INVESTIGATION AT GOSPORT WAR MEMORIAL HOSPITAL

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 a number of 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 their concerns with CHI. This has contributed to the recommendations CHI has been able to make, both locally and nationally 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 did not identify high levels of prescribing on wards caring for older people.

The absence of adequate trust supervision and appraisal systems meant that poor prescribing practice was not identified.

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 purpose of each of the wards caring for older people and about the aims of the care provided. This confusion had been communicated to patients and relatives, some of whom had 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 and lack of review of medicines prescribed to older people on Dryad and Deadalus wards in 1998. This is based on the findings of police expert witnesses and pharmacy data provided for the wards. A protocol existed in 1998 for palliative care prescribing the "Wessex guidelines", this was inappropriately applied to patients admitted for rehabilitation.

- The data provided by Portsmouth Healthcare NHS Trust shows an increase in the amount of diamorphine, haloperidol and midazolam used on Daedalus ward in 1998. 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 detected and prevented.

- 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 Deadalus 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 Deadalus, 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 an review of prescribing practices. The trust should have responded earlier and faster 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.

Communication (Chapter 8)

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

RECOMMENDATIONS

It is evident from a number of local recommendations, that close and effective working relationships between the Fareham and Gosport PCT and the East Hampshire PCT will be essential in order to implement these recommendations. CHI is aware of the high level of existing interdependence which already exists between these two organisations and hopes that this will continue.

Fareham & 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 to ensure that any quality of care and performance shortfalls are identified and addressed swiftly is in place.

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

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

4. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Deadalus 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. 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 are trained in the prescription, administration, review and recording of medicines

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 compliment 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. The provision of out of hours medical cover to Deadlus, 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.

12. The PCTs responsible for the provision of care of older people should continue to work with colleagues to ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

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

14. That Fareham and Gosport PCT and East Hampshire PCT 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.

15. That both PCTs involved in the provision of care for older people, 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.

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

17. 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.

Hampshire and Isle of Wight Strategic Health Authority

18. The findings of this investigation should be used to influence the nature of local monitoring of the national service framework for older people by the Hampshire and Isle of Wight strategic health authority.

Department of Health

19. National guidelines for employing trusts, for GPs working as clinical assistants and for GPs admitting patients to GP led wards should be developed ??.

20. GPs working with older people in community hospital settings must have an adequate knowledge base of the medical needs of older people and the particular of prescribing for older people

21. That CHI work with the Association of Chief Police Officers and Investigations and Inquiries Unit of the Department of Health to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible. CHI will also work with the

Association of Chief Police Officers to develop police awareness of the NHS and its management and accountability structures.

Commission for Health Improvement

22. That CHI ensures that any organisation demonstrating trends of serious concern arising from the prescription of any medicines, be referred immediately to the National Patients' Safety Agency.

CHAPTER 1 TERMS OF REFERENCE AND PROCESS OF THE INVESTIGATION~~N~~

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 a~~n~~ 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 that the terms of reference would deliver a comprehensive report 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.

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, Lifespan Healthcare NHS Trust
- Julie Miller, CHI Lead Investigations Manager
- Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
- Mary Parkinson, lay member (Age Concern)
- Jennifer Wenborne, 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
- Kellie-Ann Rehill, CHI Investigations Coordinator
- a medical notes review group established by CHI to review anonymised medical notes (see appendix ?)
- Dr Barry Tennison, CHI Public Health Advisor

THE INVESTIGATION PROCESS

1.7 The investigation consisted of five inter related parts:

- review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (see appendix ? 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 ? 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 relevant trust management were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards (see appendix ? for a list of all staff interviewed)

- interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (see appendix ? for a list of organisations interviewed)

- an independent review of 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 specific piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendix ?. CHI shared the summary with the Fareham & Gosport PCT in May 2002.

ACKNOWLEDGEMENTS

1.8 CHI wishes to thank the following people for their help and cooperation with the production of this report:

- the patients and relatives who contributed either in person, over the phone or in writing. CHI recognises how difficult some of these contacts were for the relatives of those who have died
- staff interviewed by CHIs investigation team (see appendix D) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millet, Chief Executive (until 31.3.02) and Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust (since 1.4.02)
- 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

CHAPTER 2 BACKGROUND TO THE INVESTIGATION

EVENTS SURROUNDING THE CHI INVESTIGATION

POLICE INVESTIGATIONS

2.1 A relative of a 91 year old female patient who died in August 1998 on Daedalus ward made a complaint to the trust about her care and treatment. A daughter of the patient contacted the police in September 1998 alleging that her mother had been unlawfully killed. A range of issues were identified by the police in support of the allegation. Following an investigation, 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 This police investigation was the subject of a complaint to the police regarding its thoroughness. A further police investigation was started in August 1999. Subsequently, in December 2000, further information was submitted to the Crown Prosecution Service concerning the circumstances of the patient's death. 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 eleven 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 November and December 2001 and these 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 trust were made aware of potential issues around diamorphine usage by the police in December 1998.

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

2.6 There have been ten complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and November 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 initial complaint was not pursued through the NHS complaints procedure.

ACTION TAKEN BY HEALTH AUTHORITY

2.6 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.

2.7 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.

2.8 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. CHI then began a screening process to determine whether to initiate an investigation.

2.9 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 NHS SOUTH EAST REGIONAL OFFICE

2.10 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 regarding concerns around prescribing levels at the Gosport War Memorial Hospital. Information included a report by the Health Service Ombudsman and serious untoward incident reports completed by the NHS south east region 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.

CHAPTER 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 patient's 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 benchmarks for assessing nursing practice against fundamental aspects of care such as nutrition, 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 was 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 PCTs to host provider services on a district wide basis but each PCT retains responsibility for commissioning its share of district wides 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. Further detail of PCT hosting arrangements can be found at appendix ?

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 elderly medicine.

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.

The Department of Medicine for Elderly People has now transferred to East Hampsire PCT. The nursing staff of Dryad, Daedalus and Sultan wards are now employed by the Fareham and Gosport PCT.

General acute services were, and remain, based at Queen Alexandra and St Mary's Hospitals, part of the Portsmouth Hospitals Trust, the local acute trust. Though an unusual arrangement, a precedent for this model of care existed, for example in Southampton Community NHS Trust. Management of all services for older people has now transferred to the East Hampshire PCT.

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

3.10 Divisional management at Portsmouth Healthcare NHS Trust was well defined, with clear systems for reporting and monitoring. The quarterly divisional review was the principle 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

3.11 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 community rehabilitation and post acute beds.

3.12 In 1998 four 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 as in 1998, except that 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. 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 strokes and other conditions.

3.14 There was, and still is, a comprehensive list of admission criteria for Sultan ward that were 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.

