Hampshire NHS
Primary Care Trust

CONFIDENTIAL

Gosport War Memorial Hospital
Patient Inquests
Spokesperson's Briefing Pack

INTERNAL REFERENCE DOCUMENT ONLY - NOT FOR EXTERNAL DISTRIBUTION

Contents **Page**

Hampshire NHS
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Spokespersons and distribution

Insert contact details (mobile and landlines)

- Richard Samuel, Director of Performance and Standards, NHS Hampshire (d/l Code A
- Neil Hardy, Head of Medicines Management, NHS Hampshire (Code A Code A
- Sue Harriman, Director of Nursing, Hampshire Community Health Care
- John Hughes, Medical Director, Hampshire Community Health Care Code A Code A
- Sara Tiller, Associate Director of Communications, NHS Hampshire Code A Code A
- Graeme Zaki, Medical Director, Portsmouth Hospital Trust
- Toni Scammell, Modern Matron, Hampshire Primary Care Trust (Code A Code A

Consultation on legal issues

- Jill Mason / Stuart Knowles, Portsmouth Hospitals Trust Code A Code A
- Kiran Bhogal, Hampshire Primary Care Trust
- Chris Green, RCN (Code A

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Primary Care Trust

Communications policy for inquests

Following a consultation process with the communications teams from NHS Hampshire, PHT and HCHC and senior management, clinical leads and legal representation from these organisations the following approach to dealing with media enquiries during the inquest has been agreed.

- Pre inquest briefing (factual background) with BBC has been arranged for 2nd March. Richard Samuel and Toni Scammell to attend. Tour of the hospital to be conducted – library shots to be permitted but no interviews will take place.
- Pre inquest media briefings to be arranged with local press to provide factual background information regarding the inquests.
- Media pack to be distributed to press prior to inquests to provide detailed background information and a selection of Q&As.
- From 18th March Richard Samuel to attend the early days of the inquests to demonstrate that the matter is being taken seriously.
- No interviews or comments to be provided during the course of the inquests on evidence or comments as they arise. Statements to be provided to correct misconceptions or provide policy information where appropriate (in response to requests which might otherwise become FOI requests or to correct misrepresentation). Advice to be sought from Kiran Bhogal in each instance.
- Press conference and 1-2-1s to be organised at the court post verdict with panel of spokespersons.

It is acknowledged that this approach will inevitably result in media seeking information from staff, families, residents etc. Staff will be briefed as to how to handle media requests and on the nature of coverage expected. PALS will be briefed to expect calls and the procedures for handling them. Patient information will be drafted for GWMH patients and their families.

Enquiries relating to nurses will be referred to RCN press office.
Enquiries relating to PHT staff will be referred to PHT communications team.
Enquiries relating to Dr Barton will be fielded by HPCT in the first instance but HPCT will not answer specific queries as Dr Barton has separate legal representation.
Enquiries relating to HCHC will be handled by HCHC communications team.
Enquiries of a 'corporate' nature will be handled by NHS Hampshire communications team.

Negative coverage is expected throughout the course of the inquests and it will not be possible to comment on or engage in this coverage while the legal process is in place.

Media will be informed that it is inappropriate for us to provide comment until all evidence has been heard as some issues relating to the individual cases are intrinsically linked. There will be a press conference and opportunities for individual interviews after the verdicts have been delivered by the coroner.

Key areas of media interest are anticipated to be:

- Dr Barton;
- The issue of nurses' concerns not being acted upon by management (whistle blowing);
- Prescribing practice;
- Policies and procedures e.g. patient communication, record keeping.

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Handling media enquiries

Press should identify themselves to you and will have a press badge. They are not permitted to film on NHS premises without prior consent.

Refer enquiries in the first instance to the communications team.

The communications team is proactively managing media enquiries around the GWMH inquests and will co-ordinate all statements and interviews.

