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Code A

From: Williams, David M
Sent: 26 January 2006 14:56
To: Grocott, David
Cc: Niven, Nigel; Code A
Subject: FW: Barton generic employment.doc

Dave..

Thanks for your work on this..Top job. (The only issue that I cannot find specifically addressed is the assessment of the patient upon admission or is this linked into the care plan issue)..

Nigel.. Can you have a look at this.. Anything further?..

DW.

From: Grocott, David
Sent: 24 January 2006 16:42
To: Williams, David M; Code A
Subject: Barton generic employment.doc

Barton generic employment.doc ...

TOPIC AREAS

Dr Jane Barton

The following 8 topic areas are suggested as being the basic guide for a preliminary interview with Dr Jane Barton. These areas and questions are applicable to each of the cases currently under investigation. The questions are designed to be general and none specific to each case. This interview in its entirety could then be added as a precursor to any subject interview. The list of questions is not exhaustive and is intended as a guide for the interviewing officers.

In addition nothing contained within this guidance is intended to inhibit an interviewing officer asking relevant lines of questioning as appear appropriate to the circumstances.

Qualifications

1. ***When did you qualify as a doctor(1972)***
2. ***Were did you qualify(Oxford Uni)***
3. ***Were did you train to become a General Practitioner***
4. ***When did you start working at Gosport (1980)***
5. ***What is the organizational set up of the practice?***
6. ***How many doctors were working at the practice from 1990 onwards***
7. ***Since qualifying as a GP what further professional qualifications have you obtained***
8. ***Since you started working at Gosport what further training have you undertaken in the field of medicine.***
9. ***What is your GMC registration number?***
10. ***What do you understand as being your responsibilities under that registration?***

Role of the GP

1. ***What are your responsibilities as a General Practitioner***
2. ***How did the practice work particularly in relation to the care of the elderly?***
3. ***How many patients were you responsible for within the practice during the 90's?(1500)***
4. ***How was your working day constructed***
5. ***What call out system did you operate?***
6. ***What areas of specialty were you responsible for within the practice?***
7. ***How would your patients end up in GWMH***
8. ***Who would look after them?***
9.

Clinical Assistant (CA)

1. ***What was the role of the GWMH within the local community as far as you were concerned?***
2. ***Prior to your starting work as a clinical assistant how were the patients from the community cared for within the hospital?***
3. ***What are the bed fund holders?***
4. ***How and why did you become the clinical assistant?***
5. ***Was there a selection board for the post?***
6. ***What was the purpose of having a CA***
7. ***What were you expected to do on a daily basis***
8. ***What was the remuneration package for the post?***
9. ***How was the job description for the post decided upon if you were the post holder (D136)***

10. *Using the job description obtain an explanation of what each of the thirteen duties of the post holder were and how were these duties applied.*
11. *you were employed for five sessions a week. How long was a session and did you spend longer than your allotted hours at the hospital?*
12. *Why was this?*
13. *Who did you inform in relation to your increased hours?*
14. *Whom were you accountable to on a daily basis*
15. *Whom were you responsible to overall*
16. *The contract was offered in April 1988 for one year. How was this renewed?*
17. *What training was given for the role?*
18. *What training was provided in relation to pharmacy and the prescription of drugs?*
19. *How if at all, did the role develop over the years?*
20. *If there were any changes was this reflected by a new job description?*
21. *How did you feel about your levels of responsibilities?*
22. *What did you think the hospital expected of her?*
23. *What did you think was the role of the consultant in charge of the ward?*
24. *Were you provided with enough support throughout your work when there was only one consultant to provide cover(D161)*
25. *When would you conduct your rounds?*
26. *What was the purpose of these rounds?*
27. *When would you make entries in the medical records?*
28. *What is the purpose behind formulating and recording a working diagnosis?*
29. *What are the "Wessex Protocols"?*
30. *How were they applied?*

31. *What is an analgesic ladder and how was it applied?*
32. *What policy was in place regarding the prescription of strong opiate analgesia?*
33.

Supervision

1. *Who supervised your (Dr Barton's) work?*
2. *What was the organizational set up at the hospital when you started work as a CA in 1988?*
3. *How and were did you fit into this organization?*
4. *How was your work supervised on a day to day, week to week basis?*
5. *When were you given a yearly appraisal/ performance assessment, if yes by whom?*
6. *If there wasn't any appraisal system in the early years of her employment then when did it start, finally has she ever had any kind of appraisal whilst employed at GWMH.*
7. *How was your contract renewed each year.*
8. *Who would you refer to if she had any problems either with the patients or with the organization of the hospital?*
9. *How was help and support for your role offered?*
10. *What were your responsibilities towards the supervision of the nursing staff?*
11. *Who supervised the work of the nurses?*
12. *Who supervised the work of the sisters/senior nurses?*
13. *Were did Phillip Beed fit into the system*
14. *Were you responsible for appraising, supervising any staff?*
15. *What did you understand to be the role of the named nurse*
16.

Syringe Drivers

1. ***What kinds of syringe drivers were being used on the ward? The documentation that was on the wall of the ward in 2002 was this (D162). Were these the kind of syringe drivers that were used on the ward from 1988***
2. ***What was/is the purpose of a syringe driver?***
3. ***Who would make the decision to start someone on a syringe driver?***
4. ***Were there policies on the ward as to how syringe drivers should be set up, monitored, maintained?***
5. ***Who was responsible for ensuring that appropriate staff were trained in the operation of syringe drivers?***
6. ***What rationale had to be in place before a syringe driver could be used?***
7. ***What would be recorded in the notes re the rationale and by whom?***
8.