KEY FINDINGS

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. CHI found the divisional management quarterly review process to have been an appropriate method of monitoring the performance of the Fareham and Gosport division.

3. 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 which may have compormised patient care.

4. There was lack of clarity amongst all groups of staff and stakeholders about the purpose of each of the wards caring for older people and about the aims of the care provided. This confusion had been communicated to patients and relatives, some of whom had expectations of rehabilitation which 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 to ensure that any quality of care and performance shortfalls are identified and addressed swiftly is in place.

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

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

CHAPTER 4 ARRANGEMENTS FOR THE PRESCRIPTION, ADMINISTRATION, REVIEW AND RECORDING OF MEDICINES

POLICE INQUIRY AND EXPERT WITNESS REPORTS

CHIs 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.

The police expert witnesses reviewed the care of five individual 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 drugs, 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 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 of any 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
- 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

MEDICINE USAGE

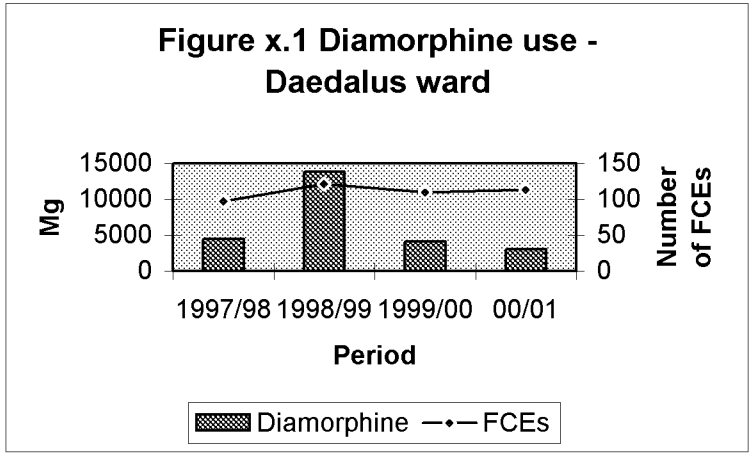
In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines issued from the pharmacy and does not

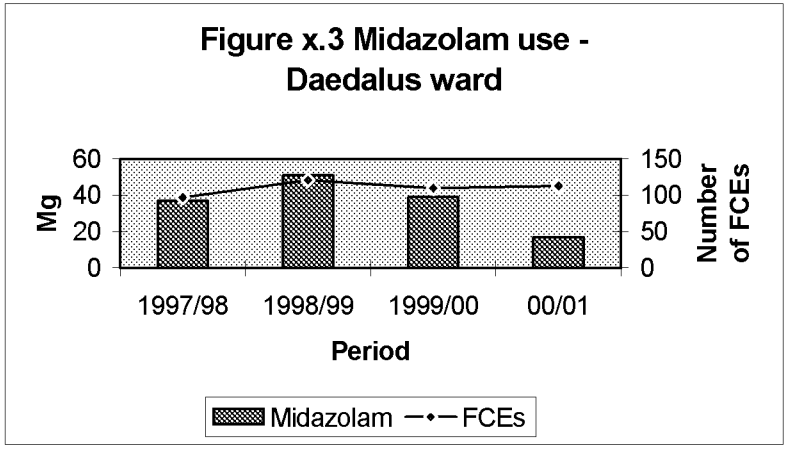
include any wastage, nor can it prove the amounts of medicines actually administered. As the data does not offer any breakdown of casemix, it is not possible to determine how complex the needs of patients were in each year. A detailed breakdown of medicines for each ward is attached at appendix H.

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

(Ali – these need to be set out 3 per ward)

Medicine issued 1997/1998-2000/2001 according to the number of finished consultant episodes per ward