Office hours Communications Team numbers

Main contact number where all calls will be logged and referred to the appropriate team member / spokesperson: Code A

Out of office hours:

NHS Hampshire/HCHC: Code A

Team mobiles :

Sara Tiller, NHS Hampshire, - mobile Code A
Michael Goodeve, HCHC, - mobile Code A
Elizabeth Harris, NHS Hampshire, - mobile Code A
Sue Lloyd, HPCT, - mobile Code A
Emma Topping, PHT, - Code A
Heather Dealey, PHT, - Code A
Caroline Searle, Trimedia, Code A
Julie Dean, Trimedia, mobile - Code A

Other contacts:

Royal College of Nursing

Helen Wigginton (SE Press officer): Code A
National press office: Code A

GWMH Press Office Number

Code A

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Overview

On 18th March a coroners inquest into the deaths of ten patients at Gosport War Memorial Hospital (GWMH) from 1996 – 1999 will commence. The inquests are scheduled for six weeks from 18th March 2009 and ten separate verdicts will be delivered at the close of proceedings. The coroner is AM Bradley, HM Assistant Deputy Coroner Portsmouth and South East. The inquests will take place at Portsmouth Combined Court, Winston Churchill Avenue, Portsmouth.

It is likely that there will be media interest in the process. A communications team is in place to liaise with the media. This pack is designed to provide you with some background information and importantly the steps you should take if approached for information by the press and members of the media. If you have any questions please call the communications team on 023 8062 7434.

What is an Inquest?

An inquest is a limited fact-finding inquiry to establish the answers to

- **who** has died,
- **when** and **where** the death occurred, and
- **how** the cause of death arose

An inquest is not a trial. It is an inquiry into the facts surrounding a death. It is not the job of the coroner to blame anyone for the death, as a trial would do, and there are no speeches. However, the Coroner does have the power to investigate the main cause of death and also "any acts or omissions which directly led to the cause of death".

Inquest patients (average age at time of death: 84)

- Code A
- Elsie Lavender (06/03/96) Daedalus Ward - aged 84
- Robert Wilson (died 18/10/96) Dryad Ward - aged 73
- Helena Service (died 05/06/97) Dryad Ward - aged 99
- Ruby Lake (died 21/08/98) Dryad Ward - aged 85
- Arthur Cunningham (died 26/09/98) Dryad Ward - aged 79
- Enid Spurgeon (died 13/04/99) Dryad Ward - aged 92
- Geoffrey Packman (died 03/09/99) Dryad Ward - aged 68
- Elsie Devine (died 21/11/99) Dryad Ward - aged 88
- Sheila Gregory (died 22/11/1999) Dryad Ward - aged 91

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Media statement approved for response to initial enquiries

Inquest into deaths at Gosport War Memorial Hospital

A coroner's inquest is being held into the deaths of ten patients at Gosport War Memorial Hospital in the late 1990s. The inquests are due to commence on 18th March 2009.

The local NHS has been working closely with HM Coroner over the last few months to ensure that all the relevant information is available to support the Coroner's investigation.

We co-operated fully with previous police investigations [1998, 1999 and 2002] and with an earlier independent review by the Commission for Health Improvement (CHI) [2002].

Procedures at Gosport War Memorial Hospital were revised as a result of the earlier enquiries. We are very confident that the hospital provides safe, high quality care to all its patients and will continue to play an important role in local healthcare services for many years to come.

Ends

For further information please contact the Hampshire PCT Communications team on Code A

NOTE: The CHI report can be found at:
http://www.popan.org.uk/policy/Policy_content/abuse_inquires/gosport_war_memorial_chi_July_2002.pdf

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Timeline of events

- In 1998 the police undertook an investigation into the death of a patient whose family were not happy about the circumstances of their death at Gosport War Memorial Hospital (GWMH). This death is not the subject of an inquest.
- In March 1999 the Crown Prosecution Service (CPS) decided that there was insufficient evidence to bring a successful prosecution.
- In 1998 there was a complaint to the NHS Commissioner (Ombudsman) about the care of a different patient. This death is not the subject of an inquest.
- In 2001 there was an independent NHS review panel into the care of a third patient which was subsequently referred to the NHS Commissioner. The Commissioner concluded that the prescribing was appropriate in the circumstances. This death is the subject of an inquest.
- In 1999 following publicity surrounding the initial investigation, the Police looked at the notes of four more patients who had died at GWMH. Two of these deaths are the subject of inquests, Arthur Cunningham, and Robert Wilson.
- In February 2002 the police decided there was no evidence for a prosecution and they were not going to investigate further.
- In the course of their investigation the Police alerted the Commission for Health Improvement (CHI) in August 2001 and CHI commenced an investigation in October 2001.
- In July 2002 CHI published a report with recommendations.
- In November 2002 Fareham and Gosport and East Hampshire PCTs produced a joint action plan to address the recommendations made in the CHI report.
- In January 2004 the Fareham and Gosport Clinical Governance group took over responsibility for overseeing the CHI action plan and ensuring objectives were met.
- In September 2002 the Police began a third investigation into the deaths of patients at GWMH.

