appropriate action is taken in relation to a person's |
|---|

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During the interview of CHI staff, the following standards are considered part of patient care.

Medical records
Continence
Consent
Control of infection - MRSA
Rehabilitation
Continuing care

Findings

Recommendations

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Chapter 7 - Arrangements for the prescription, administration, review and recording of medicines

The trust supplied the following breakdown of usage of diamorphine, hydrocine and medazolam from 1997/98 until 2000/01 based on pharmacy data, this demonstrates a clear reduction in these drugs.

Portsmouth Hospitals NHS Trust Pharmacy Service Summary of Medicines Use 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
Diamorphine Injection	Daedalus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0

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	Sultan	100mg	5	20	27	0	31
	Total	100mg	5	34	51	3	0
	Daedalus	500mg	5	0	1	0	0
	Dryad	500mg	5	0	2	0	4
Diamorphine Injection	Sultan	500mg	5	1	1	0	4
	Total	500mg	5	1	4	0	0
	Daedalus	100mcg/hr	5	0	1	0	0
	Dryad	100mcg/hr	5	0	1	0	0
Fentanyl Patch	Sultan	100mcg/hr	5	0	0	0	0
	Total	100mcg/hr	5	0	2	0	0
	Daedalus	25mcg/hr	5	3	7	2	0
	Dryad	25mcg/hr	5	8	9	.8	8
Fentanyl Patch	Sultan	25mcg/hr	5	0	1	0	1
	Total	25mcg/hr	5	9	17	20	9
	Daedalus	50mcg/hr	5	1	3	0	0
	Dryad	50mcg/hr	5	1	3	9	0
Fentanyl Patch	Sultan	50mcg/hr	5	0	0	1	1
	Total	50mcg/hr	5	2	6	10	1
	Daedalus	75mcg/hr	5	3	0	0	0
	Dryad	75mcg/hr	5	3	2	2	0
Fentanyl Patch	Sultan	75mcg/hr	5	0	0	0	0
	Total	75mcg/hr	5	6	2	0	0
	Daedalus	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
Haloperidol Injection	Sultan	5mg/5ml	10	43	.5	6	0
	Total	5mg/5ml	10	44	.9	6	0
	Daedalus	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
Haloperidol Injection	Sultan	5mg/5ml	5	0	0	0	16
	Total	5mg/5ml	5	0	0	0	21

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Midazolam	Daedalus	10mg/2ml	10	37	11	39	17
	Dryad	10mg/2ml	10	75	08	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total	10mg/2ml	10	133	68	116	47

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

Liz, sister still in post

Assessment and management of pain

The Trust's policy for the assessment and management of pain was introduced in April 2001 in collaboration with Portsmouth Hospitals NHS Trust and is due for review in 2003. The stated purpose of the document was to identify mechanisms to ensure that all patients have early and effective management of pain or distress. The policy places responsibility for ensuring that pain management standards are implemented in every clinical setting and sets out the following:

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

CHI has also seen evidence of a pain management cycle chart and an analgesic ladder. The analgesic ladder indicates the drug doses for different levels of pain, how to calculate opiate doses and advice on how to evaluate the effects of analgesia and how to observe for any side effects. Nurses interviewed by CHI demonstrated a good understanding of pain assessment tools and the progression up the analgesic ladder. CHI

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welcomes the introduction and application ? of this policy, though sensitive administration of medicine does depend to some extent upon patients being articulate enough to indicate pain.

At the same time, CHI was also told by nursing staff that following the introduction of the policy, it was now taking longer for patients to be made pain free and that there was a timidity amongst medical staff about using diamorphine.update following case note review.
Nurses also spoke of a reluctance of some patients to take pain relief.

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

Other prescribing guidelines in use

Many staff interviewed referred to the "Wessex" guidelines & Rowans these booklets are dated ?? and are in general use on the ward. More when see
Prescription writing policy

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

The policy also covers a section on verbal orders. Telephone orders for single doses of drugs can be accepted over the telephone by a registered nurse if the doctor is unable to attend the ward. This is in line with UKCC guidance on telephone orders ??? CHI understands that this is common practice in GP led wards and works well on the Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours. (possible back up of evidence from case note review?)