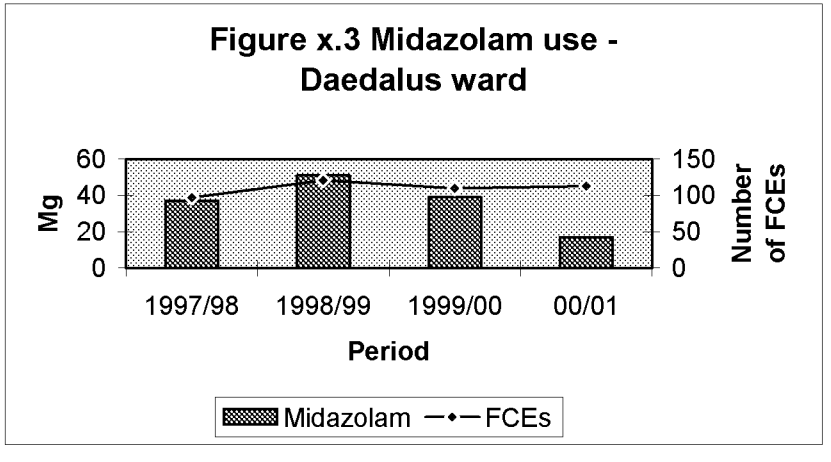


Figure x.4 Diapmorphine use - Dryad ward

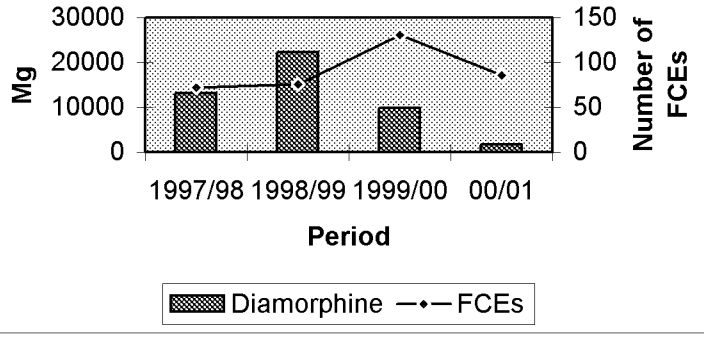


Figure x.5 Haloperidol use - Dryad Ward

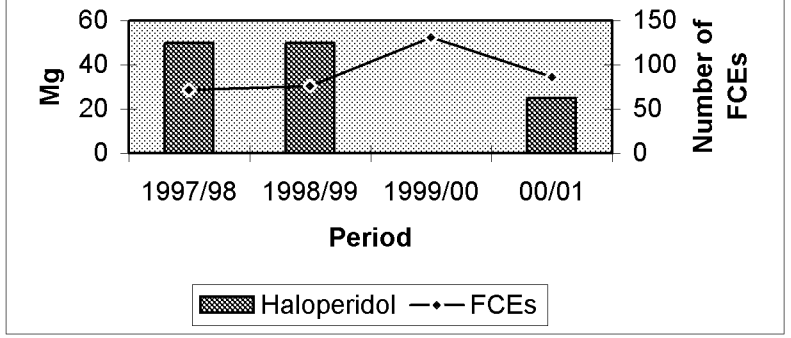
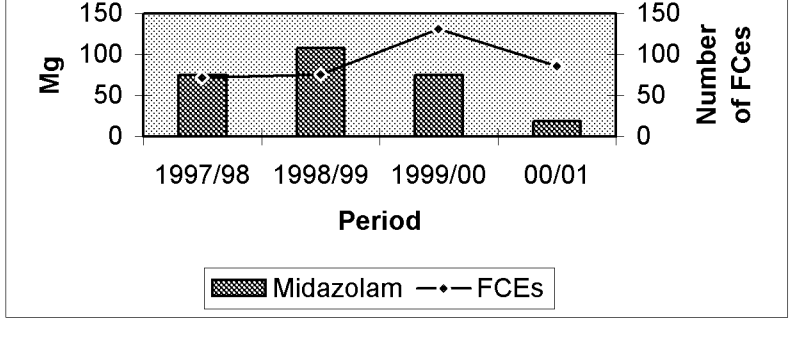


Figure x.6 Midazolam use - Dryad ward



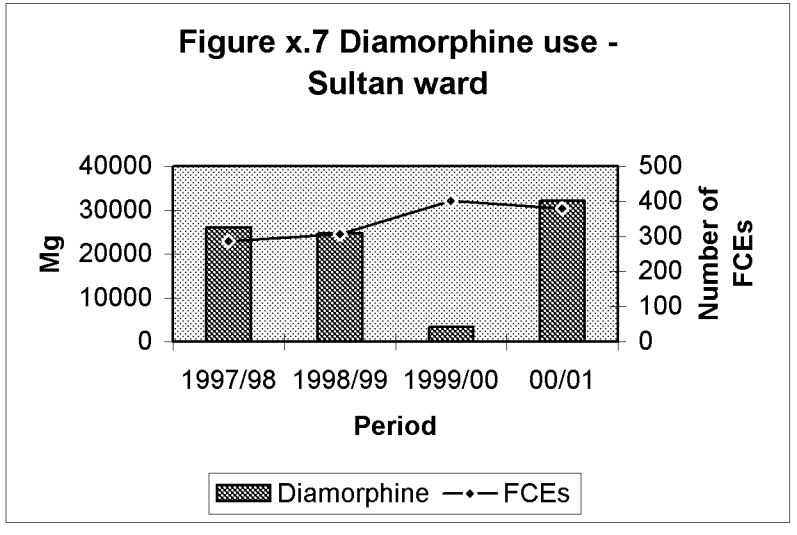


Figure x.7 Diamorphine use - Sultan ward
40000
30000
20000
10000
0
Mg
500
400
300
200
100
0
Number of FCEs
1997/98
1998/99
1999/00
00/01
Period
Diamorphine
FCEs

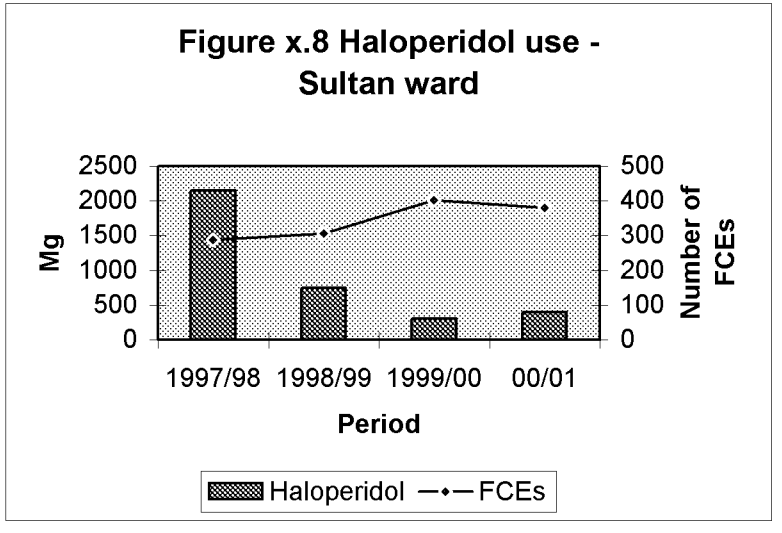
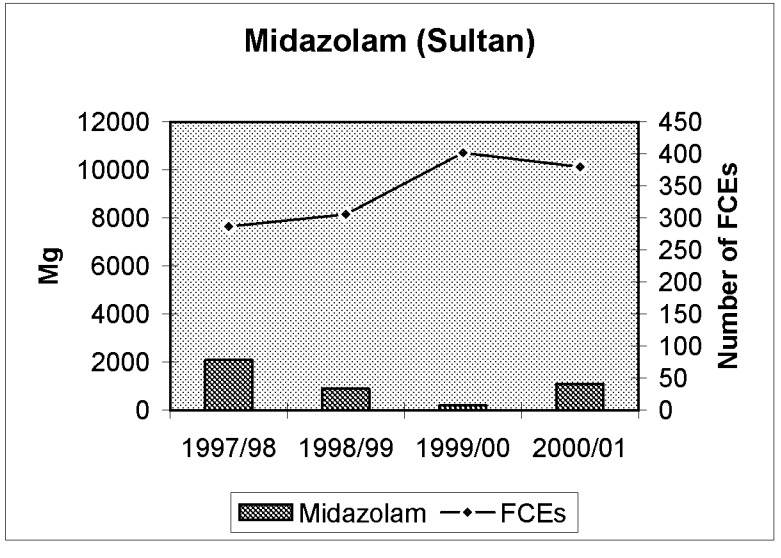


Figure x.8 Haloperidol use - Sultan ward
2500
2000
1500
1000
500
0
Mg
500
400
300
200
100
0
Number of FCEs
1997/98
1998/99
1999/00
00/01
Period
Haloperidol
FCEs


Midazolam (Sultan)
12000
10000
8000
6000
4000
2000
0
Mg
450
400
350
300
250
200
150
100
50
0
Number of FCEs
1997/98
1998/99
1999/00
2000/01
Midazolam
FCEs

ASSESSMENT AND MANAGEMENT OF PAIN

Part of the 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

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.

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 fifteen patients reviewed were not prescribed adequate pain relief for part of their stay in hospital.

Many staff interviewed referred to the "Wessex guidelines" This is a booklet "Palliative Care Handbook Guidelines on Clinical Management" drawn up by Portsmouth Healthcare trust, the Portsmouth Hospitals 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".

The Wessex guidelines are comprehensive and include detail, in line with British National Formulary recommendations, *(need to check)* on the use, dosage, and side effects of drugs commonly used in a palliative care, rather that a rehabilitation environment.

