investigation

Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital

JULY 2002

CHI
COMMISSION FOR HEALTH IMPROVEMENT

Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

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- 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
- staff interviewed by CHI's investigation team (see appendix C) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millett, Chief Executive (until 31 March 2002) and Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust (since 1 April 2002)
- staff and patients who welcomed the CHI team on to the wards during observation work
- Detective Superintendent John James, Hampshire Constabulary
- the agencies listed in appendix D who gave their views and submitted relevant documents to the investigation

Executive summary

CHI has undertaken this investigation as a result of concerns expressed by the police and others around the care and treatment of frail older people provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001. CHI is grateful to the Hampshire Constabulary for sharing information with us which contributed towards the local and national recommendations CHI makes to improve the care of this vulnerable group of NHS patients.

CHI has conducted a detailed review of the systems in place to ensure good quality patient care. CHI does not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual.

Key conclusions

CHI concludes that a number of factors, detailed in the report, contributed to a failure of trust systems to ensure good quality patient care:

- there were insufficient local prescribing guidelines in place governing the prescription of powerful pain relieving and sedative medicines
- the lack of a rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for older people not being questioned
- the absence of adequate trust wide supervision and appraisal systems meant that poor prescribing practice was not identified
- there was a lack of thorough multidisciplinary total patient assessment to determine care needs on admission

CHI also concludes that the trust now has adequate policies and guidelines in place which are being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Key findings

National and local context (Chapter 3)

- Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team.
- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.

Arrangements for the prescription, administration, review and recording of medicines (Chapter 4)

- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the "Wessex guidelines", this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.
- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

Quality of care and the patient experience (Chapter 5)

- Relatives speaking to CHI had some serious 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 highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.
- Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

Staffing arrangements and responsibility for patient care (Chapter 6)

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff.

Lessons learnt from complaints (Chapter 7)

- The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

Clinical governance (Chapter 8)

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

Recommendations

It is clear from a number of CHI recommendations to the Fareham and Gosport Primary Care Trust (PCT) and the East Hampshire PCT, that continued close and effective working relationships between both PCTs will be essential in order to implement the recommendations in this report. CHI is aware of the high level of interdependence that already exists between these two organisations and urges that this continues.
CHI is aware that many of these recommendations will be relevant to emerging PCTs and urges all PCTs to take action where appropriate.

Fareham and Gosport/ East Hampshire Primary Care Trust

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

2. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

3. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

4. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

5. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

6. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

7. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

8. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

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

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

11. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

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

13. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

14. The Fareham and Gosport PCT and the East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

15. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

16. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangements, clinical governance responsibilities and training needs.

17. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

18. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

19. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

20. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

21. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

22. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

Hampshire and Isle of Wight Strategic Health Authority

23. Hampshire and Isle of Wight Strategic Health Authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

Department of Health

24. The Department of Health should assist in the promotion of an NHS wide understanding of the various terms used to describe levels of care for older people.

25. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

1 | Terms of reference and process of investigation

1.1 During the summer of 2001, concerns were raised with CHI about the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the Gosport War Memorial Hospital. These concerns were also about the responsibility for clinical care and transfer arrangements with other hospitals.

1.2 On 22 October 2001, CHI launched an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust was responsible at the Gosport War Memorial Hospital. CHI's decision was based on evidence of high risk activity and the likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

1.3 The investigation terms of reference were informed by a chronology of events provided by the trust surrounding the death of one patient. Discussions were also held with the trust, the Isle of Wight, Portsmouth and South East Hampshire Health Authority and the NHS south east regional office to ensure maximum learning locally and for the NHS.

1.4 The terms of reference agreed on 9 October 2001 are as follows:

The investigation will look at whether, since 1998, there had been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i) staffing and accountability arrangements, including out of hours

ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management

iii) arrangements for the prescription, administration, review and recording of drugs

iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations

v) arrangements to support patients and their relatives and carers towards the end of the patient's life

vi) supervision and training arrangements in place to enable staff to provide effective care

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

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

CHI's investigation team

1.5 CHI's investigation team were:

- Alan Carpenter, Chief Executive, Somerset Coast Primary Care Trust
- Anne Grosskurth, CHI Support Investigations Manger
- Dr Tony Luxton, Consultant Geriatrician, Cambridge City Primary Care Trust
- Julie Miller, CHI Lead Investigations Manager
- Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
- Mary Parkinson, lay member (Age Concern)
- Jennifer Wenborn, Independent Occupational Therapist

1.6 The team was supported by:

- Liz Fradd, CHI Director of Nursing, lead CHI director for the investigation
- Nan Newberry, CHI Senior Analyst
- Ian Horrigan, CHI Analyst
- Kellie Rehill, CHI Investigations Coordinator
- a medical notes review group established by CHI to review anonymised medical notes (see appendix E)
- Dr Barry Tennison, CHI Public Health Adviser

The investigation process

1.7 The investigation consisted of five interrelated parts:

- review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (see appendix A for a list of documents reviewed)
- analysis of views received from 36 patients, relatives and friends about care received at Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls and a short questionnaire (see appendix B for an analysis of views received)

- a five day visit by CHI's investigation team to Gosport War Memorial Hospital when a total of 59 staff from all groups involved in the care and treatment of older people at the hospital and trust managers were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards (see appendix C for a list of all staff interviewed)
- interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (see appendix D for a list of organisations interviewed)
- an independent review of anonymised clinical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendices E and F. CHI shared the summary with the Fareham & Gosport PCT in May 2002

2 | Background to the investigation

Events surrounding the CHI investigation

Police investigations

2.1 A relative of a 91 year old patient who died in August 1998 on Daedalus ward made a complaint to the trust about her care and treatment. The police were contacted in September 1998 with allegations that this patient had been unlawfully killed. A range of issues were identified by the police in support of the allegation and expert advice sought. Following an investigation, documents were referred to the Crown Prosecution Service in November 1998 and again in February 1999. The Crown Prosecution Service responded formally in March 1999 indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.

2.2 Following further police investigation, in August 2001, the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

2.3 Local media coverage in March 2001 resulted in 11 other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate. Two expert reports were received in December 2001 which were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.

2.4 In February 2002, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the General Medical Council, the United Kingdom Central Council (after 1 April 2002, the Nursing and Midwifery Council), the trust, the Isle of Wight, Portsmouth and East Hampshire Health Authority and the NHS south east regional office.

2.5 The police made the trust aware of potential issues around diamorphine usage in December 1998, and were sent the expert witness reports in February 2002.

Action taken by professional regulatory bodies

2.6 The General Medical Council is currently reviewing whether any action against any individual doctor is warranted under its fitness to practice procedures.

2.7 The Nursing and Midwifery Council are considering whether there are any issues of professional misconduct in relation to any of the nurses referred to in police documentation.

Complaints to the trust

2.8 There have been 10 complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and December 1998 raised concerns which included pain management, the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which triggered the initial police investigation. This complaint was not pursued through the NHS complaints procedure.

Action taken by the health authority

2.9 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 in 1998 and, secondly, as the body through which GPs were permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered by GPs on hospital premises.

2.10 In June 2001, the health authority voluntary local procedure for the identification and support of primary care medical practitioners whose practice is giving cause for concern reviewed the prescribing practice of one local GP. No concerns were found. This was communicated to the trust.

2.11 In July 2001, the chief executive of the health authority asked CHI for advice in obtaining a source of expertise in order to reestablish public confidence in the services for older people in Gosport. This was at the same time as the police contacted CHI.

2.12 Following receipt of the police expert witness reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers and sedatives (opiates and benzodiazepines) in general practice.

Action taken by the NHS south east regional office

2.13 For the period of the investigation, the NHS regional offices were responsible for the strategic and performance management of the NHS, including trusts and health authorities. The NHS south east regional office had information available expressing concerns around prescribing levels at the Gosport War Memorial Hospital. Information included a report by the Health Service Ombudsman and serious untoward incident reports forwarded by the trust in April and July 2001 in response to media articles about the death of a patient at the Gosport War Memorial Hospital.
The health authority and NHS south east regional office met to discuss these issues on 6 April 2001.

3 | National and local context

National context

3.1 The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS Plan and the Standing Nursing and Midwifery Committee's 2001 annual report found aspects of care to be deficient. National concerns raised include: 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, detailed in the national service framework.

3.2 The national service framework for older people was published in March 2001 and sets standards of care for 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 patients and their relatives in the care process, including care planning.

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

Trust background

3.4 Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust between April 1994 and April 2002. The hospital is situated on the Gosport peninsula and has 113 beds. Together with outpatient services and a day hospital, there are beds for older people and maternity services. The hospital does not admit patients who are acutely ill and it has neither an A&E nor intensive care facilities. Portsmouth Healthcare NHS Trust 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.

3.5 The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/2002 the trust had a budget in excess of £100 million and over 20% of income spent on its largest service, elderly medicine. All the trust's financial targets were met in 2000/2001.

Move towards the primary care trust

3.6 Portsmouth Healthcare NHS Trust was dissolved on 31 March 2002. Services have been transferred to local primary care trusts (PCTs), including Fareham and Gosport PCT, which became operational as a level four PCT in April 2002. Arrangements have been made for each PCT to host provider services on a district wide basis but each PCT retains responsibility for commissioning its share of district wide services from the host PCT. Fareham and Gosport PCT will manage many of the staff, premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Medical staff involved in the care of older people, including those working at the Gosport War Memorial Hospital, are now employed by the East Hampshire PCT.

Portsmouth Healthcare NHS Trust strategic management

3.7 The trust board consisted of a chair, five non executive directors, the chief executive, the executive directors of operations, medicine, nursing and finance and the personnel director. The trust was organised into six 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 medicine for elderly people.

3.8 CHI heard that the trust was well regarded in the local health community and had developed constructive links with the health authority and local primary care groups (PCGs). For example, in the lead up to the formation of the new PCT, Portsmouth Healthcare NHS Trust's director of operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the trust on the development of intermediate care and clinical governance. High regard and respect for trust staff was also commented on by the local medical committee, Unison and the Royal College of Nursing.

Local services for older people

3.9 Before April 2002, access to medical beds for older people in Portsmouth (which included acute care, rehabilitation and continuing care) was managed through the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. Some of the beds were located in community hospitals such as the Gosport War Memorial Hospital, where the day to day general management of the hospital was the responsibility of the locality divisions of Portsmouth Healthcare NHS Trust. The Fareham and Gosport division of the trust fulfilled this role at the Gosport War Memorial Hospital.

3.10 The department of medicine for elderly people has now transferred to East Hampshire PCT. The nursing staff of the wards caring for older people at the Gosport War Memorial Hospital are now employed by the Fareham and Gosport PCT. Management of all services for older people has now transferred to the East Hampshire PCT.

3.11 General acute services were, and remain, based at Queen Alexandra and St Mary's hospitals, part of the Portsmouth Hospitals NHS Trust, the local acute trust. Though an unusual arrangement, a precedent for this model of care existed, for example in Southampton Community NHS Trust.

3.12 Until August 2001, the Royal Hospital Haslar, a Ministry of Defence military hospital on the Gosport peninsula, also provided acute medical care to civilians, many of whom were older people, as well as military staff.

Service performance management

3.13 Divisional management at Portsmouth Healthcare NHS Trust was well defined, with clear systems for reporting and monitoring. The quarterly divisional review was the principal tool for the performance management of the Fareham and Gosport division. The review considered regular reports on clinical governance, complaints and risk. Fareham and Gosport division was led by a general manager, who reported to the operational director. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level.

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

3.14 Gosport War Memorial Hospital provides continuing care, rehabilitation, day hospital and outpatient services for older people and was managed by the Fareham and Gosport division. In November 2000, as a result of local developments to develop intermediate and rehabilitation services in the community, there was a change in the use of beds at the hospital to provide additional rehabilitation beds.

3.15 In 1998, three wards at Gosport War Memorial Hospital admitted older patients for general medical care: Dryad, Daedalus and Sultan. This is still the case in 2002.

Figure 3.1 Inpatient provision at Gosport War Memorial Hospital by ward

Ward	1998	2002
Dryad	20 continuing care beds. Patients admitted under the care of a consultant, with some day to day care provided by a clinical assistant.	20 continuing care beds for frail elderly patients and slow stream rehabilitation. Patients admitted under the care of a consultant. Day to day care is provided by a staff grade doctor.
Daedalus	16 continuing care beds and 8 for slow stream rehabilitation. Patients admitted under the care of a consultant, some day to day care provided by a clinical assistant.	24 rehabilitation beds: 8 general, 8 fast and 8 slow stream (since November 2000). Patients admitted under the care of a consultant. Day to day care provided by a staff grade doctor.
Sultan	24 GP beds with care managed by patients' own GPs. Patients were not exclusively older patients; care could include rehabilitation and respite care. A ward manager (or sister) managed the ward, which was staffed by Portsmouth Healthcare NHS Trust staff.	The situation is the same as in 1998, except that the nursing staff are now employed by Fareham and Gosport PCT.

Admission criteria

3.13 The current criteria for admission to both Dryad and Daedalus wards are that the patient must be over 65 and be registered with a GP within the Gosport PCG (now a part of Fareham and Gosport PCT). In addition, Dryad patients must have a Barthel score of under 4/20 and require specialist medical and nursing intervention. The Barthel score is a validated tool used to measure physical disability. Daedalus patients must need multidisciplinary rehabilitation, for example following a stroke.

3.14 There was, and still is, a comprehensive list of admission criteria for Sultan ward developed in 1999, all of which must be met prior to admission. The criteria state that patients must not be medically unstable and no intravenous lines must be in situ.

Elderly mental health

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

Terminology

3.16 CHI found considerable confusion about the terminology describing the various levels of care for older people in written information and in interviews with staff. For example, the terms stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care were all used. CHI was not aware of any common local definition for these terms in use at the trust or of any national definitions. CHI stakeholder work confirmed that this confusion extended to patients and relatives in terms of their expectations of the type of care received.

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

2. The case note review undertaken by CHI confirmed that the admission criteria for both Dryad and Daedalus wards were being adhered to over recent months and that patients were being appropriately admitted. However, CHI found examples of some recent patients who had been admitted to Sultan ward with more complex needs than stipulated in the admission criteria that may have compromised patient care.

3. There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation that had not been fulfilled.

RECOMMENDATIONS

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

2. Hampshire and Isle of Wight strategic health authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

3. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

4. The Department of Health should assist in the promotion of an NHS wide shared understanding of the various terms used to describe levels of care for older people.