Death Certificates

1. ***What is the difference between verification and certification of death?***
2. ***In what circumstances would it be acceptable if at all for nurses to verify death?***
3. ***What process was undertaken by a doctor in certifying a death?***
4. ***How was a death notified to the Coroners office?***

Palliative Care

1. ***What does palliative care mean?***
2. ***What is the difference between rehab/slow stream rehab/recuperative/ terminal/ respite care?***
3. ***Who would make the decision as to what kind of care a patient would receive?***
4.

Record Keeping

1. ***What should be recorded in patient's medical notes and by whom?***
2. ***What is the purpose of a care plan***
3. ***Who would accept patients onto the wards?***
4. ***When would you see them?***
5. ***Were you responsible for clerking***
6. ***When would the Consultant see the patient?***
7. ***When patients arrived at GWMH were they then under the sole charge of you?***
8. ***Who else was responsible for the patients?***
9. ***Was there a policy for the completion of notes and what should be in them?***
10. ***What is your understanding of the resuscitation policy in particular relating to entries in patient notes?***
11.

From Barton statement

1. ***What is a "full time commitment" as described in your statement***

2. ***You state that you worked 8 GP surgery sessions each week? What is a "session" in relation to time etc***

3. ***What is a "full time commitment" as described in your statement***

4. ***You state that you worked 8 GP surgery sessions each week? What is a "session" in relation to time etc (Wilcock states a session to be four hours)***

5. ***You state that you started in 1988 on 4 sessions a week but the contract you signed in May 1988 shows that the job was for five sessions a week, is this correct?***

6. ***What times of the day would you conduct house calls on your patients?***

7. ***Why didn't you reduce the amount of hours you were working at the surgery when you undertook the role of CA?***

8. ***Did you discuss working all of your CA sessions instead of GP sessions with anyone within the PCT or within your practice.***

9. ***The job description states you were to provide 24 hour cover to "long stay patients" who are for slow stream rehabilitation. Describe what these categories of patients were?***

10. ***What happened when you were on leave?***

11. ***Who covered for you, how were they paid?***

12. ***Page 1 paragraph 4: The job description states 46 beds, Dr Barton states 48 beds. The CHI report says 44 beds (20 on Dryad and 24 on Daedalus) how many beds were you responsible for?***

13. ***The post of Clinical Assistant is not a training post but a service post or a career grade post in the NHS. (The only medical training grade posts are pre-registration house officers, senior house officers, specialist registrars and GP registrars.) What do you think a training post is?***

14. Who was training you?

15. Who decided to allocate some of the sessions to "out of hour's aspects of the post"? Who was this discussed and or agreed with?

16. What was the line management for your post as a C.A?

17. Where you ever appraised?

18. How long would a normal set of rounds take?

19. What was your routine for the rounds?

20. Page 4 para 1, Why couldn't you attend the Thursday rounds, given that you so rarely saw the consultants?

21. You state that you arrived in the hospital at approx 0730 and were in your own surgery for 0900 that probably relates to no more than an hour in the morning, return to the hospital at 1200 to admit patients, possibly another hour, return at 1900 and also be available out of hours. This accounts for more than your 3.5 sessions. Did you ever raise the amount of time you were spending at the hospital with anyone at the hospital?

22. Was the amount of time spent at the hospital raised as an issue with your partners?

23. (Page 5 paragraph 2: The patients who were genuinely long stay or continuing care do not need to be reviewed medically every day, nor would a medical record be made daily. Indeed with average length of stay of six or more weeks, it is clear that many patients were genuinely long-stay patients and one would expect them to be medically reviewed no more than once a week and any medical comments to be no more than once a week. However, whenever patients' physical or mental state has changed and they are reviewed by a doctor, it would be normal practice to always make a comment in the notes. Patients who are in rehabilitation and making a good progress, then review and comments in the notes once or twice a week would also be the norm.) If you felt that you could not meet the demands of the ward or the job why didn't you raise your concerns? If you did to whom?

24. Page 5 para 3. You list the duties of the post. The duties as you describe them are not covered in the job description. Was this ever discussed with anyone?

25. Define the difference between "rehabilitation, continuing & palliative care"?

26. Page 8 para 2, your statement reads that "YOU" adopted a policy of proactive prescribing. Did you discuss this with anyone? Where did the authority come from?

27. Page 4 para 2 states that you were available to discuss or provide advice to the nurses regarding medication. In addition you shared the 24hr callout with other members of your surgery. Why then was it necessary to adopt a pro active policy?

28. Why if you or your partners were available, weren't the normal guidelines of telephone prescribing followed?

29. Why is it that the only drugs that were proactively prescribed were "terminal drugs" Diamorphine, Oramorph, Hyoscine & Midazolam?

30. Why didn't you keep notes in line with GMC guidance (General practitioners may see approximately 20 patients in a morning or evening surgery at 6–10minute intervals and they are expected to keep clear and accurate records. Being busy may mean the notes are concise, but nevertheless, when there were significant changes in the patients condition or medication prescribed, an entry however brief should have appeared in the medical notes. Being busy is probably not a good enough reason on its own to fail to keep good records. Wilcock)

31. Why weren't appropriate doses of analgesics or other symptom relieving medication prescribed as stat doses on the 'as required' section of the drug chart. This would have allowed patients easy access to additional medication they required at any time and removed the need for the medication in the syringe drivers to be written as large dose ranges