CHI's random case note review of fifteen 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. CHI understands that one of the people who initiated this change of practice was the staff grade physician appointed in September 2000, who, based on knowledge gained elsewhere, had expressed concern over the range of anticipatory doses being prescribed on the wards.

PRESCRIPTION WRITING POLICY

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.

The policy has a section on verbal orders. Telephone orders for single doses of medicines can be accepted over the telephone by a registered nurse if the doctor is unable to attend the ward. According to United Kingdom Central Council guidelines (October 2000), this is only acceptable where, "the medication has been previously prescribed and the prescriber is unable to issue a new prescription. Where changes to the dose are considered necessary, the use of information technology (such as fax or email) is the preferred method. The UKCC suggests a maximum of 24 hours, in which a new prescription confirming the changes should be provided. In any event, the changes must have been authorised before the new dosage is administered."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

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 which 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.

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.

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 Deadalus 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

Registered nurses are regulated by the Nursing and Midwifery Council, a new statutory body which replaced the United Kingdom Central Council on I April 2002. Registered nurses must work within their code of professional conduct (UKCC, June 1992). The scope of professional practice (UKCC, June 1992) 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 and every nurse should have a copy of the standards.

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

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 the 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.

CHI was made aware of one trust audit 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 that "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, including part time staff and the clinical assistant. 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.

STRUCTURE OF PHARMACY

Portsmouth healthcare nhs trust has a service level agreement for pharmacy services with the local acute trust, portsmouth hospitals nhs trust. The contract is managed locally by a grade e pharmacist 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 the pharmacist would 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 use the trust intranet to provide a compendium of drug therapy guidelines, although the intranet is not easily available to all staff.

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

There were no systems in place in 1998 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 and lack of review of medicines prescribed to

older people on Dryad and Deadalus wards in 1998. This is based on the findings of police expert witnesses and pharmacy data provided for the wards. A protocol existed in 1998 for palliative care prescribing the "Wessex guidelines", this was inappropriately applied to patients admitted for rehabilitation.

2. The data provided by Portsmouth Healthcare NHS Trust shows an increase in the amount of diamorphine, haloperidol and midazolam used on Daedalus ward in 1998. 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 detected and prevented.

3. The useage of all three drugs in recent years illustrates a decline, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. This should be seen against a slight rise in patient numbers. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998. CHI's review of recent case notes confirmed that prescribing levels of diamorphine, midazolam and haloperiodol has reduced substantially.

4. CHI found some evidence to suggest a recent reluctance amongst clinicians to prescribe opiates though trust pharmacy data indicated ???? recent large increase in diamorphine used on Sultan ward - needs further explanation when have final graph.

5. 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.

6. CHI found little evidence to suggest that thorough whole patient assessments were being made by multidisciplinary teams in 1998. CHIs 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 were able to produce data in 2002 relating to the issue of medication by pharmacy in 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

The East Hampshire PCT and Fareham and Gosport PCT and should review all local prescribing guidelines to ensure their appropriateness for the current use of the wards.

The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Deadalus 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.

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. Consideration must be given to the adequacy of IT support available to facilitate this.

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

CHAPTER 5 QUALITY OF CARE AND THE PATIENT EXPERIENCE

INTRODUCTION

4.1 This chapter details CHI's findings following contact with patients and relatives. This needs to be put into the context of the 1725 finished consultant episodes for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Details of the methodology used to gain an insight into the patient experience and of the issues raised with CHI are contained in appendix B.

PATIENT EXPERIENCE

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 invididual 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.

4.2 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.

4.3 Secondly, CHI made a number of observation visits, including at nighttime, 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

4.4 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.

Relatives expressed concern around a perceived lack of nutrition and fluids as patients neared the end of their life: "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.

Following comments by stakeholders, CHI reviewed trust policy for nutrition and fluids. The trust conducted an 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

A second trust audit in 2000 concluded that, overall, the implementation of the *Feeding People* standards has 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.

CHIs review of recent case notes concluded that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses were not able to make swallowing assessments; this could lead to delays over weekends, for example, when speech and language therapy staff were not available.

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.

CHIs review of recent case notes found no evidence of inappropriate catheterisation of patients in recent months.

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".

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 felt 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.

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.

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.

Comments about the attitude of staff ranged from the very positive "Everyone was so kind and caring towards him in both Deadalus 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

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

All wards were built during the 1991 expansion of the hospital and are modern, welcoming and bright. This view was echoed by stakeholders who were complimentary about the décor and patient surroundings. Wards were tidy, clean and fresh smelling.

Day rooms are pleasant and Daedalus ward has direct access to a well 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.

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.

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.

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.

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.

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.

KEY FINDINGS

Relatives speaking to CHI had some serious concerns about the care their relatives received on Deadalus 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.

Figure 4.1 Concerns about care raised by stakeholders by ward and date

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

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 Deadalus, 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.

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 compliment 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.

CHAPTER 6 – STAFFING ARRANGEMENTS AND RESPONSIBLITY FOR PATIENT CARE

RESPONSIBILITY FOR PATIENT CARE

Patient care on Daedlus and Dryad wards at Gosport War Memorial Hospital for the period of the CHI investigation was provided by consultant led teams. The complex needs of these vulnerable patients are best met by a multidisciplinary, multiprofessional team of appropriately trained staff. 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 which is understood by every member of the team.