CHI was told of the practice of anticipatory prescribing of palliating opiates need dates JB;;sinterview). As a result of the pain and assessment policy, this practice has now stopped (confirm with case note review) CHI understands that one of the drivers for this change on practice was the staff grade physician appointed in

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September 2000, who expressed concern over the range of anticipatory doses prescribed on the wards, based on knowledge gained elsewhere. CHIs case note review confirmed that anticipatory prescribing no longer occurs. (*confirm true for out of hours & Sultan too*)

Administration - use of syringe drivers

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

Think stakeholder feedback confirmed that relatives are being consulted - need to check and include in case note review

Role of nurses & HCSW - checking of competencies re syringe drivers - in Liz'a view HCSW should not be involved.?

Information provided by the Trust indicates that two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five nurses had also completed a drugs competencies course. No qualified nurses from either Dryad or Deedalus 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.

Need to ask analysts to find evidence

Review of medication

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

Role of pharmacy

Insert staffing levels and IM&T available

Findings

Role of Drugs and Therapeutics committee

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- CHI has serious concerns regarding the quantity, combination and review of drugs prescribed to older people on Dryad and Deadalus wards in 1997/98. This is confirmed by the expert witness reports the police have made available to CHI.
- Concerns were raised and not listened to by staff regarding the amounts of drugs administered via syringe driver in 1998 ?? & 1999 - Check
-
- Policies have been developed timescales and are being adhered to (evidence to include case note audit) regarding the prescription, administration, review and recording of drugs. The policies do not include methods of non-verbal assessment of pain.
-
- Pharmacy support to the wards in 1998 - ?? was inadequate. The inavailability of electronic pharmacy data could compromise the trust's ability to monitor drug useage.

The Wessex guidelines provide staff with good information - some thing about ranges

Recommendations

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

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Chapter 8 - Communication

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

Patients, Relatives and Carers

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

The HAS Standards for Health and Social Care Services for Older People (2000) states that "each service should have a written information leaflet or guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers". During the site visit, CHI saw a number of separate information leaflets provided for patients and relatives, though in one case these were stored too high to reach. This is also in accord with the Trusts user framework.

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

Communication Towards the End of Life

Though the prescription writing policy does not specify that attempts should be made to inform relatives if the prescription of opiates is becoming necessary, many relatives speaking to CHI were informed.

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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 quickly. Staff were aware more medically unstable patients being transferred.

syringe driver policy does not outline Examples of involvement in decision making eg discharge planning and use of syringe drivers expand Users and carer strategy/pals

Staff

Most staff interviewed by CHI spoke of good internal communications, and were well informed about the transfer of services to the Fareham and Gosport PCT. The trust used newsletters to inform staff of key developments an intranet is available??? The trust intranet is ???.expand

Primary care

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

Acute trust/Haslar

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

Social Services

Joint planning arrangements, involvement in discharge planning. Community Enabling Scheme. Good OT relationships, joint visits. Senior OT due to be seconded to social services for two days per week to enhance joint working and continuity of care. MDT meetings - often not have input from social services - little continuity. Funding assessment and care package delays. Sultan 25% of bed blocking ue to lack of cae package (*needs expanding*) Anne to expand

Nursing homes

CHI talked to staff from the nursing homes which most frequently receive patients from the Gosport War Memorial Hospital. Nursing home staff spoke of good, collaborative relationships with ward staff. Expand

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Findings

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

Rel with Social services?

User and carer involvement??

Recommendations

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

Consult with user groups to determine the best way to communicate with older patients and their relatives and carers.

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Chapter 9 – Complaints

Put in context regarding total number of complaints in trust/elderly med

The trust forwarded details of nine complaints made surrounding the care and treatment of patients on Dryad, Deadalus and Sultan wards between 1998 and 2001. CHI was told that over four hundred letters of thanks had been received during the same period. A number of the complaints raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death. Three such concerns were raised in the last five months of 1998.