4 | Arrangements for the prescription, administration, review and recording of medicines

Police inquiry and expert witness reports

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

4.2 Police expert witnesses reviewed the care of five patients who died in 1998 and made general comments in the reports about the systems in place at the trust to ensure effective clinical leadership and patient management on the wards. The experts' examination of the use of medicines in Daedalus, Dryad and Sultan wards led to significant concern about three medicines, the amounts which had been prescribed, the combinations in which they were used and the method of their delivery. In summary:

- there was no evidence of trust policy to ensure the appropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain. It was the view of the police expert witnesses that a more reasonable response would have been the prescription of mild to moderate medicine initially with appropriate review in the event of further pain followed up
- there was inappropriate combined subcutaneous administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death
- there were no clear guidelines available to staff to prevent assumptions being made by clinical staff that patients had been admitted for palliative, rather than rehabilitative care
- there was a failure to recognise potential adverse effects of prescribed medicines by clinical staff
- clinical managers failed to routinely monitor and supervise care on the ward

It is important to emphasise that these reports were not produced for this CHI investigation and CHI cannot take any responsibility for their accuracy. Whilst the reports provided CHI with very useful information, CHI has relied on its own independent scrutiny of data and information gathered during the investigation to reach the conclusions in this chapter.

Medicine usage

4.3 In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines issued from the pharmacy and does not include any wastage, nor can it verify the quantity of medicines administered to each patient. As the data does not offer any breakdown of casemix, it is not possible to determine how complex the needs of patients were in each year. Staff speaking to CHI described an increase in the numbers of sicker patients in recent years. A detailed breakdown of medicines issued to each ward is attached at appendix I.

4.4 The experts commissioned by the police had serious concerns about the level of use of these three medicines (diamorphine, haloperidol and midazolam) and the apparent practice of anticipatory prescribing. CHI shares this view and believes the use and combination of medicines used in 1998 was excessive and outside normal practice. The following figures indicate the use of each medicine by ward and year, plotted alongside the number patients treated (finished consultant episodes).

4.5 The trust's own data, provided to CHI during the site visit week, illustrates a marked decline in the usage of diamorphine, haloperidol and midazolam in recent years. This decline has been most pronounced on Dryad ward and is against a rise in FCEs during the same timeframe. The trust's data demonstrates that usage of each of these medicines peaked in 1998/99. On Sultan ward, the use of haloperidol and midazolam have also declined in recent years with a steady increase in FCEs. Diamorphine use, after declining dramatically in 1999/00, showed an increase in 2000/01.

Medicine issued 1997/1998–2000/2001 according to the number of finished consultant episodes per ward, based on information provided by the Portsmouth Healthcare NHS Trust (see appendices H and I)

Figure 4.1 Diamorphine use – Daedalus ward

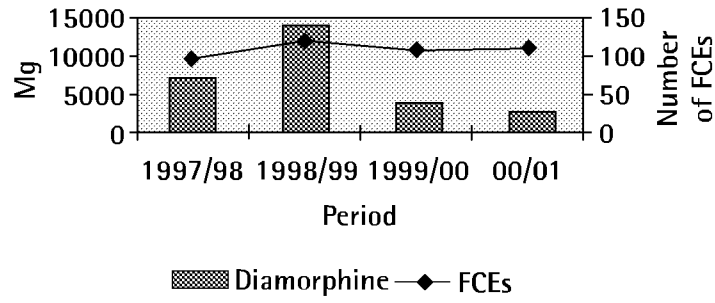


Figure 4.2 Haloperidol use – Daedalus ward

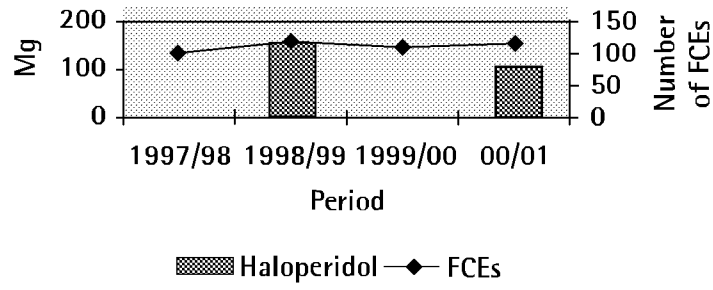


Figure 4.3 Midazolam use – Daedalus ward

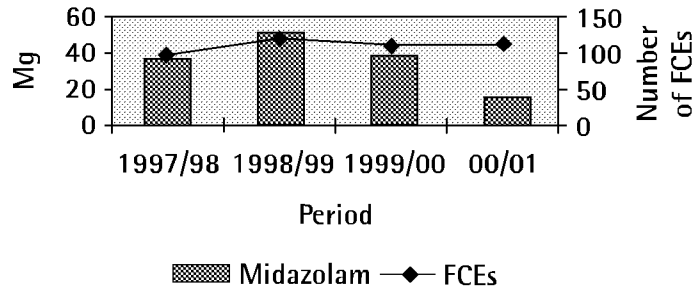


Figure 4.4 Diamorphine use – Dryad ward

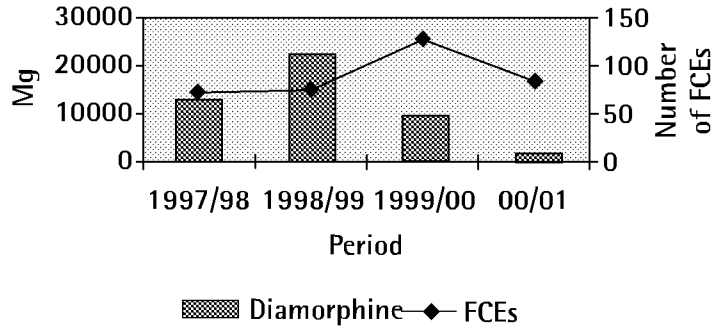


Figure 4.5 Haloperidol use – Dryad ward

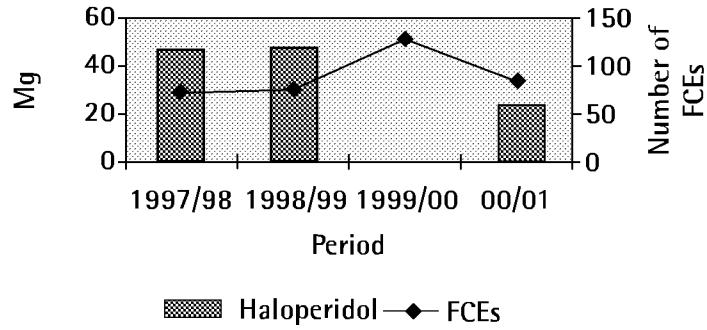


Figure 4.6 Midazolam use – Dryad ward

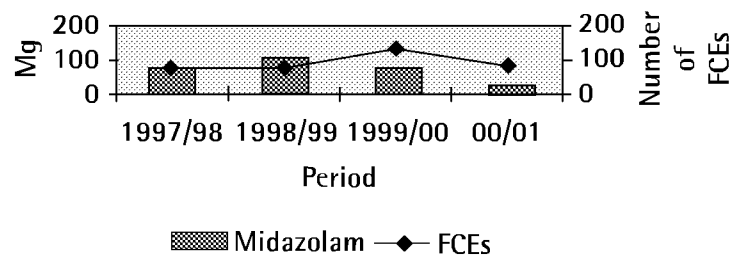


Figure 4.7 Diamorphine use – Sultan ward

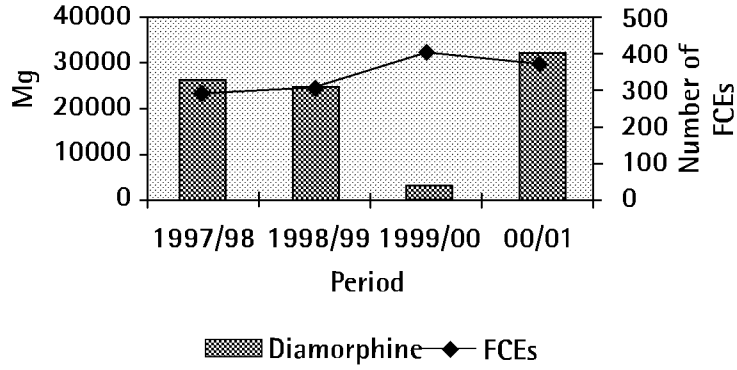


Figure 4.8 Haloperidol use – Sultan ward

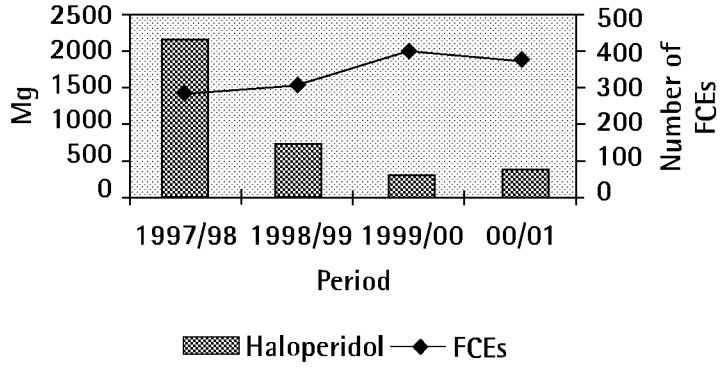
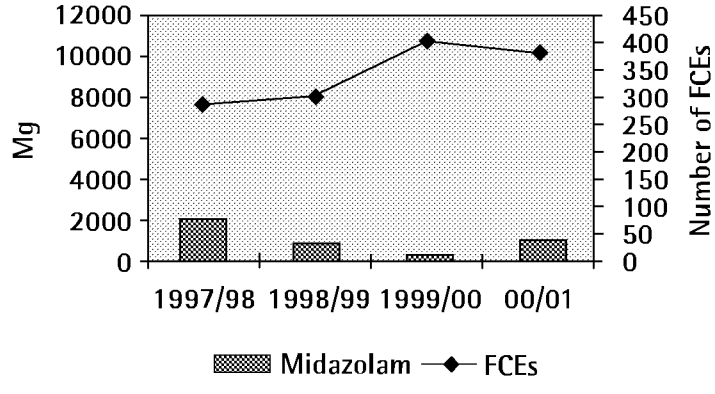


Figure 4.9 Midazolam use – Sultan ward



Assessment and management of pain

4.6 Part of the individual total assessment of each patient includes an assessment of any pain they may be experiencing and how this is to be managed. In 1998, the trust did not have a policy for the assessment and management of pain. This 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 placed responsibility for ensuring that pain management standards are implemented in every clinical setting and sets out the following:

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

4.7 CHI has also seen evidence of a pain management cycle chart and an 'analgesic ladder'. The analgesic ladder indicates the drug doses for different levels and types of pain, how to calculate opiate doses, gives 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 use of the analgesic ladder.

4.8 CHI was told by some nursing staff that following the introduction of the policy, it took longer for some patients to become pain free and that medical staff were apprehensive about prescribing diamorphine. Nurses also spoke of a reluctance of some patients to take pain relief. CHI's case note review concluded that two of the 15 patients reviewed were not prescribed adequate pain relief for part of their stay in hospital.

4.9 Many staff interviewed referred to the "Wessex guidelines". This is a booklet called *Palliative care handbook guidelines on clinical management* drawn up by Portsmouth Healthcare NHS Trust, the Portsmouth Hospitals NHS Trust and a local hospice, in association with the Wessex palliative care units. These guidelines were in place in 1998. Although the section on pain focuses on patients with cancer, there is a clear highlighted statement in the guidelines that states "all pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold".

4.10 The Wessex guidelines are comprehensive and include detail, in line with British National Formulary recommendations, on the use, dosage, and side effects of medicines commonly used in palliative care. The guidelines are not designed for a rehabilitation environment.

4.11 CHI's random case note review of 15 recent admissions concluded that the pain assistance and management policy is being adhered to. CHI was told by staff of the previous practice of anticipatory prescribing of palliative opiates. As a result of the pain and assessment policy, this practice has now stopped.

Prescription writing policy

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

4.13 The policy has a section on verbal prescription orders, including telephone orders, in line with UKCC guidelines. CHI understands that arrangements such as these are common practice in GP led wards and work well on the Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours. These arrangements were also confirmed by evidence found in CHI's case note review.

Administration of medicines

4.14 Medicines can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and via a syringe driver. Some of the medicines used in the care of older people can be delivered by a syringe driver, which delivers a continuous subcutaneous infusion of medication. Syringe drivers can be an entirely appropriate method of medicine administration that provides good control of symptoms with little discomfort or inconvenience to the patient. Guidance for staff on prescribing via syringe drivers is contained within the trust's policy for assessment and management of pain. The policy states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

4.15 Evidence from CHI's case note review demonstrated good documented examples of communication with both patients and relatives over medication and the use of syringe drivers and the application of the trust's policy.

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

Role of nurses in medicines administration

4.17 Registered nurses are regulated by the Nursing and Midwifery Council, a new statutory body which replaced the United Kingdom Central Council on 1 April 2002. Registered nurses must work within their code of professional conduct (UKCC, June 1992). The scope of professional practice clarified the way in which registered nurses are personally accountable for their own clinical practice and for care they provide to patients. The standards for the administration of medicines (UKCC, October 1992) details what is expected of nurses carrying out this function.

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

Review of medicines

4.19 The regular ward rounds and multidisciplinary meetings should include a review of medication by senior staff, which is recorded in the patient's case notes. CHI recognises the complexity of multidisciplinary meetings. Despite this, a process should be found to ensure that effective and regular reviews of patient medication take place by senior clinicians and pharmacy staff.

Structure of pharmacy

4.20 Portsmouth Healthcare NHS Trust has a service level agreement for pharmacy services with the local acute trust, Portsmouth Hospitals NHS Trust. An E grade pharmacist manages the contract locally and the service provided by a second pharmacist, who is the lead for older peoples' services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing workload. Pharmacy staff were confident that ward pharmacists would now challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to put the trust's *A compendium of drug therapy guidelines* on the intranet, although this is not easily available to all staff.

4.21 Pharmacy training for non pharmacy staff was described as "totally inadequate" and not taken seriously. Nobody knew of any training offered to clinical assistants.

4.22 There were no systems in place in 1998 for the routine review of pharmacy data which could have alerted the trust to any unusual or excessive patterns of prescribing, although the prescribing data was available for analysis.