MEDICAL RESPONSIBILITY

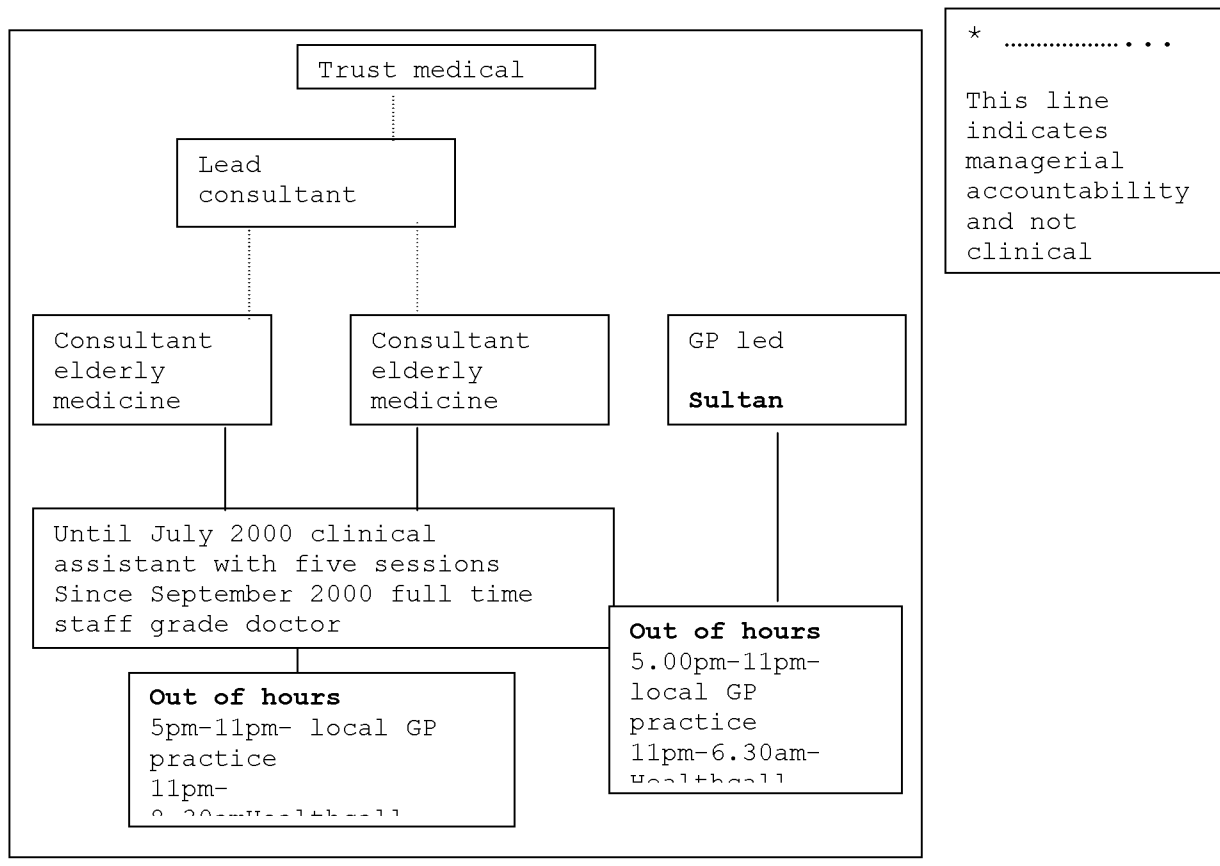
For the period covered by the CHI investigation, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. This is still the case today. All patients on both wards are admitted under the care of a consultant. Since 1995, there was been a lead consultant for the department of elderly medicine 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 twelve functions and states that the post is a major challenge for "a very part time role".

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 is provided by a staff grade physician who is 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.

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 elderly medicine 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 x.1 Line management accountabilities



GENERAL PRACTICE ROLE AND ACCOUNTABILITY

Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation: as clinical assistants 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

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.

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 clinical assistant could be pursued through the trust's disciplinary processes. CHI could find no evidence to suggest that this option was explored at the time of the initial police investigation in 1998 around allegations of unlawful killing. Though the trust was aware of police involvement in 1998, it did not receive the police expert witness reports until February 2002.

CHI is not aware of any trust systems in place to monitor or appraise the performance of the clinical assistant 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.

SULTAN WARD

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 have no medical accountablity framework within the trust.

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

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 Deadalus 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.

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

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 current work for the trust, including the medical director, who works five sessions in the department of elderly medicine, have regular appraisals. Those appraising the work of other doctors have been trained to do so.

NURSING RESPONSIBILITY

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

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

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.

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 were identified to lead the development of clinical supervision.

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

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 Deadalus ward which was attended by a consultant, a senior ward nurse, a physiotherapist and an occupational therapist. No junior staff were present. Hospital staff describe access to input from social services as good when available, though this is not always the case.

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.

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

Allied health professionals are a group of staff including 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.

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.

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.

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

WORKFORCE AND SERVICE PLANNING

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 client 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

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 the previous 5 session of clinical assistant cover.

ACCESS TO SPECIALIST ADVICE

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.

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 Macmillian nurses. Nurses gave recent examples of joint training events with the hospice.

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

STAFF WELFARE

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.

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 investigation - others feel the same".

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 inadequate and does not reflect current levels of patient dependency.

RECOMMENDATIONS

1. National guidelines for employing trusts, for GPs working as clinical assistants and for GPs admitting patients to GP led wards should be developed ??.

2. The provision of out of hours medical cover to Deadlus, 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. GPs working with older people in community hospital settings must have an adequate knowledge base of the medical needs of older people and the particular of prescribing for older people

4. The PCTs responsible for the provision of care of older people should continue to work with colleagues to ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

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

CHAPTER 7 LESSONS LEARNT FROM COMPLAINTS

CHI to check with HSC if they are looking at Mrs D (daughter Mrs R – before publication)
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.

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. One recent complaint concerned admission arrangements in Sultan ward. 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. (findings summarised on page ??)

EXTERNAL REVIEW OF COMPLAINTS

One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical advisor 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

The trust had a policy for handling patient related complaints produced in 1997, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure*, published in 1996 and reviewed in

2000. 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 resolved to their satisfaction together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards during CHIs visit.

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.

CHI found that letters to complainants in response to their complaints did not always include an explanation of the independent review process, although this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. Audit standards for complaints handling are good with at least 80% of complainants satisfied with complaint handling and 100% of complaints resolved within national performance targets. *(CHI check date)* 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.

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 an 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 trust investigation.

TRUST LEARNING REGARDING PRESCRIBING

The trust's medical director told CHI that following receipt of a complaint in August 1998 he confirmed with a colleague in a neighbouring trust that prescribing parameters at the War Memorial Hospital were within an acceptable range.

Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter??). 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.

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 200mgs a day. CHI understands this protocol to be the Wessex guidelines. Further correspondence in October 1999, indicated that a doctor working on the wards asked for a trust policy on the prescribing of opiates in community hospitals.

A draft protocol for the prescription and adminstration of diamorphine by subcutaneous infusion was piloted on Dryad ward in 1999 and discussed at the trusts 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

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 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.

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

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 trends in recent complaints. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

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.

The trust had a well defined and respected line management structure through which staff are now confident will help to identify emerging themes from complaints.

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 and faster 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 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. That CHI work with the Association of Chief Police Officers and Investigations and Inquiries Unit of the Department of Health to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible. CHI will also work with the Association of Chief Police Officers to develop police awareness of the NHS and its management and accountability structures.

2. That CHI ensures that any organisation demonstrating trends of serious concern arising from the prescription of any medicines, be referred immediately to the National Patients' Safety Agency.

3. That Fareham and Gosport PCT and East Hampshire PCT 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.

4. That both PCTs involved in the provision of care for older people, 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.

CHAPTER 8 COMMUNICATION

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

PATIENTS, RELATIVES AND CARERS

The trust had an undated user involvement in service development framework, which sets out the principles behind effective user involvement within the national policy framework described in the NHS National 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. This was one of the action points arising from a complaints workshop in February 2001. 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, the relevant ward purchased thermometers to address the problem. CHI could find no evidence to suggest that the findings from patient surveys were shared across the trust.