- In October 2006 Portsmouth Hospitals NHS Trust took over the management of services for Medicine for Older People throughout South East Hampshire including those provided at Gosport War Memorial Hospital.

- Following detailed investigation which included expert reports the Police handed the outcome of their investigation into ten deaths to the CPS in July 2006.
- In October 2007 the CPS concluded that there was insufficient evidence to prosecute any health care staff.
- This Police report was passed to HM Coroner in early 2008.
- Following discussion with the Police and representation from families of the deceased, the Coroner met with the Minister for Justice, the Department of Health and the Assistant Chief Constable in August 2007 to discuss the potential of opening inquests on 10 cases.
- Following this meeting the Coroner (SE Area) opened and adjourned Inquests on 10 named cases in May 2008.

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Organisation structure in South East Hampshire 1994 - Present

Date	Organisation	Function
April 1994	Portsmouth Healthcare NHS Trust established. SI 1993/2569	Department of Medicine for Elderly People provided acute care, stroke care, continuing care, rehabilitation, day hospitals, and outpatient department at QAH and St Mary's Hospitals. Provided both medical and nursing staff on wards at GWMH. Service at GWMH was for continuing care, intermediate care, day hospital and outpatients department.
From April 1995	Portsmouth Hospitals NHS Trust	Provided care at QAH but at this stage was not providing any care at GWMH.
March 2002	Portsmouth Healthcare NHS Trust dissolved SI 2002/1323	
April 2002	Fareham & Gosport PCT established SI 2002/1120 East Hants PCT established SI 2001/331	F&G responsible for management of wards at GWMH. Employed ward nurses on Dryad and Daedalus. EHants managed Medicine for Elderly People service. Employed consultants for this service at GWMH.
2005	Fareham & Gosport and East Hampshire PCTs merge to form one 'cluster'.	Cluster retains responsibilities and roles from both PCTs as above.
Sept 2006	'Cluster' dissolved.	
October 2006	Hampshire PCT established SI2006/2072	Hampshire PCT assumes responsibility (commissions) for services at GWMH. Responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff goes to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust. Sultan ward is staffed by Hampshire PCT, but medical input is from local GP consortium.

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Primary Care Trust

Detailed chronology of events		
Date		**Note**
1980	Dr J Barton contracts with Health Authority to work at GWMH	
1988	New contract for Dr JB with Health Authority.	
1991	First formal letter sent expressing concerns at prescribing practice and use of syringe drivers at Redclyffe Annexe. More detail in separate dedicated document. This dedicated document refers to concerns having been raised two years earlier, and them not being addressed since then.	
1994	Portsmouth Healthcare Trust (PHCT) established. Provides care at all community hospitals in SE Hants. Service management and medical staff come from Medicine for Elderly People division, and nursing staff managed by F&G division of PHCT	New service provider taking over responsibility from the Health Authority
1995	Portsmouth Hospitals NHS Trust established. Provides acute care in this area.	
1996	Code A Dryad Ward Elsie Lavender died – Daedalus Ward Robert Wilson died – Dryad Ward	All highlighted patients have family members on witness list
1997	Helena Service died – Dryad Ward	
1998	Arthur Cunningham died – Dryad Ward Ruby Lake died – Dryad Ward	
1999 Dec 98 – March 99 Oct 99	Enid Spurgin died – Dryad Ward Geoffrey Packman died – Dryad Ward Elsie Devine died – Dryad Ward Sheila Gregory died – Dryad Ward. Police conducted investigation into the death of Gladys Richards (RIP 22/08/98), but CPS decided insufficient evidence to prosecute. Second Police investigation announced.	 1st Police inv. 2nd Police inv.
2000	Staff grade took up post at GWMH, replacing clinical assistant (Dr JB)	
2001 March 01 2001 onwards April 01 Aug 01 Oct 01	Independent Review into death of Elsie Devine. Local media coverage leads to other families coming forward with concerns. Dr JB enters into voluntary agreement to restrict her prescribing and for her prescribing to be monitored. PCPCT established 2nd Police investigation concludes insufficient evidence for prosecution, but have concerns about practices at GWMH and refer to CHI. CHI starts investigation.	 New service provider CHI
2002	PHCT dissolved, and F&G PCT and EH PCTs established. Management of wards and employment of nurses at GWMH transferred to F&GPCT, whilst management of Medicine for	New service providers