KEY FINDINGS

1. CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing (the "Wessex guidelines") but this was inappropriately applied to patients admitted for rehabilitation.

2. Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.

3. The usage of diamorphine, midazolam and haloperidol has declined in recent years, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998.

4. CHI found some evidence to suggest a recent reluctance amongst clinicians to prescribe sufficient pain relieving medication. Despite this, diamorphine usage on Sultan ward 2000/2001 showed a marked increase.

5. CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Anticipatory prescribing is no longer evident on these wards. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

6. CHI found little evidence to suggest that thorough individual total patient assessments were being made by multidisciplinary teams in 1998. CHI's case note review concluded that this approach to care had been developed in recent years.

7. Pharmacy support to the wards in 1998 was inadequate. The trust was able to produce pharmacy data in 2002 relating to 1998. A system should have been in place to review and monitor prescribing at ward level, using data such as this as a basis.

RECOMMENDATIONS

1. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

2. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

3. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

4. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

5 | Quality of care and the patient experience

Introduction

5.1 This chapter details CHI's findings following contact with patients and relatives. This needs to be put into the context of the 1,725 finished consultant episodes for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Details of the methods used to gain an insight into the patient experience and of the issues raised with CHI are contained in appendix B.

Patient expeience

5.2 As with all patients being cared for when they are sick and vulnerable, it is important to treat each person as a whole. For this reason, the total holistic assessment of patients is critical to high quality individual care tailored to each patient's specific needs. The following sections are key elements (though not an exhaustive list) of total assessments which were reported to CHI by stakeholders.

5.3 CHI examined in detail the experience of older patients admitted to the Gosport War Memorial Hospital between 1998 and 2001 and that of their relatives and carers. This was carried out in two ways. Firstly, stakeholders were invited, through local publicity, to make contact with CHI. The police also wrote to relatives who had expressed concern to them informing them of CHI's 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.

5.4 Secondly, CHI made a number of observation visits, including at night, to Daedalus, Dryad and Sultan wards during the site visit week in January 2002. Some of the visits were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed.

Stakeholder views

5.5 The term stakeholder is used by CHI to define a range of people that are affected by, or have an interest in, the services offered by an organisation. CHI heard of a range of both positive and less positive experiences, of the care of older people. The most frequently raised concerns with CHI were: the use of medicines, the attitude of staff, continence management, the use of patients' own clothing, transfer arrangements between hospitals and nutrition and fluids. More detail on each of these areas is given below.

5.6 Relatives expressed concern around a perceived lack of nutrition and fluids as patients neared the end of their lives: "no water and fluids for last four days of life". Comments were also raised about unsuitable, unappetising food and patients being left to eat without assistance. A number of stakeholders commented on untouched food being cleared away without patients being given assistance to eat.

5.7 Following comments by stakeholders, CHI reviewed the trust policy for nutrition and fluids. The trust conducted a trust wide audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy *Feeding People*. The trust policy, *Prevention and management of malnutrition* (2000), included the designation of an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure full compliance. The standards state:

- all patients must have a nutritional risk assessment on admission
- registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary
- all staff must ensure that documented evidence supports the continuity of patient care and clinical practice
- all clinical areas should have a nominated nutritional representative who attends training/updates and is a resource for colleagues
- systems should be in place to ensure that staff have the required training to implement and monitor the *Feeding People* standards

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

5.9 CHI's review of recent case notes concluded that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses appeared unable to make swallowing assessments out of hours; this could lead to delays in receiving nutrition over weekends, for example, when speech and language therapy staff were not available.

5.10 Continence management is an important aspect of the care of older people, the underlying objective is to promote or sustain continence as part of the holistic management of care, this includes maintaining skin integrity (prevention of pressure sores). Where this is not possible, a range of options including catheterisation are available and it is imperative that these are discussed with patients, relatives and carers. Some stakeholders raised concerns regarding the 'automatic' catheterisation of patients on admission to the War Memorial. "They seem to catheterise everyone. My husband was not incontinent; the nurse said it was done mostly to save time". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.

5.11 CHI's review of recent case notes found no evidence of inappropriate catheterisation of patients in recent months.

5.12 The use of pain relieving medicines and the use of syringe drivers to administer them was commented on by a number of relatives. One relative commented that her mother "certainly was not in pain prior to transfer to the War Memorial". Although a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI also received comments that families would have liked more information: "Doctors should disclose all drugs, why [they are being used] and what the side effects are. There should be more honesty".

5.13 Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by their families. "They were never in their own clothes". Relatives also thought patients being dressed in other patients' clothes was a potential cross infection risk. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes. This is an important means by which patients' dignity can be maintained.

5.14 Concern was expressed regarding the physical transfer of patients from one hospital to another. Amongst concerns were lengthy waits prior to transfer, inadequate clothing and covering during the journey and the methods used to transfer patients. One person described their relative as being "carried on nothing more than a sheet". CHI learnt that this instance was acknowledged by Portsmouth Healthcare NHS Trust, who sought an apology from the referring hospital, which did not have the appropriate equipment available.

5.15 Though there were obvious concerns regarding the transfer of patients, during the period of the investigation, the Hampshire Ambulance Service NHS Trust, who were responsible for patient transfers between hospitals, received no complaints relating to the transfer of patients to and from the Gosport War Memorial Hospital.

5.16 Comments about the attitude of staff ranged from the very positive "Everyone was so kind and caring towards him in both Daedalus and Dryad wards" and "I received such kindness and help from all the staff at all times" to the less positive "I was made to feel an inconvenience because we asked questions" and "I got the feeling she had dementia and her feelings didn't count".

Outcome of CHI observation work

5.17 CHI spent time on Dryad, Sultan and Daedalus wards throughout the week of 7 January 2002 to observe the environment in which care was given, the interactions between staff and patients and between staff. Ward staff were welcoming, friendly and open. Although CHI observed a range of good patient experiences this only provides a 'snap shot' during the site visit and may not be fully representative. However, many of the positive aspects of patient care observed were confirmed by CHI's review of recent patient notes.

Ward environment

5.18 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.

5.19 Day rooms are pleasant and Daedalus ward has direct access to a well designed garden suitable for wheelchair users. The garden is paved with a variety of different textures to enable patients to practice mobility. There is limited storage space in Daedalus and Dryad wards and, as a result, the corridors had become cluttered with equipment. This can be problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe.

5.20 CHI saw staff address patients by name in a respectful and encouraging way and saw examples of staff helping patients with dressing and holding friendly conversations. The staff handovers observed were well conducted, held away from the main wards areas and relevant information about patient care was exchanged appropriately.

5.21 Mealtimes were well organised with patients given a choice of menu options and portion size. Patients who needed help to eat and drink were given assistance. There appeared to be sufficient staff to serve meals, and to note when meals were not eaten. CHI did not observe any meals returned untouched. Healthcare support workers told CHI that they were responsible for making a note when meals were not eaten.

5.22 There are day rooms where patients are able to watch the television and large print books, puzzles and current newspapers are provided. CHI saw little evidence of social activities taking place, although some patients did eat together in the day room. Bells to call assistance are situated by patients' beds, but are less accessible to patients in the day rooms. The wards have an activities coordinator, although the impact of this post has been limited.

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

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

Communication with patients, relatives and carers

The trust had an undated user involvement service development framework, which sets out the principles behind effective user involvement within the national policy framework described in the NHS Plan. It is unclear from the framework who was responsible for taking the work forward and within what time frame. Given the dissolution of the trust, a decision was taken not to establish a trust wide Patient Advice and Liaison Service (PALS), a requirement of the NHS Plan. However, work was started by the trust to look at a possible future PALS structure for the Fareham and Gosport PCT.

The Health Advisory Service *Standards for health and social care services for older people* (2000) states that "each service should have a written information leaflet or guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers". CHI saw a number of separate information leaflets provided for patients and relatives during the site visit.

The trust used patient surveys, given to patients on discharge, as part of its patient involvement framework, although the response rate was unknown. Issues raised by patients in completed surveys were addressed by action plans discussed at clinical managers meetings. Ward specific action plans were distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, thermometers were purchased to address the problem. CHI could find no evidence to suggest that the findings from patient surveys were shared across the trust.

Support towards the end of life

Staff referred to the Wessex palliative care guidelines, which are used on the wards and address breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure on Queen Alexandra and St Mary's hospitals to "discharge patients too quickly to Gosport War Memorial Hospital". Staff were aware of increased numbers of medically unstable patients being transferred in recent years.

Both patients and relatives have access to a hospital chaplain, who has links to representatives of other faiths. The trust had a leaflet for relatives *Because we care* which talks about registering the death, bereavement and grieving. The hospital has a designated manager to assist relatives through the practical necessities following a death.

KEY FINDINGS

1. Relatives speaking to CHI had some serious 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 highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.

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

3. The ward environments and patient surroundings are good.

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

5. CHI was concerned, following the case note review, of the inability of any ward staff to undertake swallowing assessments as required. This is an area of potential risk for patients whose swallowing reflex may have been affected, for example, by a stroke.

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

7. The trust had a strong theoretical commitment to patient and user involvement.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

2. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

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

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

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

6 | Staffing arrangements and responsibility for patient care

Responsibility for patient care

6.1 Patient care on Daedalus and Dryad wards at Gosport War Memorial Hospital for the period of the CHI investigation was provided by consultant led teams. A multidisciplinary, multiprofessional team of appropriately trained staff best meets the complex needs of these vulnerable patients. This ensures that the total needs of the patient are considered and are reflected in a care plan, which is discussed with the patient and their relatives and is understood by every member of the team.

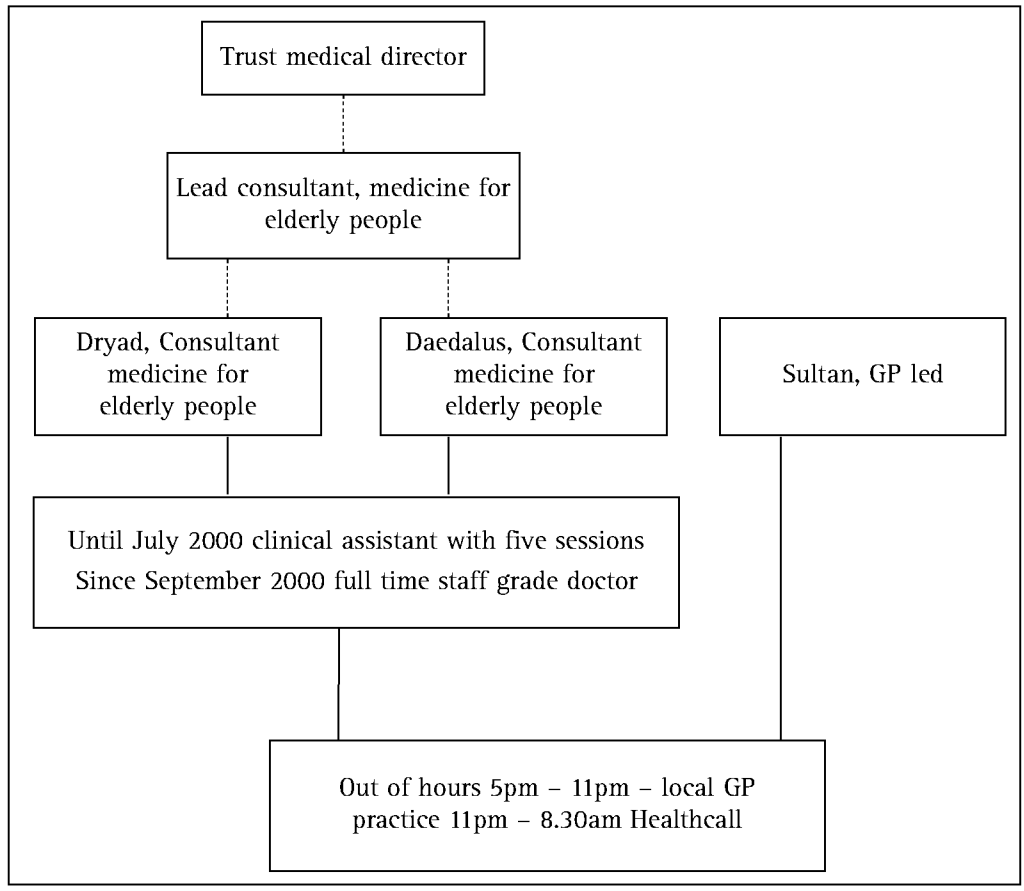
Medical responsibility

6.2 For the period covered by the CHI investigation, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. This is still the case today. All patients on both wards are admitted under the care of a consultant. Since 1995, there has been a lead consultant for the department of medicine for elderly people who held a two session contract (one session equates to half a day per week) for undertaking lead consultant responsibilities. These responsibilities included overall management of the department and the development of departmental objectives. The lead consultant is not responsible for the clinical practice of individual doctors. The post holder does not undertake any clinical sessions on the War Memorial site. The job description for the post, outlines 12 functions and states that the post is a major challenge for "a very part time role".

6.3 Since 2000, two department of elderly medicine consultants provide a total of 10 sessions of consultant cover on Dryad and Daedalus wards per week. Since September 2000, day to day medical support has been provided by a staff grade physician who was supervised by both consultants. Until July 2000, a clinical assistant provided additional medical support. Both consultants currently undertake a weekly ward round with the staff grade doctor. In 1998, there was a fortnightly ward round on Daedalus ward. On Dryad, ward rounds were scheduled fortnightly, though occurred less frequently.

6.4 CHI feels that the staff grade post is a pivotal, potentially isolated post, due to the distance of Gosport War Memorial Hospital from the main department of medicine for elderly people based at Queen Alexandra Hospital, no full time support from medical colleagues on the wards and a difficulty in attending departmental meetings. In 2001, the trust identified the risk of professional isolation and lack of support at Gosport War Memorial Hospital as a reason not to appoint a locum consultant.

Figure 6.1 Line management accountabilities



(*---------- this line indicates managerial accountability and not clinical accountability)

General practice role and accountability

6.5 Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation: as clinical assistants employed by the trust, as the clinicians admitting and caring for patients on the GP ward (Sultan) and as providers of out of hours medical support to all patients on each of the three wards.