COMMUNICATION AND 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.

STAFF COMMUNICATION

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.

TRANSFER INTO THE COMMUNITY

CHI talked to staff from the nursing homes that most frequently received patients from the Gosport War Memorial Hospital. Nursing home staff spoke of good, collaborative relationships with ward staff. Patients admitted into local nursing homes recently, were thought by staff to have been well cared for at Gosport War Memorial Hospital. For example, no concerns were raised with CHI regarding skin integrity (pressure sores) or nutritional status. District nurses echoed these positive views.

KEY FINDINGS

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

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

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

RECOMMENDATIONS

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

2. 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.

CHAPTER 9 CLINICAL GOVERNANCE

INTRODUCTION

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."

CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems support the delivery of continuing and rehabilitative inpatient care for older people at the Gosport War Memorial Hospital. This chapter sets out the framework and structure adopted by the trust between 1998 and 2002 to deliver the clinical governance agenda and details those areas most relevant to the terms of reference for this investigation: risk management and the systems in place to enable staff to raise concerns.

CLINICAL GOVERNANCE STRUCTURES

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.

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.

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.

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

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

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

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.

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.

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

The trust had a whistle blowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. The policy set 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

CHI was given no positive examples of changes in patient care 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.

Need to include outcome of trust recent prescribing audit here.

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 robust system was in place to record risk events, understanding of clinical risk was not universal. The trust had a whistle blowing policy, which not all staff were aware of. 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

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 New National Health (NHS) Service, Summary, Making a Difference, July 1999.

4. The Public Interest Disclosure Act 1998 – whistleblowing in the NHS, NHS Executive, August 1999

5. Improving Working Lives – Publications, Department of Health, February 2002

6. Guidelines for the administration of medicines, (including press statement) United Kingdom Central Council for Nursing, Midwifery and Health Visiting, October 2000

7. Extension of independance nursing prescribing, Department of Health, February 2002

8. Essence of Care: patient- focused benchmarking for healthcare practitioners, Department of Health February 2001

9. Caring for older people: A nursing priority, intergaret knowledge, practice and values, The nursing and midwifery advisory committee, March 2001

(B) Documents relating to Portsmouth Healthcare NHS Trust:

1. Our work, our values – a guide to Portsmouth Healthcare NHS Trust.(undated)

2. Annual reports

2000 - 2001, 2000-1999, 1998/1999, Portsmouth Healthcare NHS Trust

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 Trust and West Hampshire NHS Trust, Portsmouth Healthcare NHS Trust, Trust Dissolution. September 2001.

4. Trust Dissolution: summary of meeting, 1 November 2001, to agree the future management arrangements for risk and clinical governance systems and groups.

5. Looking Forward…The Next Five Years 1995 - 2000, Portsmouth Healthcare NHS Trust, September 1994.

6. Business plans
2000/2001, 1999/2000, 1998/1999, 1997/1998 Portsmouth Healthcare NHS Trust

7. Gosport War Memorial Hospital key objectives 1997/1998, Portsmouth Healthcare NHS Trust, 24 July 1997

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. Patient Survey results, Portsmouth Healthcare NHS Trust, November 2001.

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

13. Portsmouth Healthcare NHS Trust leaflet, from 1923 to 1995, Portsmouth Healthcare NHS Trust (undated)

14. Gosport War Memorial Hospital outpatients clinics, 9 July 2001

15. User involvement in service development: A framework. Portsmouth Healthcare NHS Trust, (undated)

16. Isle of Wight, Portsmouth & South East Hampshire Health Authority Join Investment Plan for Older People 2001-2002, Isle of Wight, Portsmouth & South East Hampshire Health Authority, (undated)

17. Portsmouth Healthcare NHS Trust, Trust board agendas and strategic briefing documents

18. 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 October1998, 24 September 1998

19. 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, 19th November 1998

20. 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, 19th November 1998, 24 September 1998,

21. Portsmouth Healthcare NHS Trust, Divisional review 2000 Gosport and Fareham division,
8 February 2000, 10 August 2000, 16 May2000,11 November 1999

22. Draft 3, National Service Framework: Older people steering group (District wide implementation team) Terms of reference. Isle of Wight, Portsmouth and South East Hampshire health authority, (undated)

23. Correspondence: re Healthcall data 2000-2001 analysis, Knapman Practice

24. Correspondence: re Healthcall regarding contract for 2002, Healthcall, Business Manager, March 2002

25. Patient environment assessment and action plan, Portsmouth Healthcare NHS Trust, 29 August and September 2000.

26. Combined five year capital programme 2001/02-2005/06, Portsmouth Healthcare NHS Trust, Portsmouth City primary Care Trust, East Hampshire NHS Primary Care Trust, 8 November 2001.

27. Portsmouth Healthcare NHS Trust, Investors in people report, July 1999.

28. 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

29. Annual quality report to Portsmouth and South East Hampshire health authority (quarter 3 2000/01), Portsmouth HealthCare NHS Trust 27 February 2001

30. Community hospitals third quarter quality report, Portsmouth HealthCare NHS Trust, January 2000

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APPENDIX

VIEWS FROM PATIENTS AND RELATIVES/FRIENDS

1. 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

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

ii. 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 police force agreed to forward CHI contact details to families who had previously expressed their concerns to them.

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 ranged from:

- **Voluntary organisations**- e.g. Motor Neurone Disease, Alzheimer Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- **Statutory stakeholder**- Portsmouth and SE Hampshire Community Health Council, Isle of Wight, Portsmouth and SE Hampshire Health Authority, Local Medical Council, Members of Parliament, Nursing Homes and

Portsmouth Social Services, and Fareham Primary Care Group and Gosport Primary Care Group.

- **Stakeholders** who had contacted CHI-patients, relatives/carers/friends.

2. Stakeholder Responses

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

Letters	***Questionnaires***	**Telephone Interviews**	***Stakeholder Interviews**
7	*1*	10	16

*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.

3. Analysis of views received:

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

Positive Experiences

CHI received 9 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.

Table to show the most frequent positive views of patient and relative/friend experiences

View	***Frequency of responses***
Staff Attitude	5
ENVIRONMENT	5
Other comments included: Access to Services, Transfer, Prescribing, End of Life arrangements, Communication and Complaints.	

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 the there was no complaints against the staff". The environment was described as being tidy and clean with good décor. Another comment recognised the wards attention to maintaining patient dignity with curtains been drawn reducing attention to the patient. A Stakeholder also commented on the positive experience they had when dealing with the trust concerning a complaint they had made.

Less Positive Experiences

A number of less positive experiences of patients/friends and relatives were shared with CHI by stakeholders.