	Elderly People service, including employment of medical staff working at GWMH, transferred to EHPCT.	
July 2002	CHI reports. 1991 events made public. SHA set up helpline as more families come forward with concerns.	CHI
Sept 02	Police begin collating evidence for third investigation. The Chief Executives of Fareham and Gosport and East Hants PCTs temporarily redeployed whilst independent investigation commissioned by SHA/PCT initiated. This was because they were party to management decisions taken in 1991.	3rd Police inv.
Nov 02	Joint Action Plan between F&G and EH PCTs to address recommendations made in CHI report approved by F&G PCT Board.	CHI
March 03	Tony Horne and Ian Piper reinstated in their posts.	
Jan 04	F&G Clinical Governance group takes over responsibility for overseeing CHI Action Plan, which has met its objectives.	
March 05	F&G and EH PCTs linked into one cluster PCT	New organisational arrangement
Sept 06	F&G and EH PCT cluster formally dissolved.	
Oct 06	Portsmouth Hospitals Trust takes over the management of services for Medicine for Older People (DMOP). Now both nurses and medical staff have same employer. Dryad and Daedalus ward teams formally transferred to PHT, and so medical services for older people now provided in Collingwood and Ark Royal wards. CPS concludes the 3rd Police investigation, saying insufficient evidence to prosecute any health care staff.	New service provider
May 07	Home Secretary ordered inquest into the deaths of 10 people at GWMH (listed earlier).	
Aug 07	Coroner met with Ministry of Justice and DH to discuss inquest	
Dec 07	GMC decides to hold hearing into deaths regarding the role of Dr J Barton	
May 08	Coroner opens and adjourns inquests into ten deaths at GWMH.	
Jan 09	Coroner holds pre-inquest review with families and legal teams from NHS and NMC.	
March 09	Inquests start.	

Abbreviations:

CHI	Commission for Health Improvement
CPS	Crown Prosecution Service
DMOP	Division of Medicine for Older People, part of Portsmouth Hospitals NHS Trust
DH	Department of Health
F&GPCT	Fareham and Gosport Primary Care Trust
GMC	General Medical Council
GWMH	Gosport War Memorial Hospital
NMC	Nursing and Midwifery Council
PCPCT	Portsmouth City Primary Care Trust
PHCT	Portsmouth Healthcare NHS Trust
SEPCT	South East Hampshire Primary Care Trust
SHA	Strategic Health Authority

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Primary Care Trust

Details of previous investigations

Background

In 1996 Mulberry Ward at GWMH comprised 40 beds split into A (13 beds), B (13 beds) and C (14 beds) areas. All areas were run by Portsmouth Healthcare NHS Trust (a predecessor of PCTs and a separate organisation from Portsmouth Hospitals NHS Trust).

In January 2000 Mulberry A, B and C became Ark Royal Ward (13 beds) and Collingwood Ward (27 beds). Later these numbers became 17 beds on Ark Royal and 17 beds on Collingwood.

In April 2002 Fareham and Gosport PCT took over responsibility for management of Dryad, Daedalus and Sultan wards at GWMH. East Hampshire PCT took over responsibility for managing the older people's mental health service in Ark Royal and Collingwood wards and employed consultants for this service at GWMH.

In April 2006 responsibility for Dryad and Daedalus wards and the employment of the nursing and medical staff transferred to Division of Medicine for Older People (DMOP) at Portsmouth Hospitals NHS Trust. Nursing staff on Sultan Ward transferred to Hampshire PCT, but medical input was provided by the local GP consortium. Hampshire Partnership NHS Trust took over responsibility for Older People's Mental Health Services in Ark Royal and Collingwood wards.