Clinical assistant role

6.6 Clinical assistants are usually GPs employed and paid by trusts, largely on a part time basis, to provide medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years. Portsmouth Healthcare NHS Trust employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants work as part of a consultant led team and have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

6.7 From 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states that the clinical assistant was accountable to "named consultant physicians in geriatric medicine". The post holder was responsible for arranging cover for annual leave and any sickness absence with practice partners. The trust and the practice partners did not have a contract for this work. The job description does state that the post is subject to the terms and conditions of hospital medical and dental staff. Therefore, any concerns over the performance of any relevant staff could be pursued through the trust's disciplinary processes. CHI could find no evidence to suggest that this option was considered at the time of the initial police investigation in 1998.

Appraisal and supervision of clinical assistants

6.8 CHI is not aware of any trust systems in place to monitor or appraise the performance of clinical assistants in 1998. This lack of monitoring is still common practice within the NHS. The consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, had no system for supervising the practice of the clinical assistant, including any review of prescribing. CHI found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions.

6.9 CHI is aware of work by the Department of Health on GP appraisal which will cover GPs working as clinical assistants and further work to develop guidance on disciplinary procedures.

Sultan ward

6.10 Medical responsibility for patients on Sultan ward lay with the admitting GP throughout the period of the CHI investigation. The trust issued admitting GPs with a contract for working on trust premises, which clearly states "you will take full clinical responsibility for the patients under your care". CHI was told that GPs visit their patients regularly as well as when requested by nursing staff. This is a common arrangement in community hospitals throughout the NHS. GPs had no medical accountablity framework within the trust.

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

Out of hours cover provided by GPs

6.12 Between the hours of 8.30am and 5.00pm on weekdays, hospital doctors employed by the trust manage the care of all patients on Dryad and Daedalus wards. Out of hours medical cover, including weekends and bank holidays, is provided by a local GP practice from 5.00pm to 11.00pm, after which, between 11.00pm and 8.30am, nursing staff call on either the patient's practice or Healthcall, a local deputising service for medical input. If an urgent situation occurs out of hours, staff call 999 for assistance.

6.13 Some staff interviewed by CHI expressed concern about long waits for the deputising service, CHI heard that waiting times for Healthcall to attend a patient could sometimes take between three and five hours. However, evidence provided by Healthcall contradicts this. Nurses expressed concern over Healthcall GPs' reluctance to 'interfere' with the prescribing of admitting GPs on Sultan and Dryad wards. The contract with Healthcall is managed by a local practice.

Appraisal of hospital medical staff

6.14 Since April 2000, all NHS employers have been contractually required to carry out annual appraisals, covering both clinical and non clinical aspects of their jobs. All doctors interviewed by CHI who currently work for the trust, including the medical director, who works five sessions in the department of medicine for elderly people, have regular appraisals. Those appraising the work of other doctors have been trained to do so.

Nursing responsibility

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

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

Nursing supervision

6.17 Clinical supervision for nurses was recommended by the United Kingdom Central Council in 1996 and again in the national nursing strategy, *Making a difference*, in 1999. It is a system through which qualified nurses can maintain lifelong development and enhancement of their professional skills through reflection, exploration of practice and identification of issues that need to be addressed. Clinical supervision is not a

managerial activity, but provides an opportunity to reflect and improve on practice in a non judgemental environment. Clinical supervision is a key factor in professional self regulation.

6.18 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 Nursing to develop the processes. As part of the trust's clinical nursing development programme, which ran between January 1999 and December 2000, nurses caring for older people were identified to lead the development of clinical supervision on the wards.

6.19 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.

Teamworking

6.20 Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. Staff interviewed by CHI spoke of teamwork, although in several instances this was uniprofessional, for example a nursing team. CHI observed a multidisciplinary team meeting on Daedalus ward, which was attended by a consultant, a senior ward nurse, a physiotherapist and an occupational therapist. No junior staff were present. Hospital staff described input from social services as good when available, though this was not always the case.

6.21 Regular ward meetings are held on Sultan and Daedalus wards. Arrangements are less clear on Dryad ward, possibly due to the long term sickness of senior ward staff.

6.22 Arrangements for multidisciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multidisciplinary goal setting for patients, but were hopeful of further development.

Allied health professional structures

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

6.24 Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right through to home treatment. Physiotherapists described good levels of training and supervision and involvement in Daedalus ward's multidisciplinary team meetings.

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

6.26 The staffing structure in dietetics consists of one full time dietitian based at St James Hospital. Each ward has a nurse with lead nutrition responsibilities able to advise colleagues.

Workforce and service planning

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

- consultant cover
- medical risk with a change in patient group and the likelihood of more patients requiring specialist intervention. The trust believed that the introduction of automated defibrillators would go some way to resolve this. The paper also spoke of "the need for clear protocols...within which medical cover can be obtained out of hours"
- the trust identified a course for qualified nursing staff, ALERT, which demonstrates a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration

6.28 Despite this preparation, several members of staff expressed concern to CHI regarding the complex needs of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages and high sickness levels. Concerns were raised formally with the trust in early 2000 around the increased workload and complexity of patients. This was acknowledged in a letter by the medical director. CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix, though a full time staff grade doctor was in post by September 2002 to replace and increase the previous five sessions of clinical assistant cover.

Access to specialist advice

6.29 Older patients are admitted to Gosport War Memorial Hospital with a wide variety of physical and mental health conditions, such as strokes, cancers and dementia. Staff demonstrated good examples of systems in place to access expert opinion and assistance.

6.30 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. Staff spoke of strong links with the local hospice and Macmillan nurses. Nurses gave recent examples of joint training events with the hospice.

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

Staff welfare

6.32 Since its creation in 1994, the trust developed as a caring employer, demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy that has won national recognition. The hospital was awarded Investors in People status in 1998. Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship.

6.33 However, many staff, at all levels in the organisation, spoke of the stress and low morale caused by the series of police investigations and the referrals to the General Medical Council, the United Kingdom Central Council and the CHI investigation. Trust managers told CHI they encouraged staff to use the trust's counselling service and support sessions for staff were organised. Not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, "I don't feel I've had the support I should have had before and during the police investigation – others feel the same".

Staff communication

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

Key findings

1. Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards. It was not made clear to CHI how GPs working as clinical assistants and admitting patients to Sultan wards are included in the development of trust procedures and clinical governance arrangements.

2. There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff. Currently, there is effective nursing leadership on Daedalus and Sultan wards, this is less evident on Dryad ward. CHI was concerned regarding the potential for professional isolation of the staff grade doctor.

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

4. There was a planned approach to the service development in advance of the change in use of beds in 2000. The increasing dependency of patients and resulting pressure on the service, whilst recognised by the trust, was neither monitored nor reviewed as the changes were implemented and the service developed.

5. Portsmouth Healthcare NHS Trust should be congratulated for its progress towards a culture of reflective nursing practice.

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

7. Out of hours medical cover for the three wards out of hours is problematic and does not reflect current levels of patient dependency.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangemnts, clinical governance responsibilities and trianing needs.

2. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

3. Fareham and Gosport PCT and East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

4. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

5. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

7 | Lessons learnt from complaints

7.1 A total of 129 complaints were made regarding the provision of elderly medicine since 1 April 1997. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra hospitals. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

7.2 Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. Three complaints in the last five months of 1998 expressed concern regarding pain management, the use of diamorphine and levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients, was considered by the police expert witnesses.

External review of complaints

7.3 One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical adviser found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 was referred to an independent review panel, which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Although 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.

Complaint handling

7.4 The trust had a policy for handling patient related complaints produced in 1997 and reviewed in 2000, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure.* A leaflet for patients detailing the various stages of the complaints procedure was produced, which indicated the right to request an independent review if matters were not satisfactorily resolved together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards during CHI's visit.

7.5 Both the trust and the local community health council (CHC) described a good working relationship. The CHC regretted, however, that their resources since November 2000 had prevented them from offering the level of advice and active support to trust complainants they would have wished. The CHC did continue to support complainants who had contacted them before November 2000. New contacts were provided with a "self help" pack.

7.6 CHI found that letters to complainants in response to their complaints did not always include an explanation of the independent review stage, although this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. The 2000 update of the complaints policy stated that audit standards for complaints handling were good with at least 80% of complainants satisfied with complaint handling and 100% of complaints resolved within national performance targets. The chief executive responded to all written complaints. Staff interviewed by CHI valued the chief executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services.

7.7 Once the police became involved in the initial complaint in 1998, the trust ceased its internal investigation processes. CHI found no evidence in agendas and minutes that the trust board were formally made aware of police involvement. Senior trust managers told CHI that the trust would have commissioned a full internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not preclude full internal clinical investigation. CHI was told that neither the doctor nor portering staff involved in the care and transfer of the patient whose care was the subject of the initial police investigation were asked for statements during the initial complaint investigation.

Trust learning regarding prescribing

7.8 Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter 4). In addition, CHI learnt that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem". This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20mg to 40mg per day.

7.9 Portsmouth Healthcare NHS Trust correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mg a day. CHI understands this protocol to be the Wessex guidelines. Further correspondence in October 1999, indicated that a doctor working on the wards requested a trust policy on the prescribing of opiates in community hospitals.

7.10 A draft protocol for the prescription and administration of diamorphine by subcutaneous infusion was piloted on Dryad ward in 1999 and discussed at the trust's Medicines and Prescribing Committee in February and April 2000 following consultation with palliative care consultants. This guidance was eventually incorporated into the joint Portsmouth Healthcare NHS Trust and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain which was introduced in April 2001.

Other trust lessons

7.11 Lessons around issues other than prescribing have been learnt by the trust, though the workshop to draw together this learning was not held until early 2001 when the themes discussed were communication with relatives, staff attitudes and fluids and nutrition. Action taken by the trust since the series of complaints in 1998 are as follows:

- an increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999
- the appointment of a full time staff grade doctor in September 2000 which increased medical cover following the resignation of the clinical assistant
- piloting pain management charts and prescribing guidance approved in April 2001. Nursing documentation is currently under review, with nurse input
- one additional consultant session began in 2000, following a district wide initiative with local PCGs around intermediate care
- nursing documentation now clearly identifies prime family contacts and next of kin information to ensure appropriate communication with relatives
- all conversations with families are now documented in the medical record. CHI's review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff

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

Monitoring and trend identification

7.13 A key action identified in the 2000/2001 clinical governance action plan was a strengthening of trust systems to ensure that actions following complaints were implemented. Until the dissolution of Portsmouth Healthcare NHS Trust, actions were monitored through the divisional review process, the clinical governance panel and trust board. A trust database was introduced in 1999 to record and track complaint trends. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

7.14 Portsmouth Healthcare NHS Trust offered specific training in complaints handling, customer care and loss, death and bereavement, which many staff interviewed by CHI were aware of and had attended.

KEY FINDINGS

1. The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake an review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation which it was aware of in late 1998.

2. Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

3. Though Portsmouth Healthcare NHS Trust did begin to develop a protocol for the prescription and administration of diamorphine by syringe driver in 1999, the delay in finalising this protocol in April 2001, as part of the policy for the assessment and management of pain, was unacceptable.

4. There has been some, but not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

RECOMMENDATIONS

1. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

2. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

3. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

8 | Clinical governance

Introduction

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

8.2 CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems supported 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 and the systems in place to enable staff to raise concerns.

Clinical governance structures

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

8.4 The medical director took lead responsibility for clinical governance and chaired the clinical governance panel, a sub committee of the trust board. A clinical governance reference group, whose membership included representatives from each clinical service, professional group, non executive directors and the chair of the community health council, supported the clinical governance panel. Each clinical service also had its own clinical governance committee. This structure had been designed to enable each service to take clinical governance forward into whichever PCT it found itself in after April 2002. Since February 2000, the trust used the divisional review process to monitor clinical governance developments.

8.5 The service specific clinical governance committees were led by a designated clinician and included wide clinical and professional representation. Baseline assessments were carried out in each specialty and responsive action plans produced. The medical director and clinical governance manager attended divisional review meetings and reported key issues back to the clinical governance panel.

8.6 District Audit carried out an audit of the trust's clinical governance arrangements in 1998/1999. The report, dated December 1999, states that the trust had fully complied with requirements to establish a framework for clinical governance. The report also referred to the trust's document, *Improving quality – steps towards a first class service*, which was described as "of a high standard and reflected a sound understanding of clinical governance and quality assurance".

8.7 Whilst commenting favourably on the framework, the District Audit review also noted the following:

- the process for gathering user views should be more focused and the process strengthened
- the trust needed to ensure that in some areas, strategy, policy and procedure is fed back to staff and results in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and reaudited; lessons learnt from complaints and incidents not always used to change practice and that research and development 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

8.8 Following the review, the trust drew up a trust wide action plan (December 1999) which focused on widening the involvement and feedback from nursing, clinical and support staff regarding trust protocols and procedures, and on making greater use of research and development, clinical audit, complaints, incidents and user views to lead to changes in practice. CHI was told of a link nurse programme to take elements of this work forward.

Risk management

8.9 A trust risk management group was established in 1995 to develop and oversee the implementation of the trust's risk management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The group had links with other trust groups such as the clinical and service audit group, the board and the nursing clinical governance committee. Originally the finance director had joint responsibility for strategic risk with the quality manager; this was changed in the 2000/2003 strategy when the medical director became the designated lead for clinical risk. The trust achieved the clinical negligence scheme for trusts (CNST) level one in 1999. A decision was taken not to pursue the level two standard assessment due to dissolution of the trust in 2002.

8.10 The trust introduced an operational policy for recording and reviewing risk events in 1994. New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non clinical risk. The same trust policy was used to report clinical and non clinical risks and accidents. All events were recorded in the trust's risk event database (CAREKEY). This reporting system was also used for near misses and medication errors. Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, although CHI was less confident that medical staff regularly identified and reported risks. CHI was told that risk forms were regularly submitted by wards in the event of staff shortages. Staff shortage was not one of the trust's risk event definitions.

8.11 The clinical governance development plan for 2001/2002 stated that the focus for risk management in 2000/2001 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 were held with each successor organisation to agree future arrangements for areas such as risk event reporting, health and safety, infection control and medicines management.

Raising concerns

8.12 The trust had a whistle blowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. The policy sets out the process staff should follow if they wished to raise a concern about the care or safety of a patient "that cannot be resolved by the appropriate procedure". NHS guidance requires systems to enable concerns to be raised outside the usual management chain. Most staff interviewed were clear about how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. Fewer staff were aware of the trust's whistle blowing policy.

Clinical audit

8.13 CHI was given no positive examples of changes in patient care or prescribing as a result of clinical audit outcomes. Despite a great deal of work on revising and creating policies to support good prescribing and pain management, there was no planned audit of outcome.