Table to show the most frequent 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	
patients	4
relatives/carers/friends	6
Humanity of care i.e. access to buzzer, clothes	8

The table above highlights some of the less positive views from stakeholder responses, which correspond to the investigation's term of reference.

- **Patient Transfer: -**
  Contacts commented on the complexity of the patient's health before and during the transfer, "Patients should be physically fit to transfer", "Family felt if they knew how ill their father was they would not have moved him from Queen Alexandra Hospital" and "Hospital claimed that the patient is in very serious pain following their transfer from Queen Alexandra Hospital". Other contacts mentioned the time that it took to transfer the patient and also highlighted the in appropriate method of transporting the patient, such as being carried " on a sheet, with no poles- like a sack of potatoes" or being transferred, " naked from the waist down apart from a piece of padding".

- **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.

- **Humanity of care: -**
  - Incontinence management- stakeholders felt that there was limited help with patients that needed to use the toilet, "asked on three separate occasions but did not receive help" and "never able to reach emergency button so the patient wet herself "
  - Attitude of staff- stakeholders commented on staff attitude mentioning waiting times for staff to respond, " waited 40 minutes for the nurse to come" other comments included, "basic care lacking in last few days e.g. moistening of mouth, clean pillows" and "main concern is culture on the ward especially manner of staff with patients and relatives".
  - 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" and that "one patient rarely had a cover on their legs"

- **Arrangements for the prescription, administration, review and recording of drugs**

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.

- **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.

- **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, this was fedback to CHI through comments such as, "no doctors entered room in last days of the patient's life", " family received no support from GWMH staff after told them that the patient would die".

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

APPENDIX

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

CHI is grateful to Caroline Harrington for scheduling interviews.

- Baldacchino, Linda, Health Care Social Worker
- Banks, Dr Vicki, Lead Consultant
- Barker, Debbie, Staff Nurse
- Barker, Marilyn, Enrolled Nurse
- Barrett, Lynn, Staff Nurse
- Beed, Mr, Phillip, Clinical Manager
- Brind, Shelly, Occupational Therapist

- Cameron, Fiona, General Manager
- Carroll, Mr, Patrick, Occupational Therapist
- Clasby, Jerry, Senior Nurse
- Crane, Rosemary, Senior Dietician
- Day, Ginny, Senior Staff Nurse
- Douglas, Tina, Staff Nurse
- Dunleavy, Jo, Staff Nurse
- Dunleavy, Shirley, Physiotherapist
- Goode, Pauline, Health Care Social Worker
- Hair, Rev, James, Chaplain
- Hallman, Shirley, Staff Nurse (until 11th September 2000)
- Hamblin, Gill, Senior Staff Nurse
- Haste, Anne, Clinical Manager
- Hooper, Mr, Bill, Project Director
- Humphrey, Lesley, Quality Manager
- Hunt, Deborah, Staff Nurse(until……please fill in)
- Jarrett, Dr David, Lead Consultant
- Joice, Chris, Staff Nurse (until 4th October 1999))
- Jones, Julie, Corporate Risk Advisor
- Jones, Teresa, Ward Clerk
- King, Mr, Peter, Personnel Director
- King, Steve, Clinical Risk Advisor
- Landy, Sharone, Senior Staff Nurse
- Langdale, Helen, Health Care Social Worker
- Law, Diane, Patient Affairs Manager
- Lawrence, Vanessa, Ward Pharmacist
- Lee, Mr, David, Complaints Convenor & Non Executive Director
- Lock, Joan, Sister (retired 1999)
- Loney, Mr, Mick, Porter
- Lord, Dr, Althea, Lead Consultant
- Mann, Katie, Senior Staff Nurse
- Melrose, Barbara, Complaints
- Millett, Mr, Max, Chief Executive
- Monk, Anne, Chairman
- Nelson, Sue, Staff Nurse
- Neville, J, Staff Nurse ((until 1st Janurary 2001)
- O'Dell, Jo, Practice Development Facilitator
- Parvin, Jane, Senior Personnel Manager
- Peach, Jan, Service Manager

- Peagram, Lin, Physio Assistant
- Pease, Yong, Staff Nurse
- Phillips, Catherine, Speech & Language Therapist
- Piper, Ian, Operational Director
- Qureshi, Dr, Consultant
- Ravindrance, Dr, Consultant
- Reid, Dr, Ian, Medical Director
- Robinson, Barbara, Deputy General Manager
- Scammel, Toni, Senior Nurse Coordinator
- Taylor, Jo, Senior Nurse
- Thomas, Dr, Eileen, Nursing Director
- Thorpe, Maria, Health Care Social Worker
- Tubbitt, Anita, Senior Staff Nurse
- Walker, Fiona, Senior Staff Nurse
- Wells, Penny, District Nurse
- Wigfall, Margaret, Enrolled Nurse
- Wilkins, Pat, Senior Staff Nurse
- Williams, Jane, Nurse Consultant
- Wilson, Angela, Senior Staff Nurse
- Wood, Mr, Andy, Finance Director
- Woods, Linda, Staff Nurse
- Yikona, Dr, Staff Grade Physician

APPENDIX

Meetings or Telephone Interviews with external agencies with an involvement in Elderly Care at the Gosport War Memorial Hospital.

- **Royal Hospital Haslar**
  Sam Page, Bed Manager

- **Portsmouth NHS Hospital Trust**
  Gill Angus, Clinical Discharge Coordinator, St Mary's Hospital
  Wendy Peckham, Discharge Planner for Medicine, St Mary's Hospital
  Clare Bownass, Ward Sister, St Mary's Hospital
  Sonia Baryschpolec, Staff Nurse, St Mary's Hospital

- **Hampshire Ambulance Services**
  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 Servces

- **NHS Executive- East Regional Office**
  Dr Mike Gill, 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
  Margaret Lovell, Chief Officer
  Christine Wilks,

- **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**
  Sr Rose Cook, Manager

- **Glen Heathers Nursing and Residential Care Home**
  John Perkins, Manager

Other

- **League of Friends**
  Mary Tyrell, Chair

- **Motor Neuron Association**
  Mrs Fitzpatrick

- **Members of Parliament**
  Peter Viggers, MP Gosport
  Sydney Norman Rapson, MP for Porstmouth North

- **Primary Care Groups**
  John Kirtley, Chief Executive, Fareham & Gosport PCG
  Dr Pennell, Chairperson, Gosport Primary Care Group

- **Local Medical Council**
  Dr Stephen McKenning, Chairman

- **GWMH Medical Committee**
  Dr Warner, Chairman

- **Local Royal College of Nursing**
  Betty Woodlands,

- **Local Unison**
  Patrick Carroll

APPENDIX

Medical case note review

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 CHIs 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 & 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 March 31st 2002 at the latest.