In line with national guidance the mental health service was transferred to Dryad and Daedalus wards on the ground floor in Feb 2008.

Early Police investigations

Between 1998 and 2002, Hampshire Constabulary undertook two investigations into the potential unlawful killing of patients at Gosport War Memorial Hospital.

These investigations did not result in any criminal prosecutions, but the police shared their concerns about the care of older people at Gosport War Memorial Hospital (GWMH) with the then Commission for Health Improvement (CHI) (a fore-runner of the Healthcare Commission) in August 2001. These concerns centred on the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the hospital.

Commission for Health Improvement investigation

In 2001, CHI commenced an investigation into the management, provision and quality of healthcare at Gosport War Memorial Hospital managed by Portsmouth Healthcare NHS Trust (the predecessor of the then Fareham and Gosport PCT and East Hampshire PCT and a different organisation to Portsmouth Hospitals NHS Trust).

CHI concluded that in the late1990s there had been a failure of the then PCT systems to ensure good quality patient care, including insufficient local prescribing guidelines, lack of a rigorous, routine review of pharmacy data, and the absence of adequate Trust-wide supervision and appraisal systems.

CHI also concluded that by the time of their investigation, in 2002, the successor PCTs had addressed these. CHI reported that the PCTs (Fareham and Gosport PCT and East Hampshire PCT) had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to.

Outcome of the final Police investigation

The publicity accompanying the announcement of the findings of the CHI investigation prompted a number of relatives of patients who had died at GWMH to contact the Hampshire and Isle of Wight Strategic Health Authority regarding the care and treatment of their relatives between 1998 and 2001. Following these contacts the police initiated another investigation into the deaths of patients at GWMH in September 2002.

Following detailed investigation and expert reports ten cases were passed to the Crown Prosecution Service (CPS) for review once the police investigation was complete. The CPS concluded that there was insufficient evidence to prosecute and that there was no realistic prospect of any conviction.

Following the CPS' decision, the police met with the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and H.M. Coroner to determine whether general 'standard of care' issues in respect of the deaths required further examination. The Police, however, reiterated that their investigation was now closed.

Coroner

Following the meeting with the Police and representation from families of the deceased, the Coroner met with the Minister for Justice, the Department of Health and the Assistant Chief Constable to discuss the potential of opening inquests on 10 cases. Following this meeting the Coroner (SE Area) opened and adjourned Inquests on 10 named cases. The Coroner held a pre-inquest review meeting with the families in August 2008. No NHS representation occurred at the pre-inquest review as the invitation did not reach the appropriate people within the NHS.

The Coroner has announced that he intends to conduct separate inquests into each death, and has set aside six weeks for the inquests to take place. Verdicts into each death will be reached when all inquests have been concluded.

General Medical Council (GMC) and Nursing and Midwifery Council (NMC)

The Police forwarded papers in respect of 14 cases to the GMC and NMC. Until the completion of the Police investigation, neither organisation felt able to consider any of the referrals they had received in order not to prejudice the police investigation. The GMC are holding a hearing scheduled to take place from June 2009. Staff are being supported through this process, to date the NMC have not taken any action.

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Primary Care Trust

GWMH IN 2009

Since the time of these deaths over ten years ago and the subsequent CHI review in 2002 much has changed at Gosport War Memorial Hospital, in line with developments in clinical practice across the country.

1991 saw the commencement of a £10.5 million, two-phase development which was complete in 1995. This was followed by a £6m redevelopment in the last year. The Hospital now houses:

- 20 bed GP ward
- 32 beds for older peoples' mental health
- 35 beds for stroke and general rehabilitation
- Blake birth centre
- Physiotherapy department
- Two day hospitals for older people
- X-ray and ultrasound
- Red Cross
- Minor injuries unit
- Endoscopy unit
- Community health clinics
- GP Out of Hours Service

By the time of the CHI investigation in 2002 the regulator was satisfied that GWMH had adequate policies and guidelines in place governing the prescription and administration of pain relieving medicines to older patients and that these policies and procedures were being adhered to. This remains the case and there have been no incidents subsequently which have required external investigation by CHI or its successor the Healthcare Commission or the Police.

