NHS

Fareham and Gosport
Clinical Commissioning Group

GWMH: additional commissioner assurance questions

(Based on Wessex Area Team feedback and Baker report)

No.	Question for additional assurance	SHFT Response
1.	Are there explicit policies on the use of opiate medication? Please list the titles of these and indicate when they were ratified/are due for review.	The Southern Health NHS Foundation Trust (SHFT) Clinical Policy (CP 99) Guidance on the Safe Prescribing and Administration of Opioid Doses for Pain, Palliative Care or Substance Misuse was ratified October 2010 and is due for review December 2013. In addition to this SHFT policy the Countess Mountbatten House Palliative care handbook 'Green book' (7th Edition) has been endorsed by the medicines management committee and is available on the ward or via the medicines management website http://www.southernhealth.nhs.uk/knowledge/medicines-management/useful-links/. This is a joint publication developed with CMPC and The Rowans and is available for use in each ward. The prescribing of opiates in palliative care also follows National NICE guidance CG140 Opioids in palliative care available at http://guidance.nice.org.uk/CG140/NICEGuidance/pdf/English and a step wise approach is taken which is based on the World Health Organisation (WHO) analgesic ladder http://www.who.int/cancer/palliative/painladder/en/ Medicines management training is classified as essential training for all Registered Nurses and each RN has a formal assessment of a drug round to assess their competency in practice.
2.	Do the policies for opiates include guidance on the assessment of patients who deteriorate and the indications for commencing opiates in accordance with national guidance?	Nursing assessment of deteriorating patients is covered by the Trust 'Track and Trigger' tool. Palliative care prescribing advice is accessed by contacting The Rowans Hospice, our local specialist palliative care team. Consultant and nurse specialists will visit the ward or give advice over the phone. The Countess Mountbatten House Palliative care handbook 'Green book' (7th Edition) is also available on the ward and online via the SHFT medicines management website. The prescribing of opiates in palliative care also follows National NICE guidance CG140 Opioids in palliative care available at

		http://guidance.nice.org.uk/CG140/NICEGuidance/pdf/English and a step wise approach is also based on the WHO analgesic ladder http://www.who.int/cancer/palliative/painladder/en/ The SHFT Clinical Policy (CP 112) Acute Pain Guidelines and current British National Formulary (BNF) guidance are followed for non-palliative care patients requiring analgesia.
3.	Can the trust provide assurance that the policies are being adhered to especially in relation to prescriptions, administration/review and recording of medicines – please provide details of audit processes	SHFT Clinical Policy (CP 1) Medicines Control and Prescribing Policy (MCAPP) is an overarching policy defining the policies and procedures to be followed for the prescribing, administering, supplying, dispensing, storing and recording of medicines. Adherence to the MCAPP policy was last audited prior the inclusion of integrated community services (ICS) within the Trust. Assurance of adherence to all SHFT policies (including MCAPP) is provided by regular prescription monitoring. The SHFT pharmacist provides a twice weekly clinical ward visit where all in-patient prescription charts are reviewed. The SHFT pharmacist will challenge prescriber's on dosing increments in discussion with nursing team, when necessary, to ensure patient safety and recommend dose reductions where side effects are identified or pain intensity reduced. The SHFT pharmacist will also identify and challenge the in-appropriate or un-explained initiation of medication on admission through the medicines reconciliation process and on each prescription chart review. The SHFT medicines management intervention audit is undertaken annually. This was last undertaken in January 2013. The objective of the audit being to evaluate the extent to which prescribing issues would potentially harm patients' health or mitigate the effectiveness of treatment and the extent to which SHFT medicines management team interventions are medically beneficial. Correct documentation of drug administration is continually monitored by the SHFT pharmacist during the twice weekly clinical visits to the ward. Data is also collected during the annual SHFT omissions audit. The last omissions audit was completed in September 2012 and a local action plan was developed, agreed and is regularly reviewed. Data collection for 2013 omissions audit has been completed and the report will be available in due course. Spot checks are also undertaken as part of the Modern Matron walk around and nursing teams check for omissions and 'blanks' on the drug charts at each nursing hand over. We also undertake and monitor Matrons Walkround tool to review omissions, and 1/4rly CD audits