Complaint 3 was referred to the Health Services Commissioner (Ombudsman) whose medical advisor found the choice of pain relieving drugs appropriate in terms of medicines, doses and administration. Complaint 5 was referred to an Independent Review Panel (IRP), which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Though the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

The trust's Medical Director told CHI that following receipt of Complaint 1, he confirmed with a colleague in a neighbouring trust that prescribing parameters at the War Memorial Hospital were within acceptable range. Some comment on acceptability of that range from notes review group??

(Initials must be removed in later drafts)

August 1998 Complaint 1 (MRS R)
Care and treatment on Deadalus ward (concerns subsequently raised with police regarding use of pain relief). This complaint was not taken through the NHS complaints procedure.

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

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November 1998 Complaint 3 (MRS P)
Medical and nursing care. Diamorphine usage on Dryad ward.

This complaint was reviewed by the Health Service Commissioner as outlined above.

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

January 2000 Complaint 5 (MRS D)
Clinical care, including use of sedation and communication with family on Dryad ward.

This complaint was reviewed by an Independent Review Panel as outlined above.

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

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

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

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

Complaint Handling

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

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

CHI found that letters to complainants in response to their complaints do not always include an explanation of

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the IRP process, though this is outlined in the leaflet forwarded to complainants earlier in the process. Audit standards for complaints handling (1.4 p6??) are good with at least 80% of complainants satisfied with complaint handling and performance targets for responses met. All written complaints were responded to corporately. Staff interviewed 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 adopts an open response to complaints and apologises for any shortcomings in its services. What do the board see??

Once the police became involved in Complaint 1 the trust ceased internal investigation processes. CHI discovered that the Trust Board was not formally informed about the ongoing police investigation until ... One senior trust manager told CHI that the trust would have commissioned an internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not need to preclude an internal clinical investigation. The GP Clinical Assistant involved in the care of this patient wrote to the trust's quality manager expressing concern that she discovered Complaint 1 had been made by chance three months later. Neither the Clinical Assistant nor portering staff involved in the transfer of the patient were asked for statements during the initial investigation of this complaint.

Trust Learning

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

Lessons around 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

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relatives, staff attitudes and fluids and nutrition. Action taken by the trust following the workshop is as follows:

- Piloting of pain management charts and prescribing guidance approved in May 2001. Nursing documentation is currently under review, with nurse input.
- The appointment of a staff grade doctor in September 2000.
- One additional consultant session in ?? following a district wide initiative with local PCGs around intermediate care.
- Increase in consultants ward round on Daedalus ward, from fortnightly to weekly from February 1999.
- Nursing documentation now clearly identifies prime family contacts and next-of-kin information to ensure appropriate communication with relatives.
- All conversations with families are now documented in the medical record.

Monitoring and Trend Identification

A key action identified in the 2000/01 Clinical Governance Action Plan was a strengthening of trust systems to ensure that actions following complaints have occurred. The Trust's Quality Manager plays a key role in this. Actions are now monitored through the divisional review process and the Clinical Governance Panel and Trust Board. A Trust database was introduced in 1999 to record and track trends in recent complaints. An investigations officer was also appointed in order to improve fact finding behind complaints.

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

Findings

- That the trust did not use the complaints made between 1998 and 2001 as a trigger for an internal investigation into the prescribing practices of all clinicians working in the department of elderly medicine.

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- That the trust now have a robust system through the Divisional Review Process, supported by the clinical governance framework, to identify and address potential patterns of concern and failure highlighted by formal complaints.
- That changes to improve the quality of care to older people and communication with their relatives have been made by the trust as a result of patient complaints.
- The systems are not in place to ensure that the impact of these changes have been robustly monitored and reviewed.
-
- That there has not been consistent training of all staff in communicating with patients and carers.

- Whole issue of difficult complainants???

Recommendations

- That any trends demonstrating concern, within the NHS, emerging from the prescription of any medicines be referred immediately to the National Patients Safety Agency.
- That the PCT ensures attendance of all staff on trust customer care and complaints training events.
- That the PCT ensures that the learning and monitoring of action arising from complaints undertaken through the Divisional Review system is maintained.
- Increased pharmacy safeguards?