Policies and procedures at the Hospital are reviewed regularly and staff receive mandatory training every year. Details of the policies in place on Sultan ward can be found at:
http://www.hampshirepct.nhs.uk/index/documents/policies-home/policies-clinical.htm
Details of policies in place on Ark Royal and Collingwood wards are available from Portsmouth Hospitals NHS Trust on request.

The Patient Environment Action Team inspection last year rated the Hospital as good on cleanliness, excellent for food and good for privacy and dignity. Patient experience surveys are conducted regularly and feedback is very positive, with comments including 'privacy and dignity is well respected' and 'cleanliness impeccable'.

There were six complaints relating to Portsmouth Hospitals NHS Trust re: the Department of Medicine for Older people, Stroke and Rehabilitation last year (this includes GWMH and QAH) and five relating to Hampshire Community Healthcare for the other wards at GWMH. All complaints are taken very seriously and investigated internally in line with the PCT and Trust's complaints policy. All complaints in 2007/2008 were resolved locally.

The Hospital also receives many thanks and compliments from patients and their families, with over 200 cards and letters last year.

Staff at the Hospital received a Chairman's award from Portsmouth Hospitals NHS Trust Chairman in 2007 for their professionalism and dedication.

In 2008 Portsmouth Hospitals NHS Trust's modern matron at GWMH received a Clinical Governance Award from the Trust's Patient Experience Council. This award of £9773 contributed to the installation of cushioned floor in both wards, to minimize injury if a patient should experience a fall during rehabilitation.

In February Ark Royal, Collingwood and Sultan wards have benefitted from anti microbial curtains and new bedside lockers and tables which are much easier to clean. Overhead hoists are available over every bed and in bathrooms and the Trust have increased call bells in day room areas enhancing patient safety.

In 2008/09 Portsmouth Hospitals NHS Trust was independently assessed as providing an 'excellent' quality of services by the Healthcare Commission (formerly CHI) and Hampshire PCT was assessed as providing a 'good' quality of services by the Healthcare Commission.

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Q&A

Q. What is the purpose of an Inquest?

A. The purpose of an inquest is for the coroner to determine how an individual met his/her death, the cause/ nature of the death and the circumstances around that person's death. An inquest is not a trial.

Q. What is this inquest concerned with?

A. This inquest is concerned with the deaths of people who were in-patients on Dryad and Daedalus wards, at Gosport Ward Memorial Hospital (GWMH) between 1996 and 1999. These deaths came to police and public attention following one complaint made by a relative in 1998.

Q. Isn't it rare to have an inquest 10 years after the death of a person and in the absence of a body or post mortem reports?

A. Yes it is. The decision to conduct these inquests was taken by the Coroner following representation from families of the deceased and a meeting with the Minister for Justice, the Department of Health and the Assistant Chief Constable. There have been three thorough police investigations and a further independent investigation (Commission for Health Improvement) into these matters since 1998.

Q. Why has an inquest into these deaths been called when the police investigations found no evidence of wrong doing?

A. The police investigations focused on whether there was any evidence that any crime had been committed with respect to patient deaths at Gosport War Memorial Hospital. The police were satisfied beyond all reasonable doubt that there was no evidence of any criminal wrong-doing.

The purpose of an inquest is to determine how a person met their death and potentially the circumstances surrounding that death.

Q. Were any staff disciplined as a result of the police investigations?

A. No. At the time two senior members of management were redeployed for six months, while internal investigations took place – this is standard practice. However both internal investigations and the CHI review concluded that there was no evidence to suggest that any individual should be disciplined and the staff members returned to their posts.

Q. What measures have been put in place since these incidents?

The CHI investigation in October 2001 concluded that the PCTs had put in place adequate policies and guidelines governing the prescription and administration of pain relieving medicines to older patients and that these policies and guidelines were and are being adhered to. Full details can be obtained from: http://www.popan.org.uk/policy/Policy_content/abuse_inquires/gosport_war_memorial_chi_July_2002.pdf

Four NHS organisations providing services in the south east Hampshire area have also undertaken their own more recent reviews of compliance with the recommendations CHI made. The Board of each organisation has received assurances that all policies are correct and current and that the quality of care being provided is of the highest standard and in line with modern Clinical Governance standards. Assurances have also been provided to South Central Strategic Health Authority (SHA) as the organisation responsible for monitoring quality within organisations in its area. The SHA will in turn provide assurance to the Department of Health.