4.	Prescribing practice – can the trust assure commissioners that there is a robust process for escalation of any notable increase in the prescribing of opiates? i.e. are there checking mechanisms/triggers in place that would highlight high levels of prescribing opiates	A notable increase in the prescribing of opiates would be identified during the twice weekly medicines management visits to the ward, where each in-patient prescription is clinically screened by the pharmacist. Any query regarding prescriptions would be raised to the resident FY2 (who has been in post since Sept 12) or the Consultants at their ward rounds. An increase in opiate prescribing, ordering and administration would also be identifiable via the 3 monthly controlled drug audits. Trends would also be identified by incident reporting, the clinical pharmacist receives an electronic summary of every medicine related incident reported by the ward. All controlled drug incidents are included in the SHFT controlled drug Accountable Officers report. IN addition to this, if there is concern about a patients pain control being effective, the unit has a professional line to HDOCs out of hours.
5.	Can commissioners be assured that the practice of prescribing opiates (before they are needed/on admission) is now obsolete practice and would not happen on any occasion?	The inappropriate prescribing of opiates before they are needed/on admission does not occur. Assurance can be provided by the twice weekly pharmacist clinical ward visits to review every in-patient prescription. The inappropriate prescribing of opiates would also be picked up by the medicines reconciliation process undertaken for each patient admission. The provision of a clinical pharmacy service to the ward was developed in response to the CHI report to ensure continued prescribing monitoring to include and ensure the appropriate and safe prescribing of opiates.
6.	What supervision, performance monitoring and appraisal policies and processes currently exist for medical, nursing and other staff?	SHFT clinical staff is given annual development appraisals where their clinical and leadership skills are benchmarked against core themes (releasing ambition, value through innovation, forging relationships, training). Where there are developmental needs, a plan of action will be implemented and regularly reviewed. Staff performance is monitored via regular performance reviews using standards identified within the trust Managing performance (capability) policy Medications Management is an essential training competency. To support performance, the following are in place:- • Appraisal process and supportive resources accessible via the dedicated 'Appraisal' staff intranet page. • Appraisal training – for managers • Medical Appraisal for Revalidation – process and resources accessible via the dedicated 'Medical Appraisal for Revalidation' staff intranet page. • Formal 'Appraisal Policy' which aligns with the new appraisal system and the medical 'Appraisal for Revalidation Policy' are pending final approval.

		• Managing Performance (Capability) Policy, Procedure & Toolkit – to help manage concerns with performance both formally and informally. • Clinical Supervision Policy
7.	Can the trust provide evidence from recent audit of good record keeping around the assessment of patients before prescribing opiates for example: • The reason for starting opiate medication, e.g. why is morphine selected rather than an non-opiate analgesic • Detailed assessment of the reasons for the patient's pain	The Trust wide audit action plan and the medicines management team action plan does not include a specific audit covering the reason for starting opiate medication or the assessment of patient's pain. Any decision to start opiates is made by senior doctor Dr J Walker or Professor Severs (Portsmouth Hospitals Trust) or the local palliative care consultant and documented in the patient notes.
8.	Can the trust give an update on how it monitors patient clinical outcomes i.e. mortality rates	Mortality rates are recognised within the framework of the community hospitals dashboard, and are monitored at Trust and Divisional level. Unexpected deaths are reviewed immediately requiring senior clinicians to complete IMA reporting as a baseline for consideration of further in-depth investigation. Patient harms are monitored monthly using a recognised national thematic tool – known as patient safety thermometer. The Division is commencing a new monthly Quality meeting in November 13, chaired by the Head of Professions, where patient safety, patient experience and clinical effectiveness outcomes will be monitored and actions and impact of actions will be reviewed, challenged and transformation plans will be developed.
9.	Can the trust provide information about the frequency and content of MDT meetings, where the management of individual patients is discussed & documented?	Inpatient settings have regular weekly MDT meeting. This is led by the ward medics with influential background information coming from the clinical nursing staff. In attendance at MDT will be designated AHP and social services. Predicted date of discharge is established to promote timely discharge The wards also have twice weekly Consultant ward rounds and daily resident FY2 ward rounds where MDT discussions take place with the patient to determine the most appropriate plans of care.
10.	What current or recent evidence can the trust provide with regard to the culture of the ward e.g. safety culture; can staff raise concerns, how is that managed?	Staff are encouraged to raise concerns using safeguard system, through supervision and also using HR for advice.