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Chapter 10 – Clinical Governance

Introduction

Clinical governance is insert latest definition 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 and appropriately to the principles of clinical governance outlined by the Department of Health in NHS a First Class Service. In September 1998 a paper outlining how the trust planned to develop a framework for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff interviewed by CHI 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 chairs a well established Clinical Governance Panel, which has lay representation from the local Community Health Council. The Panel is supported by a Clinical Governance Reference Group with representation from each clinical service and professional group, together with human resources and training/education input. Each clinical service has its own Clinical Governance Committee. This structure has 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 quarterly process to monitor clinical governance developments.

Background

District Audit carried out an audit of the trust's clinical governance arrangements in 1998/99. The

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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 needed to be more focussed and the process strengthened.
- The clinical governance loop needed to be closed in some areas to ensure that strategy, policy and procedure resulted in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and re-audited; lessons learnt from complaints and incidents not always used to change practice and that R&D did not always lead to change in practice.
- More work needed to be done with clinical staff on openness and the support of staff alerting senior management of poor performance.

Following the Review, the Trust drew up a trust-wide action plan in December 1999 which focussed on widening the involvement and feedback from nursing, clinical and support staff 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????

Structure

The Medical Director took lead responsibility for clinical governance. The appointment of a new Nurse Director with an academic background was a deliberate move by the trust to facilitate the development of evidence based practice. A Clinical Governance Panel was established as a sub committee of the Trust Board, chaired by the Medical Director. The Clinical Governance Panel was supported a Clinical Governance Reference Group, whose membership included representatives from

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each clinical service, professional group, non-executive directors and the chair of the Community Health Council. Five key themes were identified for action at the groups first meeting in October 1999: continuing professional development, clinical audit, evidence based practice, patient and user involvement and clinical risk management

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

The Trust produced an action plan for clinical governance by May 2000 and submitted a progress report to the South East Regional Office in March 2001. - what did they say - have asked RO for copy 15.3

Risk management

Definition????see first Class service???

A Risk Management group was established by the Trust in ?? to develop and oversee the implementation of Trust's Risk Management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The Group has links with other Trust groups such as the Clinical and Service Audit Group, the Board and the Clinical Nursing Governance Committee. Originally the Finance Director had joint responsibility for strategic risk with the Quality Manager, this was changed in the 2000/03 strategy to include the Medical Director, who is the designated lead for clinical risk. The Trust achieved the Clinical Negligence Scheme for Trusts (CNST) level 1 in 1999, a decision was taken by the Trust, due to pending dissolution in 2002, not to pursue the level 2 standard.

The Trust has an operational policy for "Recording and Reviewing Risk Events". New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non-clinical risk. The same trust policy is used to report clinical, non-clinical and accidents. All events are recorded in the

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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 received no evidence to suggest that doctors regularly identified and reported risks. CHI was told on a number of occasions, that risk forms were regularly completed by wards in the event of staff shortages. This is not one of the Trust's Risk Event Definitions.

The Clinical Governance Development Plan for 2001/02 states that the focus for risk management in 2000/01 was the safe transfer of services to successor organisations, with the active involvement of PCTs and PCGs in the Trust's Risk Management Group. Meetings have been held with each successor organisation to agree future arrangements for such areas as; risk event reporting, health and safety, infection control and medicines management.

Systems for reporting medication errors and near misses

To be completed with team.

Raising concerns

The Trust has had a Whistleblowing policy in place since 1998 (check as version I have is dated Nov 2001) The policy sets out the process staff should follow if they wish to raise a concern about the care or safety of a patient in the event of other procedures having failed or being exhausted. What does the act say about best practice?? Whistle-blowing policies should not rely on other procedures being exhausted- but should allow concerns to be raised without fear of retribution outside normal systems.

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

Clinical Audit

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Needs to be completed.

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

Findings

- That the Trust has responded proactively to the clinical governance agenda and has a robust framework in place with strong corporate leadership.
- That understanding of clinical risk was not universal.
- The Trust does have a Whistleblowing policy in place, this is not in line with the spirit of the Public Interest at Work Act.??

Recommendation

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

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