Since the deaths at GWMH all NHS organisations now work to modern clinical governance standards which require risk management systems and clinical audit departments. These are integral to the delivery of health services in a modern NHS and have been part of NHS evolution over the last decade.

Q. What is CHI?

A. CHI – is the Commission for Health Improvement. This organisation was replaced by the Healthcare Commission (in April 2004). The Healthcare Commission is the independent watchdog for healthcare in England. It assesses and reports on the quality and safety of services for patients and the public. From April 2009 a new "super-regulator", the Care Quality Commission will combine the functions of the

Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

Q. What is Clinical Governance?

A. Clinical Governance is essentially a term used to describe the way the NHS manages the delivery of health services within a structure of accountability and responsibility. It is intended to ensure that clinical care is delivered on the basis of agreed standards and that outcomes are measured against these standards of care.

Q. Is the mortality rate at GWMH higher than at other community hospitals?

A. There is no statistical assessment that would enable us to compare mortality rates. The range of treatments, patient circumstances, local demographics and the numbers involved all contribute to make a statistical analysis impossible at this current time although we are increasingly putting measures in place that will enable us to work towards this type of data.

However, the care provided by PHT and Hampshire PCT was rated 'excellent' and 'good' by CHI's successor last year and the Hospital received good results from the Patient Environment Action Team (PEAT).

Q. Please comment on the findings of the Baker audit

A: We haven't seen the Baker audit but would be happy to review it if you have a copy for us.

Q. Is this another 'Shipman' case?

A: Absolutely not. There have been three separate police investigations since 1998 plus an independent investigation by the Commission for Health Improvement. None of these four investigations found there to be any evidence of criminal wrong-doing. The current inquest aims to establish how the cause of death arose for the ten patients concerned.

Q. Why is Dr Barton still practising?

A: The GMC has concluded that Dr Barton remains safe and fit to practice. Due to the pressures surrounding these investigations, Dr Barton has resigned from GWMH but still practices as a GP.

Q. Why was nothing done when concerns were initially raised by nurses?
A: It is regrettable that no action was taken although these concerns were brought to the attention of the management team which was in place at the time. It is also regrettable that staff who raised these issues were not supported as they would be now.

The way the NHS monitors patient safety and the quality of care has changed considerably since the early 1990s. Staff are now required to report all incidents and 'near misses' and these are immediately logged and reviewed at the local integrated governance group, if appropriate a detailed action plan is developed and monitored.

This is supported by an active and open policy encouraging staff to report anything they are unhappy about, without fear of blame. We have policies and procedures in place to encourage staff to report any matters of concern and we take immediate action to address these.

Q: Why has it taken so long to reach an inquest?
A: Each of the four independent and police investigations has taken a period of time to complete. Each investigation was extremely thorough and the NHS has co-operated fully and quickly in each instance. Each of the four investigations concluded that there was no evidence of criminal wrong-doing.

Q: How do you account for the procedural failures that have been identified?
A: It has already been established in the four previous investigations that no criminal act has been committed. The CHI investigation details the procedural shortcomings at that time and we acknowledge that it is regrettable that our predecessor organisation did not have sufficient policies and procedures in place to optimise care in 1998. We are confident that these issues were addressed prior to and after the CHI review and in more general terms by changes in NHS governance and procedures.

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Primary Care Trust

Core messages – please review all

Corporate NHS

Spokesperson Code A (NHS Hampshire)

- The NHS in Hampshire supports the coroner's inquest as a valuable opportunity to look again at events of the late 1990s and for the families of the deceased to establish closure.

- We sympathise with relatives for the uncertainty that has surrounded these issues over the last ten years, and also with our staff who have been through four investigations over that period.

- Quality and safety is at the heart of all we do. I would like to reassure people being cared for at GWMH today that the quality of care at Gosport War Memorial Hospital is of the highest standard.

- Friends and relatives of patients should not be alarmed by these inquests which are concerned with incidents which took place more than ten years ago and practices which are now outdated.