8.14 CHI was made aware of two trust audits of medicines since 1998. In 1999, a review of the use of neuroleptic medicines, which includes tranquillisers such as haloperidol, within all trust elderly care continuing care wards concluded that neuroleptic medicines were not being over prescribed. The same review revealed "the weekly medical review of medication was not necessarily recorded in the medical notes". The findings of this audit and the accompanying action plan, which included guidance on completing the prescription chart correctly, was circulated to all staff on Daedalus and Dryad wards. A copy was not sent to Sultan ward. There was a reaudit in late 2001 which concluded that overall use of neuroleptic medicines in continuing care wards remained appropriate.

8.15 More recently, the Fareham and Gosport PCT has undertaken a basic audit based on the prescription sheets and medical records of patients cared for on Sultan, Dryad and Daedalus wards during two weeks in June 2002. The trust concluded "that the current prescriping of opiates, major tranquilisers and hyocine was within British National Formulary guidelines." No patients were prescribed midazolam during the audit timeframe.

KEY FINDINGS

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

2. Although a system was in place to record risk events, understanding of clinical risk was not universal. The trust had a whistle blowing policy, but not all staff were aware of it. The policy did not make it sufficiently clear that staff could raise concerns outside of the usual management channels if they wished.

RECOMMENDATIONS

1. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

2. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

3. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

4. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

APPENDIX A

Documents reviewed by CHI and/or referred to in the report

A) NATIONAL DOCUMENTS

1. Modern Standards and Service Models, Older People, National Service Framework for Older People, Department of Health, March 2001
2. 'Measuring disability a critical analysis of the Barthel Index', British Journal of Therapy and Rehabilitation, April 2000, Vol 7, No 4
3. The Public Interest Disclosure Act 1998 – whistleblowing in the NHS, NHS Executive, August 1999
4. Guidelines for the administration of medicines, (including press statement) United Kingdom Central Council for Nursing, Midwifery and Health Visiting, October 2000
5. Extension of independent nursing prescribing, items prescribable by nurses under the extended scheme, Department of Health, February 2002
6. Essence of Care: patient-focused benchmarking for healthcare practitioners, Department of Health, February 2001
7. Caring for older people: A nursing priority, integrated knowledge, practice and values, The nursing and midwifery advisory committee, March 2001
8. British National Formulary 41, British Medical Association, Royal Pharmaceutical Society of Great Britiain, 2001
9. Consent – What you have a right to expect: a guide for relatives and carers, Department of Health, July 2001
10. Making a Difference, strengthening the nursing, midwifery and health visiting contribution to health and healthcare, Summary, The Department for Health, July 1999
11. Improving Working Lives Standard, NHS employers commited to improving the working lives of people who work in the NHS, Department of Health, September 2000
12. The NHS plan, a plan for investment, a plan for reform, Chapter 15, dignity, security and independence in old age, The Department of Health, July 2000
13. Standards for health and social care services for older people, The Health Advisory Service 2000, May 2000
14. Reforming the NHS Complaints Procedure: a listening document, The Department of Health, September 2001

B) DOCUMENTS RELATING TO PORTSMOUTH HEALTHCARE NHS TRUST

1. Our work, our values – a guide to Portsmouth Healthcare NHS Trust, Portsmouth Healthcare NHS Trust, undated
2. Annual reports, Portsmouth Healthcare NHS Trust, 2000-2001, 2000, 1998-1999
3. Local health, local decisions – proposals for the transfer of management responsibility for local health services in Portsmouth and south east Hampshire from Portsmouth

Healthcare NHS Trust to local Primary Care Trusts and West Hampshire NHS Trust, South East regional office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Hampshire Health Authority, September 2001

4. Dissolution project proposal, Portsmouth Healthcare Trust, undated

5. Trust dissolution: summary of meeting to agree the future management arrangements for risk and clinical governance systems and groups, Portsmouth Healthcare NHS Trust, 1 November 2001

6. Looking forward... the next five years 1995-2000, Portsmouth Healthcare NHS Trust, September 1994

7. Business plans 2000-2001, 1999-2000, 1998-1999, 1997-1998, Portsmouth Healthcare NHS Trust

8. Health improvement programme 2000-2003, Portsmouth and south east Hampshire, Isle of Wight, Portsmouth and South East Hampshire, April 2000

9. Fareham health improvement programme 2000-2002, Fareham and Gosport Primary Care Groups, undated

10. A report on a future Patient Advice Liaison Service for Fareham & Gosport Primary Care Trust, Portsmouth Healthcare NHS Trust, November 2001

11. Gosport War Memorial Patient Survey results, Portsmouth Healthcare NHS Trust, November 2001, October 2001, July 2001.

12. 2001/2002 Services and Financial Framework (SAFF) cost and service pressures, Portsmouth Healthcare NHS Trust, undated

13. Gosport War Memorial Hospital outpatient clinics rota, 9 July 2001

14. User involvement in service development: A framework, Portsmouth Healthcare NHS Trust, undated

15. Isle of Wight, Portsmouth & South East Hampshire Health Authority joint investment plan for older people 2001-2002, Isle of Wight, Portsmouth & South East Hampshire Health Authority, undated

16. Portsmouth Healthcare NHS Trust, trust board agendas and strategic briefing documents:

    Trust board strategic briefing 18 October 2001, 19 July 2001, 21 June 2001,18 January 2001, 19 October 2000, 20 July 2000, 15 June 2000, 20 April 2000, 20 January 2000, 21 October 1999, 15 July 1999, 17 June 1999, 15 April 1999, 21 January 1999, 22 October 1998, 24 September 1998

    Public meeting of the trust board 20 September 2001, 17 May 2001,15 February 2001, 16 November 2000, 21 September 2000, 18 May 2000, 17 February 2000, 18 November 1999, 16 September 1999, 20 May 1999, 18 February 1999, 19 November 1998

    Agenda for part two of meeting of trust board 20 September 2001, 17 May 2001, 15 February 2001, 16 November 2000, 21 September 2000, 18 May 2000, 17 February 2000, 18 November 1999, 16 September 1999, 20 May 1999, 18 February 1999, 19 November 1998, 24 September 1998

17. Divisional review 2000 Gosport and Fareham division, Portsmouth Healthcare NHS Trust, 8 February 2000, 10 August 2000, 16 May 2000, 11 November 1999

18. National service framework: older people steering group (district wide implementation team) documents, Isle of Wight, Portsmouth and South East Hampshire health authority, undated

19. Correspondence: re Healthcall data 2001 analysis, Knapman practice, 22 June 2002

20. Correspondence: re Healthcall regarding contract for 2002, Healthcall business manager, March 2002

21. Patient environment assessment and action plan, Portsmouth Healthcare NHS Trust, August and September 2000

22. Combined five year capital programme 2001/2002-2005/2006, Portsmouth Healthcare NHS Trust, Portsmouth City Primary Care Trust, East Hampshire NHS Primary Care Trust, 8 November 2001

23. Portsmouth Healthcare NHS Trust: Investors in People report, Western Training and Enterprise Council, July 1999

24. Portsmouth Healthcare NHS Trust, Quality report – governance indicators, quarter ending 30 June 2001, 31 March 2001, 31 December 2000, 30 September 2000, 30 June 2000, 31 March 2000, 31 December 1999, 30 September 1999, 30 June 1999, 31 March 1999, 31 December 1998, 30 September 1998, 30 June 1998, 31 March 1998, 31 December 1997, 30 September 1997, 30 June 1997

25. Annual quality report to Portsmouth and South East Hampshire Health Authority (quarter 3 2000/2001), Portsmouth Healthcare NHS Trust, 27 February 2001

26. Improving quality – steps towards a First class service, Portsmouth Healthcare NHS Trust September 1998

27. Infection control services, Portsmouth Hospitals NHS Trust and Portsmouth Healthcare NHS Trust, Nursing practice audit, Portsmouth Healthcare NHS Trust, 9 May 2001

28. Emergency incidents originating at Gosport War Memorial Hospital, Hampshire Ambulance Service NHS Trust, April 2000-February 2002

29. Staff handbook, Portsmouth Healthcare NHS Trust, undated

30. Junior doctors' accreditation information, pack supplied by Portsmouth Healthcare NHS Trust, undated

31. GP contracts for trust working, Portsmouth Healthcare NHS Trust, December 1979-May 2001

32. GP contracts for trust working, Out of hours GP contract, Portsmouth Healthcare NHS Trust, April 1999-March 2000, June 2001-March 2002

33. Strategy for employing locum medical staff, Portsmouth Healthcare NHS Trust, undated

34. The development of clinical supervision for nurses, nurse consultant, adult mental health services, Portsmouth Healthcare NHS Trust undated

35. Correspondence/memorandum re: staff opinion survey results, Portsmouth Healthcare NHS Trust, 18 December 2001

36. Staff opinion survey 2000, Portsmouth Healthcare NHS Trust undated

37. Common actions arising from staff opinion survey results, personnel department, 19 October 2001

38. Memorandum re: senior managers on call, Portsmouth Healthcare NHS Trust, 29 September 2000

39. Personnel and human resources/management strategy and action plan, Portsmouth Healthcare NHS Trust, personnel director, October 2001

40. Strategy for human resource management and important human resource issues, Portsmouth Healthcare NHS Trust, personnel director, October 1996

41. Human resource management, Portsmouth and South East Hampshire Health Authority Community Health Care Services, November 1991

42. Audit of standards of oral hygiene within the stroke service, Portsmouth Healthcare NHS Trust November 1999-April 2000

43. Clinical Stroke service guidelines, Department of medicine for elderly people, undated

44. Reaudit evaluation of compliance with revised handling assessment guidelines, Portsmouth Healthcare NHS Trust, June 1998-November 1998

45. Feeding people, trust wide reaudit of nutritional standards, Portsmouth Healthcare NHS Trust, November 2001

46. Trust records strategy, records project manager, Portsmouth Healthcare NHS Trust March 2001

47. A guide to medical records, a pocket guide to all medical staff, Portsmouth Healthcare NHS Trust, June 2000

48. Health records all specialities core standards and procedures, Portsmouth Healthcare NHS Trust (incorporating East Hants Primary Care Trust and Portsmouth City Primary Care Trust), December 1998 updated February 2000 and May 2001

49. Referral to old age psychiatry form, Portsmouth Healthcare NHS Trust, undated

50. Patients affairs procedure – death certification and post mortems, department of medicine for elderly people, Queen Alexandra Hospital, (undated)

51. Audit of compliance with bed rails guidelines in community hospitals, Portsmouth Healthcare NHS Trust, August 2001

52. Patient flows, organisational chart, 24 October 2001

53. Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts Joint Generic Transfer Document: Protocol for the transfer to GP step down beds, Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts, November 2000

54. Discharge summary form, guidance notes for completion, Portsmouth Healthcare NHS Trust, 21 November 2001

55. Audit of patient records, December 1997-July 1998, Portsmouth Healthcare NHS Trust

56. Audit of nutritional standards, October 1997-April 1998, Portsmouth Healthcare NHS Trust, undated

57. Falls policy development - strategy to reduce the number of falls in community hospitals, Portsmouth Healthcare NHS Trust, undated

58. Minutes of falls meetings held on 26 July 2001,13 June 2001, 26 February 2001, 18 January 2001, 23 November 2000, 5 October 2000, Portsmouth Healthcare NHS Trust

59. Stepping stones: how the need for stepping stones came about, Portsmouth Healthcare NHS Trust, undated

60. Portsmouth Healthcare NHS Trust Policies: Resuscitation status policy, April 2000; Whistleblowing policy, February 2001; Risk management policy, January 2001; Recording and reviewing risk events policy, May 2001; Control and administration of medicines by nursing staff policy, January 1997; Prescription writing policy, July 2000; Policy for assessment and management of pain, May 2001; Training and education policy, April 2001; Bleep holder policy review, 15 May 2001; Prevention and management of pressure ulcers policy, May 2001; Prevention and management of malnutrition within trust residential and hospital services, November 2000; Client records and record keeping policy, December 2000; Trust corporate policies, guidance for staff, revised August 2000;

Psychiatric involvement policy, November 2001; Induction training policy, October 1999 Handling patient related complaints policy, Portsmouth Healthcare NHS Trust, January 2000; Domestic abuse in the workplace policy, July 2000

61. Medicines policy incorporating the IV policy, final draft – version 3.5, Portsmouth Hospitals NHS Trust, Royal Hospital Haslar, Portsmouth Healthcare NHS Trust, August 2001

62. Non emergency patient transport request form, Portsmouth Hospitals and Healthcare NHS Trust, undated

63. Patient transport – standards of service, Portsmouth Healthcare NHS Trust, Development Directorate, March 2001

64. Booking criteria and standards of service – criteria for use of non emergency patient transport, Portsmouth Hospitals and Healthcare NHS Trust and Hampshire Ambulance Trust, undated

65. Prescribing formulary, Portsmouth District October 2001, Portsmouth Hospitals NHS Trust, Portsmouth Healthcare NHS Trust, General Medical Practitioners, Portsmouth and South East Hampshire Health Authorities and Royal Hospital Haslar (not complete)

66. Wessex palliative care handbook: guidelines on clinical management, fourth edition, Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, The Rowans (Portsmouth Area Hospice), undated

67. National sentinel clinical audit, evidence based prescribing for older people: Report of national and local results, Portsmouth Healthcare NHS Trust, undated

68. Compendium of drug therapy guidelines 1998 (for adult patients only), Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, 1998

69. Draft protocol for prescription and administration of diamorphine by subcutaneous infusion, medical director, Portsmouth Healthcare NHS Trust, 15 December 1999

70. Medicines and prescribing committee meeting: agendas 3 February 2000, 4 May 2001, 6 April 2000, 6 July 2000, 3 November 2000

71. Medicines and prescribing committee meeting: minutes 3 November 2000, 5 January 2001

72. Correspondence: protocol for prescription administration of diamorphine by subcutaneous infusion, Portsmouth Healthcare NHS Trust, 7 February 2000, 11 February 2000

73. Correspondence: Portsmouth Healthcare NHS Trust syringe driver control, Portsmouth Healthcare NHS Trust, 21 February 2000

74. Correspondence: diamorphine guidelines, Portsmouth Healthcare NHS Trust, 21 February 2000

75. Audit of prescribing charts: questionnaire Portsmouth Healthcare NHS Trust, undated

76. Administration of controlled drugs – the checking role for support workers: guidance note for ward/clinical managers, Portsmouth Healthcare NHS Trust, February 1997