11.	Can the trust confirm there is an up to date whistleblowing policy in place which has been disseminated to all community hospital staff. What evidence is there that staff feel confident to raise concerns? Have there been any whistleblowing incidents in the last year?	The Whistleblowing Policy and Procedure has been disseminated as follows:- -Poster campaign (July 2013) – disseminated to directorates and Trust sites by the Communication team. -Dedicated 'whistleblowing' staff intranet page set up July 2013. -Regular articles in the weekly staff bulletin. The current support arrangements for staff – -Staff can access a senior manager of their choice, Trade Union representative, HR Advisor, Director or Non-Executive Director. -The 'contacted officer' will support the member of staff who raises a concern, and the Trust' designated officer' will oversee the management action. -Independent support and advice is available from a free Employment Assistance Programme – Workplace Options. The Staff Survey results from 2012 showed that 95% of staff would know how to report any concerns they may have about fraud, malpractice or wrongdoing; with 74% stating they would feel safe in raising their concern; and 59% saying they would feel confident that the organisation would address their concern. A baseline survey (10-item) was also then carried out in July/Aug 2013, to find out how confident staff feel about raising a concern. The Trust is acting on the survey results to help staff be more confident when raising a concern. There have been two whistleblowing incidents in the last year; this is comparable to other Trusts. However concerns are likely to be raised via other routes or reasons rather than a 'whistleblowing issue'. To address consistency in recording and managing whistleblowing concerns, the Trust is looking to implement a 'staff concerns service' through PALs which will enable concerns to be tracked through the 'Ulysses' computerised system. It is considered this will further enhance the current arrangements we have in place.
12.	What is the current process for raising complaints and managing family concerns?	Current process – Ward staff always attempt to resolve concerns at a local level whenever possible. Senior staff are available to discuss issues with patients and relatives. Patient or family are encouraged to make contact with SHFT PALS service. Clinical staff is happy to make the initial contact with PALS so that they can bridge

		the initial communication with the family. Once the complaint have been identified then there is a period of 30 days for the complaint to be investigated by the service lead with drafted responses going to the divisional director for sign off. Once a response to the complaint has been agreed then there will be an action plan developed by the investigating officer which consider all of the outcomes of learning out of the concerns raised.
13.	What processes are in place to monitor working time directives i.e. making sure doctors are not working beyond their contracted hours especially where they have a second contract?	PHT undertake diary card exercises for each grade of medical staff. Results are reviewed by the Divisional Management team and the Medical Workforce Lead. The Deanery are involved in the review of any borderline breeches. Senior Medical staff are monitored for WTD compliance in line with other staff groups under Trust policy. Individuals have the right to opt out of the 48 hour limit and this is formally recorded. This would apply if they have more than one job then they would inform their clinical manager, if the cumulative hours add up to more than 48 hours per week and for completing an opt-out agreement if appropriate. For Doctors in training, the trust has to ensure all doctors are working within the European Working Time Directive (EWTD) and New Deal (ND) guidelines. To ensure compliance with this, the Trust monitors the hours worked and the rest taken (or adequate compensatory rest is provided) by all Junior Doctors. This is a contractual requirement for Junior Doctors to monitor their hours of work and this is undertaken twice a year for a period of at least two weeks. The monitoring period is agreed between the trust and a trainee representative. All working patterns are under continual review to ensure that this is maintained. There is a Doctors' in Training Working Group (chaired by Director of Education, attended by Locality Clinical Tutors, Trainee Representatives and Medical HR) which meets every two months, which looks at the monitoring results and any issues identified from it. Summaries of the monitoring are also distributed to Clinical Directors and Clinical Service Directors.
14.	Is there an End of life pathway in place? Is it adhered	Sultan ward have been using the LCP for over 6-7 years, the staff are very

	to? What has been decided in terms of the use of the Liverpool care pathway and	experienced about the principles of the LCP and it recognisable in the planning and implementation of EOL care provided to patients on the ward. Syringe drivers are used effectively to manage symptoms
15.	Is there a routine process for auditing of death certificates? (To ensure investigation takes place following high numbers of deaths)	
16.	Are CD registers completed correctly? What evidence can the trust provide commissioners on recent audits of controlled drug practice at GWMH?	A quarterly controlled drug standards audit is undertaken. All lapses in standards are recorded in the Trust wide controlled drug report. The local SHFT pharmacist follows up any failed CD standards directly with the team and helps develop and review action plans to improve practice. Weekly ard checks are in place and adhered to.