- The CHI report found that our predecessor organisation didn't have adequate policies and procedures in place and that there were some elements of care that required improvement. It is a matter of regret to the NHS that in 1996 it was found not to have adequate policies in place to optimise care, however action was subsequently taken and this is no longer the case.

- I would like to reassure people that the right policies and procedures are in place at GWMH now to ensure that the care provided is of the highest standard. The Commission for Health Improvement (CHI) investigation in October 2001 concluded that our predecessor organisation had addressed the issues raised and had put in place adequate policies and guidelines, and that these policies and guidelines were being adhered to. Quality and safety are at the very heart of all we do.

- The care provided by PHT and Hampshire PCT was rated 'excellent' and 'good' by CHI's successor last year and the Hospital received good results from the Patient Environment Action Team (PEAT), which were 'Good' cleanliness, 'Excellent' for food, and 'Good' for privacy and dignity.

Clinical practice Graeme Zaki (PHT); Sue Harriman (HCHC), Dr John Hughes

- Safety and quality is at the heart of everything we do. The way the NHS monitors patient safety and the quality of care has changed considerably since the early 1990s. Staff are now required to report all incidents and 'near misses' and these are immediately logged and reviewed at the local integrated governance group, if appropriate a detailed action plan is developed and monitored.

- This is supported by an active and open policy encouraging staff to report anything they are unhappy about, without fear of blame. We have policies and procedures in place to encourage staff to report any matters of concern and we take immediate action to address these.

- We actively seek to quickly reduce and eliminate risk as an ongoing learning process. Untoward incidents or a pattern of care which suggested that clinical practice is not up to standard would be picked up there and then through these procedures and investigated internally. If necessary the Trust concerned may also commission an external investigation.

- Both PHT and Hampshire PCT have a modern matron working at GWMH. These highly experienced senior nurses are responsible for driving-up standards, ensuring privacy and dignity is protected, and that their wards areas are clean and suitable for their patients, whilst leading by example.

- There are much tighter governance arrangements in place in relation to the prescribing and administration of medicines. Reviews of prescribing practices and all medicines related incidents are reported on the national risk learning database and analysed by the Trust and action plans developed, where

appropriate. HCHC also has a pharmacist who reviews practices and prescribing and also trains and educates staff.

- Portsmouth Hospitals NHS Trust and HPCT are members of the South Central Patient Safety Federation and have a multi-disciplinary approach to integrated working. There are number of work streams in place to improve the safety of patient care, including one on the management and administration of medicines.

- All NHS organisations have well developed clinical audit departments. The quality of services at GWMH is monitored via these audits and feedback from patients on their experiences at the Hospital. HCHC has an audit strategy which includes a stringent timetable for completion of audits and implementation of improvements, where required.

- There are no similarities whatsoever between this matter and the investigation which took place at Fordingbridge Community Hospital. It is not appropriate for me to comment on the Fordingbridge investigation at this current time.

Pharmacy: Neil Hardy (NHS Hampshire)

- As current service providers Hampshire PCT and Portsmouth Hospitals NHS Trust have a range of up-to-date policies and procedures governing the administration of medicines.

- HCHC also has a dedicated pharmacist who reviews practices and prescribing and also trains and educates staff.

- There are now much tighter governance arrangements in place in relation to the prescribing and administration of medicines than there were in the early 1990s. Reviews of prescribing practices and all medicines related incidents are reported on the national risk learning database and analysed by the Trust. Action plans developed, where appropriate.

- Current policies and procedures are regularly reviewed and monitored to ensure that they are adhered to.

Hampshire NHS
Primary Care Trust

Primary Care / GP: Stuart Morgan or LMC representative - TBC

- We are confident that the care provided at Gosport War Memorial Hospital is of the highest standards and have complete confidence in referring our patients to the hospital.

Key words:

1998 / more than ten years ago

Predecessor organisation

Integrated working

Multi-disciplinary approach

Confidence

Reassure

Quality and safety

Patient centred care

Dedicated pharmacist

Audits / CHI report

Ongoing learning

Supportive policies and procedures

Minimise and eliminate risk

Tighter governance

High standard of care

Four thorough investigations since 1998

No evidence of criminal wrong-doing