77. Scoresheet – medicines management standard 2001/2002, Portsmouth Healthcare NHS Trust, undated

78. Organisational controls standards, action plan 2000/2001, Portsmouth Healthcare NHS Trust, November 2001

79. Diagram of Medicines Management Structure, Portsmouth Healthcare NHS Trust, 16 October 2000

80. Summary medicines use 1997/1998 to 2000/2001 for wards Dryad, Daedalus and Sultan, Portsmouth Hospitals NHS Trust pharmacy service, April 2002

81. **Training on demand: working in partnership**, Portsmouth Healthcare NHS Trust, undated

82. **Programme of training events 2001-2002**, Portsmouth Healthcare NHS Trust, undated

83. **Sultan ward leaflet**, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust

84. **Post mortem information for relatives and hospital post mortem consent form**, Portsmouth Healthcare NHS Trust, January 2000

85. **Proposal for Portsmouth Healthcare NHS Trust: the provision of an employee assistance programme for Portsmouth Healthcare NHS Trust**, Corecare, 16 March 2000

86. **Gosport War Memorial Hospital chaplains' leaflet**, Portsmouth Healthcare NHS Trust, undated

87. **Gosport War Memorial Hospital, chaplains and Portsmouth Healthcare NHS Trust: because we care, community health services – leaflets**, Portsmouth Healthcare NHS Trust, undated

88. **Talking with dying patients, loss death and bereavement**, staff handout, no author, undated

89. **Multidisciplinary post registration development programme**, 2001

90. **Gerontological nursing programme: proposal for an integrated work based learning and practice development project between the RCN's gerontological nursing programme**, Portsmouth Health Care NHS Trust, PCTs and Portsmouth University: COMMUNITY HOSPITALS, Royal College of Nursing, version 2.0 2001

91. **Multidisciplinary post registration year 2000-2001: lecture programme**, Portsmouth Healthcare NHS Trust, November 2001

92. **Training programme 2002 and in service training: list of lectures**, Portsmouth Healthcare NHS Trust, undated

93. **Occupational therapy service – supervision manual**, Portsmouth Healthcare NHS Trust, Portsmouth City Council, Hampshire County Council Social Service department, undated

94. **Acute life threatening events recognition and treatment (ALERT)**: A multiprofessional University of Portsmouth course in care of the acutely ill patient, October 2000

95. **Training and development for nursing staff in Portsmouth Healthcare NHS Trust community hospitals relating to intermediate care: Progress report**, Portsmouth Healthcare NHS Trust, 12 February 2001

96. **E-learning at St James's: catalogue of interactive training programmes**, November 2001

97. **Valuing diversity pamphlet: diversity matters**, Portsmouth Healthcare NHS Trust, undated

98. **Procedural statement – individual performance review: recommended documentation and guidance notes**, personnel director, Portsmouth Healthcare NHS Trust, April 2001

99. **IPR audit results 2000**, community hospitals service lead group, 22 March 2001

100. **Clinical nursing development, promoting the best practice in Portsmouth Healthcare**, Portsmouth Healthcare NHS Trust, January 1998

101. **An evaluation of clinical supervision activity in nursing throughout Portsmouth Healthcare NHS Trust**, Portsmouth Healthcare NHS Trust, December 1999

102. **Your views matter: making comments or complaints about our services**, Portsmouth Healthcare NHS Trust, undated

103. Anonymised correspondence on complaints relating to Gosport War Memorial Hospital since 1998

104. Learning from experience: action from complaints and patient based incidents, 1998-2001, Portsmouth Healthcare NHS Trust

105. Handling complaints course facilitators notes, Portsmouth Healthcare NHS Trust, 21 May 1999

106. Community hospitals governance framework, January 2001

107. Community hospitals and Portsmouth Healthcare NHS Trust clinical governance development plan, 2001- 2002

108. General rehabilitation clinical governance group, minutes of meeting 6 September 2001

109. Stroke service clinical governance meeting, minutes of meeting 12 October 2001

110. Continuing care clinical governance group, minutes of meeting 7 November 2001, Portsmouth Healthcare NHS Trust

111. Community hospitals clinical leadership programme update, Portsmouth Healthcare NHS Trust, 19 November 2001

112. Practice development programme: community hospitals clinical governance, Portsmouth Healthcare NHS Trust, March 1999

113. Third quarter quality/clinical governance report, community hospitals service lead group, Portsmouth Healthcare NHS Trust, January 2000

114. Community hospitals clinical governance baseline assessment action plan, September 1999

115. Clinical governance: minimum expectations of NHS trusts and primary care trusts from April 2000. Action plan – review March 2001, Portsmouth Healthcare NHS Trust, undated

116. Clinical governance annual report 2000/2001 and 1999/2000, Portsmouth Healthcare NHS Trust

117. Risk event forms and instructions, Portsmouth Healthcare NHS Trust, undated

118. Clinical governance baseline assessment trust wide report, 1999, Portsmouth Healthcare NHS Trust, undated

119. Trust clinical governance panel meeting minutes on 16 May 2001, Portsmouth Healthcare NHS Trust

120. Memorandum re: implementation of clinical governance, Portsmouth Healthcare NHS Trust, 11 June 1999

121. Risk management strategy 2000/2003, 1999/2002 and 1998/2001, Portsmouth Healthcare NHS Trust

122. Gosport War Memorial Hospital patient survey action plan, Portsmouth Healthcare NHS Trust, (undated)

C) DOCUMENTS RELATING TO THE DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE AT THE GOSPORT WAR MEMORIAL HOSPITAL

1. Dryad ward away day notes, Gosport War Memorial Hospital, 22 January 2001, 18 May 1998
2. Community hospital service plan 2001/2002, Portsmouth Healthcare NHS Trust, undated
3. Community hospitals GP bed service plan 2000/2001, Portsmouth Healthcare NHS Trust, 30 November 1999
4. Intermediate care and rehabilitation services proposal, Fareham and Gosport primary care groups, May 2000.
5. Team objectives 1999/2000 – Sultan ward, Portsmouth Healthcare NHS Trust, 21 November 2001
6. Gosport War Memorial Hospital key objectives 2000/2001, 1998/1999, 1997/1998 and 1996/1997, Portsmouth Healthcare NHS Trust
7. Gosport War Memorial Hospital leaflet and general information, Portsmouth Healthcare NHS Trust, undated
8. Gosport health improvement programme (HIMP) 2000-2002, Fareham and Gosport primary care groups, undated
9. Fareham and Gosport primary care groups intermediate care and rehabilitation services, Fareham and Gosport primary care groups, undated
10. Patient throughput data from Sultan, Dryad and Daedalus wards 1997/1998 – 2000/2001, Fareham and Gosport primary care groups, April 2002
11. Fareham and Gosport staff management structure, community hospitals, Portsmouth Healthcare NHS Trust, 25 October 2001
13. Fareham and Gosport locality division structure diagram, Portsmouth Healthcare NHS Trust, 25 October 2001
14. Fareham and Gosport older persons' locality implementation group progress report. Isle of Wight, Portsmouth and South East Hants Health Authority, Fareham and Gosport primary care groups, undated
15. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
16. Correspondence from department of medicine for elderly people re: national sentinel audit of stroke 1999, Portsmouth Healthcare NHS Trust, 8 March 2000
17. Job description: Lead consultant department of medicine for elderly people (draft 4), Portsmouth Healthcare NHS Trust, February 1999
18. Job description: clinical assistant position to the geriatric division in Gosport, Portsmouth and South East Hampshire Health Authority, April 1988
19. Job description: service manager (H Grade) department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 29 August 2000
20. Job description: Service manager, community hospitals Fareham and Gosport, Portsmouth Healthcare NHS Trust, February 2000
21. University of Portsmouth, Clinical nursing governance in a department of elderly medicine: an exploration of key issues and proposals for future development, Portsmouth Healthcare NHS Trust and Portsmouth University, May 2000

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

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

24. Job description: full time staff grade physician, Gosport War Memorial Hospital department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 5 July 2000

25. Correspondence re: staff grade physician contract – Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 26 September 2001

26. Correspondence re: consultant in medicine for the elderly contract, Wessex Regional Health Authority, 28 January 1992

27. Essential information for medical staff department of medicine for elderly people, Portsmouth Healthcare NHS Trust, undated

28. Department of medicine for elderly people, consultant timetables August 1997-November 2001, Portsmouth Healthcare NHS Trust

29. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated

30. Information for supervision arrangements for Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, November 2001

31. Clinical managers meeting minutes, Portsmouth Healthcare NHS Trust, 12 November 2001

32. Notes of action learning meeting, Portsmouth Healthcare NHS Trust, 11 June 2001

33. Notes from team leader meetings for the Daedalus ward, Portsmouth Healthcare NHS Trust, 5 April 2001

34. Notes of Daedalus ward meeting, Portsmouth Healthcare NHS Trust, 6 August 2001

35. Fareham & Gosport locality division, nursing accountability pathway, Portsmouth Healthcare NHS Trust, 25 October 2001

36. Medical accountability structure for Gosport War Memorial Hospital, undated

37. Supervision arrangement consultant timetable at Gosport War Memorial Hospital 1998-2001, Portsmouth Healthcare NHS Trust

38. Night skill mix review Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 28 March 2001

39. Vacancy levels 1998-2001 for Sultan, Daedalus and Dryad, Portsmouth Healthcare NHS Trust, 21 November 2001

40. Sickness absence statistics for Daedalus Ward, Gosport War Memorial Hospital, 2000-2001, undated

41. Sickness absence statistics for Sultan Ward, Gosport War Memorial Hospital, 1998-2001, undated

42. Wastage for qualified nurses – Daedalus, Dryad and Sultan Ward, undated

43. Winter escalation plans elderly medicine and community hospitals, Portsmouth Healthcare NHS Trust, undated

44. Audit of detection of depression in elderly rehabilitation patients, January-November 1998, Portsmouth Healthcare NHS Trust, undated

45. District audit review of rehabilitation service for older people 2000/2001, Portsmouth Healthcare NHS Trust, January 2001

46. Memorandum to all medical staff re: rapid tranquillisation and attached protocol – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 23 February 2001

47. Correspondence re: guidelines on management of acute confusion from general manager – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 18 October 2001

48. Memorandum to all consultants from consultant geriatrician re: management of acute confusion elderly medicine, Queen Alexandra Hospital Portsmouth Healthcare NHS Trust, 30 April 2001

49. Community hospitals: guidelines for confirmation of death, Portsmouth Healthcare NHS Trust, policy date May 1998, review date May 1999

50. Memorandum: Guidelines for admission to Daedalus and Dryad ward, Portsmouth Healthcare NHS Trust, 4 October 2000

51. Clinical policy, admission and discharge policy, Portsmouth Healthcare NHS Trust, September 2000

52. Urgent notice for all medical and nursing staff in the event of a suspected fracture and/or dislocation of a patient on the above ward, Daedalus and Dryad wards, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 16 November 2001

53. Procedure for the initial management of medical emergencies in Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 15 January 2001

54. Audit of neuroleptic prescribing in elderly medicine, Portsmouth Healthcare NHS Trust, January-November 1999, November 1998-July 1999, September–December 2001

55. Administration of medicines, community hospitals – programme for updating qualified staff, Portsmouth Healthcare NHS Trust, 13 March 1997

56. Memorandum re: seminar – osteoporosis and falls, 14 November 2001, clinical assistant teaching elderly medicine, Portsmouth Healthcare NHS Trust, 19 October 2001

57. Introduction to Gosport War Memorial Hospital for staff, Portsmouth Healthcare NHS Trust, undated

58. Competence record and development for qualified nurses 1998–2001, Sultan, Dryad and Daedalus wards

59. Fareham and Gosport induction programme, 9 November 2001, Portsmouth Healthcare NHS Trust, undated

60. Training and development in community hospitals workshops – practice development facilitators (Gosport War Memorial Hospital, St Christophers Hospital, Emsworth Victoria Cottage Hospital, Petersfield Community Hospital, Havant War Memorial Hospital), East Hampshire Primary Care Trust, undated

61. Occupational therapy service – continuous professional development and training, Fareham and Gosport locality, occupational therapy professional advisor, 23 November 2001

62. Analysis of complaints at Gosport War Memorial Hospital, workshop notes and action plans, February 2001

63. Fareham and Gosport Primary Care Groups: Proposal to establish a primary care trust for Fareham and Gosport, Isle of Wight, Portsmouth and South East Hampshire Health Authority, July 2001

64. March 2001 Final monitoring report intermediate care, Portsmouth Healthcare NHS Trust, May 2001

D) DOCUMENTS RELATING TO HAMPSHIRE CONSTABULARY INVESTIGATIONS

1. Police expert witness report, Professor B Livesley, MD, FRCP, 9 November 2000
2. Police expert witness report, Professor G Ford, MA, FRCP, 12 December 2001
3. Police expert witness report, Dr K Mundy, FRCP, 18 October 2001

E) OTHER DOCUMENTS RELATING TO GOSPORT WAR MEMORIAL HOSPITAL

1. A local procedure for the identification and support of primary care medical practitioners whose performance is giving cause for concern, Isle of Wight, Portsmouth and South East Hampshire Health Authority and local medical committee, undated
2. Clinical governance and clinical quality assurance, the baseline assessment framework, NHS Executive south east region, 1999
3. Clinical Governance, Audit 1998/1999 & Summary report, District Audit, December 1999

APPENDIX B

Views from patients and relatives/friends

METHODS OF OBTAINING VIEWS

i. The investigation sought to establish the views of people who had experience of services for older people at the Gosport War Memorial Hospital since 1998.

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

- meet with members of the investigation team
- fill in a short questionnaire
- write to the investigation team
- contact by telephone or email

iii. In November 2001, information was distributed about the CHI investigation at Gosport War Memorial Hospital to stakeholders, voluntary organisations and statutory stakeholders. This information included posters advertising stakeholder events, information leaflets about the investigation, questionnaires and general CHI information leaflets. Press releases were issued in local newspapers and radio stations. The Hampshire Constabulary agreed to forward CHI contact details to families who had previously expressed their concerns to them.

iv. The written information was distributed to a large group of potential stakeholders. In total 36 stakeholders and 59 voluntary organisations will have received the above information. These people included:

- Motor Neurone Disease Association, Alzheimer's Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- Portsmouth and South East Hampshire Community Health Council, Isle of Wight, Portsmouth and South East Hampshire Health Authority, local medical committee, members of parliament, nursing homes, Portsmouth social services and Fareham and Gosport primary care groups

STAKEHOLDER RESPONSES

i. CHI received the following responses from patients, relatives, carers, friends and voluntary organisations.

Letters	Questionnaires	Telephone interviews	*Stakeholder interviews
7	2	10	17

(*stakeholders were counted according to the number of attendees and not based on number of interviews)

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

Figure B.1 Concerns about care raised by stakeholders by ward and date

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

GWMH – Gosport War Memorial Hospital

ANALYSIS OF VIEWS RECEIVED

i. During the CHI investigation stakeholder views highlighted both positive and less positive experiences of patient care.

Positive experiences

ii. CHI received mine letters from stakeholders commenting on the satisfaction of the care that the patients received and highlighting the excellent level of care and kindness demonstrated by the staff. This was also supported by 400 letters of thanks and donations received by the Gosport War Memorial Hospital. The most frequently recurring positive comments from stakeholders were about staff attitude (five responses) and the environment (five responses). Other positive feedback was received about access to services, transfer, prescribing, end of life arrangements, communication and complaints.

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

Less positive experiences

iv. A number of less positive experiences of patients/friends and relatives were shared with CHI by stakeholders. The following table outlines the most frequently recurring negative comments that corresponded with CHI's terms of reference.

Figure B.2 Less positive views of patient and relative/friend experiences

View	Frequency of responses
Communication with relatives/carers/friends	14
Patient transfer	10
Nutrition and fluids	11
Prescription of medicines	9
Continence management, catheritisation	8
Staff attitude	8
End of life communication with:	
patients	4
relatives/carers/friends	6
Humanity of care ie access to buzzer, clothing	8

v. Patient transfer. Contacts commented on the state of the patient's health before and during the transfer. Other stakeholders mentioned the time that it took to transfer the patient and also highlighted the inappropriate method of transporting the patient.

vi. Nutrition and fluids. Stakeholders highlighted a lack of help in feeding patients. They commented on how dehydrated the patients appeared and the lack of positive communication between the relative/carer and the staff to overcome the relative/carer's concern about the level of nutrition and fluids.

vii. Humanity of care.

- incontinence management – stakeholders felt that there was limited help with patients that needed to use the toilet
- attitude of staff – stakeholders commented on staff attitude, mentioning the length of time it took for staff to respond. Other comments related to the basic lack of care for patients in their last few days
- provision of bells – stakeholders observed that the bells were often out of the patients reach
- management of clothing – stakeholders commented that the patients were never in their own clothes

viii. Arrangements for the prescription, administration, review and recording of medicines. The majority of concerns were around the prescribing of diamorphine. Others centred on those authorised to prescribe the medication to the patient and how this was communicated to the relatives/carer.

ix. Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations. Interviewees indicated a lack of staff contact with the relatives/carers about the condition of the patient and the patient's care plan. Other interviewees commented on how some of the staff were not approachable. One interviewee referred to the absence of lay terms to describe a patient's condition, making it difficult to understand the patient's status of health.

x. Arrangements to support patients and their relatives and carers towards the end of the patient's life. Stakeholders mainly thought that there was a lack of communication from the staff after their relative had died.

xi. Three of the contacts had made complaints to the trust through the NHS complaints procedure. All were dissatisfied about the trust response.

APPENDIX C

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

- Baldacchino, L, Health Care Support Worker
- Banks, Dr V, Lead Consultant
- Barker, D, Staff Nurse
- Barker, M, Enrolled Nurse
- Barrett, L, Staff Nurse
- Beed, P, Clinical Manager
- Brind, S, Occupational Therapist
- Cameron, F, General Manager
- Carroll, P, Occupational Therapist
- Clasby, J, Senior Nurse
- Crane, R, Senior Dietician
- Day, G, Senior Staff Nurse
- Douglas, T, Staff Nurse
- Dunleavy, J, Staff Nurse
- Dunleavy, S, Physiotherapist
- Goode, P, Health Care Support Worker
- Hair, Revd J, Chaplain
- Hallman, S, Senior Staff Nurse (until 11 September 2000)
- Hamblin, G, Senior Staff Nurse
- Haste, A, Clinical Manager
- Hooper, B, Project Director
- Humphrey, L, Quality Manager
- Hunt, D, Staff Nurse (until 6 January 2002)
- Jarrett, Dr D, Lead Consultant
- Joice, C, Staff Nurse (until 4 October 1999)
- Jones, J, Corporate Risk Advisor
- Jones, T, Ward Clerk
- King, P, Personnel Director
- King, S, Clinical Risk Advisor
- Landy, S, Senior Staff Nurse
- Langdale, H, Health Care Support Worker
- Law, D, Patient Affairs Manager

- Lee, D, Complaints Convenor & Non Executive Director
- Lock, J, Sister (retired 1999)
- Loney, M, Porter
- Lord, Dr A, Lead Consultant
- Mann, K, Senior Staff Nurse
- Melrose, B, Project Manager – Complaints
- Millett, M, Chief Executive (until 31 March 2002)
- Monk, A, Chairman
- Nelson, S, Staff Nurse
- Neville, J, Staff Nurse (until 1 January 2001)
- O'Dell, J, Practice Development Facilitator
- Parvin, J, Senior Personnel Manager
- Peach, J, Service Manager
- Peagram, L, Physiotherapy Assistant
- Pease, Y, Staff Nurse
- Phillips, C, Speech & Language Therapist
- Piper, I, Operational Director
- Qureshi, Dr L, Consultant
- Ravindrance, Dr A, Consultant
- Reid, Dr I, Medical Director
- Robinson, B, Deputy General Manager
- Scammel, T, Senior Nurse Coordinator
- Taylor, J, Senior Nurse
- Thomas, Dr E, Nursing Director
- Thorpe, M, Health Care Support Worker
- Tubbitt, A, Senior Staff Nurse
- Walker, F, Senior Staff Nurse
- Wells, P, District Nurse
- Wigfall, M, Enrolled Nurse
- Wilkins, P, Senior Staff Nurse
- Williams, J, Nurse Consultant
- Wilson, A, Senior Staff Nurse
- Wood, A, Finance Director
- Woods, L, Staff Nurse
- Yikona, Dr J, Staff Grade Physician

CHI is grateful to Caroline Harrington for scheduling interviews.

APPENDIX D

Meetings or telephone interviews with external agencies with an involvement in elderly care at Gosport War Memorial Hospital

- Portsmouth Hospitals NHS Trust

  Jill Angus, Clinical Discharge Coordinator

  Wendy Peckham, Discharge Planner for Medicine

  Clare Bownass, Ward Sister

  Sonia Baryschpolec, Staff Nurse

  Sam Page, Bed Manager, Royal Haslar Hospital

  Sally Clark, Patient Transport Manager

  Julie Sprack, Senior Nurse

  Jeff Watling, Chief Pharmacist

  Vanessa Lawrence, Pharmacist

- Hampshire Ambulance Service NHS Trust

  Alan Lyford, Patient Transport Service Manager

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

  Penny Humphris, Chief Executive

  Dr Peter Old, Director of Public Health

  Nicky Pendleton, Progamme Lead for Elderly Care Services

- NHS Executive south east regional office

  Dr Mike Gill, Regional Director of Public Health

  Dr David Percy, Director of Education and Training

  Harriet Boereboom, Performance Manager

- Portsmouth and South East Hampshire Community Health Council

  Joyce Knight, Chairman

  Christine Wilkes, Vice Chair

  Margaret Lovell, Chief Officer

- Hampshire Constabulary

  Detective Superintendent John James

- Portsmouth Social Services

  Sarah Mitchell, Assistant Director (Older People)

  Helen Loten, Commissioning and Development Manager

- Hampshire Social Services

  Tony Warns, Service Manager for Adults

- Alverstoke House Nursing and Residential Care Home

  Sister Rose Cook, Manager

- Glen Heathers Nursing and Residential Care Home

  John Perkins, Manager

Other

- League of Friends

  Mary Tyrell, Chair

  Geoff Rushton, Former Treasurer

- Motor Neurone Disease Association

  Mrs Fitzpatrick

- Members of Parliament

  Peter Viggers, MP for Gosport

  Sydney Rapson, MP for Portsmouth North

- Primary Care Groups

  John Kirtley, Chief Executive, Fareham and Gosport Primary Care Groups

  Dr Pennells, Chairperson, Gosport Primary Care Groups

- Portsmouth Local Medical Committee

  Dr Stephen McKenning, Chairman

- Gosport War Memorial Hospital medical committee

  Dr Warner, Chairman

- Local representative for the Royal College of Nursing

  Betty Woodland, Steward

  Steve Barnes, RCN Officer

- Local representative for Unison

  Patrick Carroll, Branch Chair

- Local general practitioners

  Dr J Barton, Knapman Practice

  Dr P Beasley, Knapman Practice

  Dr S Brook, Knapman Practice

APPENDIX E

Medical case note review team: terms of reference and membership

Terms of reference for the medical notes review group to support the CHI investigation at Gosport War Memorial Hospital

PURPOSE

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

(i) the prescription, administration, review and recording of drugs

(ii) the use and application of the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs

(iii) the quality of nursing care towards the end of life

(iv) the recorded cause of death

METHOD

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

MEMBERSHIP

- Dr Tony Luxton, Geriatrician
  Cambridge City PCT
  (CHI doctor team member and chair of the group)

- Maureen Morgan, Independent Management Consultant
  (CHI nurse member)

- Professor Gary Ford, Professor of Pharmacology of Old Age
  University of Newcastle and Freeman Hospital

- Dr Keith Munday, Consultant Geriatrician
  Frimley Park Hospital

- Annette Goulden, Deputy Director of Nursing
  NHS Trent regional office and formerly
  Department of Health Nursing Officer for elderly care

FINDINGS OF GROUP

The findings of the group will be shared with:

(i) the CHI Gosport investigation team

(ii) CHI's Nurse Director and Medical Director and other CHI staff as appropriate

(iii) the trust

(iv) relatives of the deceased (facilitated by the trust) if requested, on an individual basis

The final report of the group will be subject to the rules of disclosure applying to CHI investigation reports.

APPENDIX F

Report of the Gosport investigation medical notes review group

PURPOSE

CHI undertook a review of the anonymised medical notes of a random selection of 15 patients who had died between 1 August 2001 and 31 January 2002 on Daedalus, Dryad or Sultan wards at Gosport War Memorial Hospital.

CHI's intention for this piece of work was to determine whether the policies and systems put in place by the Portsmouth Healthcare NHS Trust since the events of 1998, to address prescribing practices are being implemented and are impacting on the quality of care patients are now receiving. CHI's review also considered the nursing notes for each patient and looked at the quality of nursing care as documented in the notes. Finally, the review considered whether the cause of death recorded in the notes was appropriate.

METHODOLOGY

The group received 15 sets of anonymised medical notes from the trust, which related to the last admission of 15 patients. Five patients were randomly selected from each of the following wards: Daedalus, Dryad and Sultan. A total of 49 patients had died whilst on these wards during the sample timeframe.

FINDINGS

(i) *Use of medicines*

Prescription

The group considered that the volume and combination of medicines used was appropriate for this group of patients and was in line with accepted good practice and British National Formulary guidelines. Single prescription, PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the trust's 'analgesic ladder' to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggest that patients had been prescribed large amounts of pain relief, such as diamorphine on admission where this was not necessary. Co-codamol had been prescribed in a number of cases as an initial analgesic, with progression to alternative medicines as and when more pain relief was needed. The use of the analgesic ladder was less evident in Sultan ward.

However, in two cases, the group saw evidence of unacceptable breakthrough pain, and six hourly rather than four hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of co-codamol and fentanyl, which was not thought by the group to be the most effective combination of medicines.

Administration

Syringe drivers had been used to deliver medication to six of the patients reviewed. Appropriate use of syringe drivers as a method of medicine administration was observed, with documented discussions with families before use.

Appropriate administration of medicines by nursing staff was evident. Prescriptions issued over the telephone by GPs on Sultan ward were appropriately completed in accordance with trust policy.

Review and recording of medicines

Evidence of consistent review of medication was seen, with evidence to suggest that patients and relatives were involved in helping to determine levels of pain. Nursing staff had appropriately administered medicines in line with medical staff prescriptions. Prescription sheets had been completed adequately on all three wards. Generally, record keeping around prescribing was clear and consistent, though this was not as clear on Sultan ward.

Based on the medical notes reviewed, the group agreed that the trust's policies on the assessment and management of pain, prescription writing and adminstration of IV drugs were being adhered to.

(ii) *Quality of nursing care towards the end of life*

The team found a consistently reasonable standard of care given to all patients they reviewed. The quality of nursing notes was generally adequate, although not always of consistent quality. There was some evidence to suggest a task oriented approach to care with an over emphasis on the completion of paperwork. This left an impression of a sometimes disjointed rather than integrated individual holistic assessment of the patient. The team saw some very good, detailed care plans and as well as a number of incidences where no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphagia had been delayed over a weekend because of the lack of availability of suitably trained nursing staff. Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, the trust's policies regarding fluid and nutrition were generally being adhered to. Though based on the nursing notes, a number of patients had only been weighed once, on admission.

There was evidence of therapy input, but this had not always been incorporated into care plans and did not always appear comprehensive. There was some concern that despite patients being assessed as at risk of pressure sores, it was not clear how this had been managed for some patients.

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. Do not attempt resuscitation decisions were clearly stated in the medical records.

Recorded cause of death

The group found no cause for concerns regarding any of the stated causes of death.

GENERAL COMMENTS

Admission criteria

The team considered that the admission criteria for Daedalus and Dryad wards was being adhered to. However there were examples of patients admitted to Sultan ward who were more dependent than the admission criteria stipulates. There is also an issue regarding patients who initially meet the admission criteria for Sultan ward who then develop complications and become more acutely sick.

Elderly medicine consultant input and access to specialist advice

Patients on Daedalus and Dryad wards received regular, documented review by consultant staff. There was clear evidence of specialist input, from mental health physicians, therapists and medical staff from the acute sector.

Out of hours cover

There was little evidence of out of hours input into the care of patients reviewed by CHI, though the team formed the view that this had been appropriate and would indicate that the general management of patients during regular hours was therefore of a good standard.

APPENDIX G

An explanation of the dissolution of services into the new primary care trusts

Figure G.1 Arrangements for hosting clinical services

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

(Source: *Local health, local decisions*, consultation document, September 2001, NHS Executive South East Regional Office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

APPENDIX H

Patient throughput data 1997/1998 – 2000/2001

Figure H.1 Throughput data 1997/1998 – 2000/2001

Financial year	Ward	Finished consultant episodes
1997/1998	Daedalus	97
1997/1998	Dryad	72
1997/1998	Sultan	287
	Total	456
1998/1999	Daedalus	121
1998/1999	Dryad	76
1998/1999	Sultan	306
	Total	503
1999/2000	Daedalus	110
1999/2000	Dryad	131
1999/2000	Sultan	402
	Total	643
2000/2001	Daedalus	113
2000/2001	Dryad	86
2000/2001	Sultan	380
	Total	579

(Source: 1997/1998 – trust ward based discharge data, 1998/1999, 1999/2000 and 2000/2001 – trust patient administration system (PAS) data).

APPENDIX I

Breakdown of medication in Dryad, Sultan and Daedalus wards at Gosport War Memorial Hospital

Figure I.1 Summary of medicine usage 1997/1998–2000/2001 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total			6	10	0	19
Diamorphine via syringe driver	Sultan	5mg	1	0	10	0	0
	Total			0	10	0	0
Diamorphine injection	Daedalus	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	67	36	24	35
	Total			128	127	107	74
Diamorphine via syringe driver	Dryad	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total			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			117	121	69	42
Diamorphine via syringe driver	Dryad	30mg	1	0	5	0	0
	Total			0	5	0	0
Diamorphine injection	Daedalus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total			34	51	3	33

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

(Source: Portsmouth Healthcare NHS Trust)

Dose: a single measured quantity of medicine

Pack: a collection of single doses, the packaging in which medicines are dispatched from the pharmacy

APPENDIX J

Glossary

accountability responsibility, in the sense of being called to account for something.

action plan an agreed plan of action and timetable that makes improvements to services.

acute care/ trust/hospital short term (as opposed to chronic, which means long term).
Acute care refers to medical and surgical treatment involving doctors and other medical staff in a hospital setting.
Acute hospital refers to a hospital that provides surgery, investigations, operations, serious and other treatments, usually in a hospital setting.

allied health professionals professionals regulated by the Council for Professions Supplementary to Medicine (new Health Professions Council). This includes professions working in health, social care, education, housing and other sectors. The professions are art therapists, music therapists and drama therapists, prosthetists and orthotists, dieticians, orthoptists, occupational therapists, physiotherapists, biomedical scientists, speech and language therapists, radiographers, chiropodists and podiatrists, ambulance workers and clinical scientists. Also called professionals allied to or supplementary to medicine.

analgesia medicines prescribed to reduce pain.

anticipatory prescribing to prescribe a drug or other remedy in advance.

antipsychotics A group of medicines used to treat psychosis (conditions such as schizophrenia) and sometimes used to calm agitation. Examples include haloperidol. Also called major tranquillisers or neuroleptics.

appraisal an assessment or estimate of the worth, value or quality of a person or service or thing.

Association of Chief Police Officers (ACPO) an association whose members hold the rank of Chief Constable, deputy Chief Constable or Assistant Chief Constable or their equivalents. They provide a professional opinion to the Government and appropriate organisations.

audit, clinical audit an examination of records to check their accuracy. Often used to describe an examination of financial accounts in a business.
In clinical audit those involved in providing services assess the quality of care. Results of a process or intervention are assessed, compared with a preexisting standard, changed where necessary, and then reassessed.

Barthel score a validated tool used to measure physical disability.

benzodiazepines a diverse group of medicines used for a range of purposes. Some reduce anxiety, others are used as sleeping tablets. Some, such as *midazolam*, act as strong sedatives and can be accompanied by memory loss whilst the medicine is active.

British National Formulary publication that provides information on the selection and use of medicines for healthcare professionals.

carers people who look after their relatives and friends on an unpaid, voluntary basis often in place of paid care workers.

casemix the variety and range of different types of patients treated by a given health professional or team.

catheter a hollow tube passed into the bladder to remove urine.

catheterisation use of a catheter.

CHI see Commission for Health Improvement.

clinical any treatment provided by a healthcare professional. This will include, doctors, nurses, AHPs etc. Non clinical relates to management, administration, catering, portering etc.

clinical assistant usually GPs, employed and paid by a trust, largely on a part time basis, to provide medical support on hospital wards and other departments.

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

clinical governance review a review of the policies, systems and processes used by an organisation to deliver high quality health care to patients. The review looks at the way these policies work in practice (a health check for a health organisation).

clinical oncologist a doctor who specialises in the treatment of cancer patients, particularly through the use of radiotherapy, but who may also use chemotherapy.

clinical risk management understanding the various levels of risk attached to each form of treatment and systematically taking steps to ensure that the risks are minimised.

clinician/clinical staff a fully trained health professional – doctor, nurse, therapist, technician etc.

clinical negligence scheme for trusts (CNST) an 'insurance' scheme for assessing a trust's arrangements to minimise clinical risk which can offset costs of insurance against claims of negligence. Successfully gaining CNST 'standards' (to level one, two, three) reduces the premium that the trust must pay.

Commission for Health Improvement (CHI) independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.

co-codamol a medicine consisting of paracetamol and codeine phosphate, used for the relief of mild to moderate pain.

community care health and social care provided by health care professionals, usually outside hospital and often in the patient's own homes.

community health council (CHC) a statutory body sometimes referred to as the patients' friend. CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.

consultant a fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care. (For training posts in medicine see specialist registrar, senior house officer and preregistration house officer.)

continence management The practice of promoting or sustaning the ability to control urination and defecation.

continuing care a long period of treatment for patients whose recovery will be limited.

defibrillator a piece of equipment which sends an electric current through the heart to restore the heart beat.

diamorphine A medicine used to relieve severe pain.

do not attempt resuscitation (DNAR) or do not resuscitate (DNR) an instruction, which says that if a patient's health suddenly deteriorates to near death, no special measures will be taken to revive their heart. This instruction should be agreed between the patient and doctor or if a patient is not conscious, then with their closest relative.

dysphagia difficulty swallowing.

fentanyl a medicine prescribed to patients who require control of existing pain.

finished consultant episode (FCE) a period of continuous consultant treatment under a specific consultant. If a patient is transferred from one consultant to another it will be counted as two FCEs.

formulary a list of preferred medicinal drugs which are routinely available in a hospital or GP surgery.

General Medical Council (GMC) the professional body for medical doctors which licenses them to practice.

general practitioner (GP) a family doctor, usually patients' first point of contact with the health service.

geriatrician a doctor who specialises in diagnosis and treatment of diseases affecting older people.

haloperidol see antipsychotics.

health authority (HA) statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities.

health community or health economy all organisations with an interest in health in one area including the community health councils, and voluntary and statutory organisations.

Health Service Ombudsman investigates complaints about failures in NHS hospitals or community health services, about care and treatment, and about local NHS family doctor, dental, pharmacy or optical services. Anyone may refer a complaint but normally only if a full investigation through the NHS complaints system has been carried out first.

holistic a method of medical care in which patients are treated as a whole and which takes into account their physical and mental state as well as social background rather than just treating the disease alone.

hyocine a medicine to relieve nausea and sickness.

Improving Working Lives a Department of Health initiative launched in 1999. It includes standards for developing modern employment services, putting in place work/life balance schemes and involving and developing staff.

incident reporting system a system which requires clinical staff to report all matters relating to patient care where there has been a special problem.

independent review stage two of the formal NHS complaints procedure, it consists of a panel, usually three members, who look at the issues surrounding a complaint.

intermediate care a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.

intranet an organisation's own internal internet which is usually private.

investigation – by CHI an in depth examination of an organisation where a serious problem has been identified.

Investors in People a national quality standard which sets a level of good practice for improving an organisation's performance through its people.

lay member a person from outside the NHS who brings an independent voice to CHI's work.

local medical committee (LMC) a group of local GPs, elected by the entire local GP population who meet with the health authority to help plan resources and inform decisions.

locum a temporary practitioner who stands in for the permanent one.

medical the branches of medicine concerned with treatment through careful use of medicines as opposed to (surgical) operations.

medical director the term usually used for a doctor at trust board level (a statutory post) responsible for all issues relating to doctors and medical and surgical issues throughout the trust.

midazolam see benzodiazepines.

multidisciplinary from different professional backgrounds within healthcare (e.g. nurse, consultant, physiotherapist) concerned with the treatment and care of patients.

multidisciplinary meetings meetings involving people from different professional backgrounds.

multiprofessional from different professional backgrounds, within and outside of healthcare (e.g. nurse, consultant, social worker) concerned with the care or welfare of people.

National Service Framework (NSF) guidelines for the health service from the Department of Health on how to manage and treat specific conditions, or specific groups of patients e.g. Coronary Heart Disease, Mental Health, NSF for older people. Their implementation across the NHS is monitored by CHI.

neuroleptic see antipsychotics.

neurology a branch of medicine concerned with medical treatment of disorders of the nervous system.

NHS regional office

NHS trust a self governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.

Nursing and Midwifery Council The Nursing Midwifery Council (NMC) is an organisation set up by Parliament to ensure nurses, midwives and health visitors provide appropriate standards of care to their patients and clients. All qualified nurses, midwives and health visitors are required to be members of the NMC in order to practice.

nursing director the term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing throughout the trust.

occupational therapist a trained professional (an allied health professional) who works with patients to assess and develop daily living skills and social skills.

ombudsman see national health service ombudsman above.

opiates a group of medicines containing or derived from opium, that act to relieve severe pain or induce sleep.

opioid a description applied to medicines that cause similar effects in the body to opiates.

outpatient services provided for patients who do not stay overnight in hospital.

pain management a particular type of treatment that concentrates on managing a patient's pain – rather than seeking to cure their underlying condition – and complements their treatment plan.

palliative a term applied to the treatment of incurable diseases, in which the aim is to mitigate the sufferings of the patient, not to effect a cure.

palliative care care for people with chronic or life threatening conditions from which they will not recover. It concentrates on symptom control and family support to help people have as much independence and quality of life as is possible.

patient administration system (PAS) a networked information system used in NHS trusts to record information and inpatient and outpatient activity.

patient advice and liaison service (PALS) a new service proposed in the July 2000 NHS plan due to be in place by 2002, that will offer patients an avenue to seek advice or complain about their hospital care.

patient centred care a system of care or treatment is organised around the needs of the patient.

patient involvement the amount of participation that a patient (or patients) can have in their care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

primary care family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

PCG Organisations now almost completely replaced by primary care trusts. Set up in 1997, PCGs were new organisations (technically Health Authority committees) that brought together all primary care practices in a particular area. PCGs were led by primary care professionals but with lay and social services representation. PCGs were expected to develop local primary health care services and work to improve the health of their populations. Some PCGs additionally took responsibility for commissioning secondary care services.

PCT Organisations that bring together all primary care practices in an area. PCTs are diverse and complex organisations. Unlike PCGs, which came before them, they are independent NHS bodies with greater responsibilities and

powers. They were set up in response to the Department of Health's *Shifting the Balance of Power* and took over many health authority functions. PCTs are responsible for

- improving the health of their population
- integrating and developing primary care services
- directly providing community health services
- commissioning secondary care services

PCTs are increasingly working with other PCTs, local government partners, the voluntary sector, within clinical networks and with 'shared service organisations' in order to fulfil their roles.

level four PCT brings together commissioning of secondary care services and primary care development with the provision of community health services. They are able to commission and provide services, run community health services, employ the necessary staff, and own property.

PRN (Pro re nata) prescribing medication as and when required.

protocol a policy or strategy which defines appropriate action.

psychiatrist a doctor who specialises in the diagnosis and treatment of mental health problems.

regional office see NHS regional office above.

rehabilitation the treatment of residual illness or disability which includes a whole range of exercise and therapies with the aim of increasing a patient's independence.

resuscitation a range of procedures used when someone has suddenly become seriously ill in a way that threatens their life.

risk assessment an examination of the risks associated with a particular service or procedure.

risk management understanding the various risks involved and systematically taking steps to ensure that the risks are minimized.

Royal College of Nursing (RCN) the world's largest professional union of nurses. Run by nurses, it campaigns on the part of the profession, provides higher education and promotes research, quality and practice development through the RCN institute.

sensory disabilities people who have problems hearing, seeing, smelling or with touch.

specialist a clinician most able to progress a patient's diagnosis and treatment or to refer a patient when appropriate.

speech and language therapist professionally trained person who assists, diagnoses and treats the whole spectrum of acquired or developmental communication disorders.

staff grade a full qualified doctor who is neither a General Practitioner nor a consultant.

staff grade doctors doctors who have completed their training but do not have the qualifications to enable them to progress to consultant level. Also called trust grade doctors.

stakeholders 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.

statutory/statute refers to legislation passed by Parliament.

strategic health authority organisations that will replace health authorities and some functions of Department of Health regional offices in 2002. Unlike current health authorities, they will not be involved in commissioning services from the NHS. Instead they will performance manage PCTs and NHS trusts and lead strategic developments in the NHS. Full details of the planned changes are in the Department of Health document, Shifting the Balance of Power, July 2001.

strategy a long term plan for success.

subcutaneous beneath the skin.

swallowing assessments the technique to access the ability of the patient to swallow safely.

syringe driver a device to ensure that a syringe releases medicine over a defined length of time into the body.

terminal care care given in the last weeks of life.

terms of reference the rules by which a committee or group does its work.

trust board a group of about 12 people who are responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and directors.

Unison Britain's biggest trade union. Members are people working in the public services.

United Kingdom Central Council (UKCC) on 1 April 2002 the UKCC ceased to exist. Its successor body is The Nursing and Midwifery Council (NMC). Its purpose was to protect the public through establishing and monitoring professional standards.

ward round A regular review of each patient conducted by a consultant, often accompanied by nursing, pharmacy and therapy staff.

Wessex palliative care guidelines local guidance to help GPs, community nurses and hospital staff as well as specialist palliative care teams. It provides a checklist for management of common problems in palliative care, with some information on medical treatment. It is not a comprehensive textbook.

whistle blowing the act of informing a designated person in an organisation that patients are at risk (in the eyes of the person blowing the whistle). This also includes systems and processes that indirectly affect patient care.

whistle blowing policy a plan of action for a person to inform on someone or to put a stop to something.

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