Membership

Dr Tony Luxton, Geriatrician - Lifespan NHS Trust (CHI doctor team member & chair of 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 Directior Of Nursing, 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 Group's findings will not be published in full in the investigation report, though a summary will be included. The final report of the Group will be subject to the rules of disclosure applying to CHI investigation reports.

APPENDIX

REPORT OF THE GOSPORT INVESTIGATION MEDICAL NOTES REVIEW GROUP

PURPOSE

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

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. Once only, PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the "analgesic ladder" to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggested that patients had been prescribed large amounts of pain relief such as diamorphine, on admission where this was not necessary. Cocodamol 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, with 6 hourly rather than 4 hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of cocodamol 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 was observed, with discussions with families prior to this documented.

Appropriate administration of medicines by nursing staff was evident. Telephone prescriptions issued over the telephone by GPs on Sultan ward were appropriately signed.

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.

The Use and Application of the Trust's policies on the Assessment & Management of Pain, Prescription Writing and Administration of IV Drugs

The group agreed that these Trust policies were being adhered to, based on the medical notes reviewed.

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 adequate, though patchy. There was some evidence to suggest a task orientated approach to care with an over emphasis on the completion of individual tasks, such as the completion of multiple (bowel? Sheets – Maureen – was this the form they were endlessly completing?) rather than on the holistic care of the patient. The team saw some very good, detailed care plans and as well as a number of cases were no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphasia had been delayed over a weekend due to the working hours of the speech and language therapist. Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, generally the trust's policies regarding fluid and nutrition were being adhered to, though a number of patients had only been weighed once on admission.

There was evidence of therapy input, though this had not always been incorporated into care plans and did not always appear comprehensive.

Some pressure sore prevention issues were identified.. Maureen – could you help here??

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. The decision of families regarding DNR were clearly stated in the medical record.

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

Out of Hours
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 opf a good standard.

APPENDIX

An explanation of the dissolution of services into the new Primary Care Trusts.

Arrangements for hosting clinical services

Department of	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 City Patients			● For Hampshire Patients
Learning disability services			●	
Subsatnce misuse	●			
Clinical pyschology	●			●
Primary care counselling	●			
Specialist family planning	●			
Palliative care		●		

(**Local Health, Local Decisions, Consultant Document September 2001,** South East Regional Office of the NHS Executive: Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

APPENDIX

Table illustrating the patient throughput in the Gosport War Memorial Hospital wards Sultan, Dryad and Daedalus.

Table . Throughput data 1997/98 – 2000/01

Financial Year	Ward	FCEs
1997/98	Daedalus	97
1997/98	Dryad	72
1997/98	Sultan	287
	GWMH	**456**
1998/99	Daedalus	121
1998/99	Dryad	76
1998/99	Sultan	306
	GWMH	**503**
1999/00	Daedalus	110
1999/00	Dryad	131
1999/00	Sultan	402
	GWMH	**643**
2000/01	Daedalus	113
2000/01	Dryad	86
2000/01	Sultan	380
	GWMH	**579**

APPENDIX

Breakdown of Medication in Dryad , Sultan and Daedalus wards at the Gosport War Memorial Hospital.

Summary of Medicine Useage 1997/98-2000/01 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine Injection	Daedauls	**5mg**	**5**	**0**	**5**	**0**	**3**
	Dryad	**5mg**	**5**	**0**	**0**	**0**	**6**
	Sultan	**5mg**	**5**	**6**	**5**	**0**	**10**
	Total	5mg	5	6	10	0	19
Diamorphine Syringe	Sultan	**5mg**	**1**	**0**	**10**	**0**	**0**
	Total	5mg	1	0	10	0	0
Diamorphine Injection	Daedalus	**10mg**	**5**	**21**	**34**	**27**	**19**
	Dryad	**10mg**	**5**	**40**	**57**	**56**	**20**
	Sultan	**10mg**	**5**	**87**	**38**	**24**	**35**
	Total	10mg	5	128	127	107	74
Diamorphine Syringe	Dryad	**10mg**	**1**	**0**	**17**	**0**	**0**
	Sultan	**10mg**	**1**	**0**	**20**	**0**	**0**
	Total	10mg	1	0	37	0	0
Diamorphine Injection	Daedalus	**30mg**	**5**	**16**	**27**	**15**	**7**
	Dryad	**30mg**	**5**	**34**	**51**	**40**	**4**
	Sultan	**30mg**	**5**	**67**	**43**	**14**	**31**
	Total	**30mg**	**5**	**117**	**121**	**69**	**42**
Diamorphine Syringe	Dryad	**30mg**	**1**	**0**	**5**	**0**	**0**
	Total	30mg	1	0	5	0	0

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine Injection	Daedalus	**100mg**	**5**	**2**	**11**	**1**	**2**
	Dryad	**100mg**	**5**	**12**	**13**	**2**	**0**
	Sultan	**100mg**	**5**	**20**	**27**	**0**	**31**
	Total	**100mg**	**5**	**34**	**51**	**3**	**0**

Diamorphine Injection	Daedalus	**500mg**	**5**	**0**	**1**	**0**	**0**
	Dryad	**500mg**	**5**	**0**	**2**	**0**	**4**
	Sultan	**500mg**	**5**	**1**	**1**	**0**	**4**
	Total	500mg	5	1	4	0	0

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	5mg/5ml	10	44	19	6	0
Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
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	5mg/5ml	5	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	10mg/2ml	10	133	168	116	47

(Summary of Medicine Useage 1997/98-2000/01 (Mar 2002), Portsmouth Hospitals Trust , Pharmacy Service)

Appendix

/GLOSSARY

As of 30 January 2002

TERM	EXPLANATION
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, following a clinical governance review.
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.
analgesia	medicines prescribed to reduce pain
analgesic ladder	the escalation and reduction of analgesia
anticipatory prescribing	to prescribe a drug or other remedy in advance
appraisal	an assessment or estimate of the worth, value or quality of a person or service or thing.
Association of Chief Police Officers	An association who's members hold the rank of Chief Constable, deputy Chief Constable or Assistant Chief Constable or their equivalents. They assist in setting the policing agenda by providing professional opinion on key issues identified to the Government, appropriate organisations and individuals.
audit, clinical	an examination of records to check

TERM	EXPLANATION
audit	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
baseline assessment	a look at what is currently happening, usually with a view to making a change or improvement.
British Medical Association (BMA)	a professional association of doctors and a trade union that represents doctors' interests and promotes medical research and education.
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.
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 assistants	A role in which duties include day to day medical management o the patients, writing up of initial case notes and to ensure follow up notes are kept up to date and reviewed regularly and to take part in *ward rounds*.
clinical governance	refers to the quality of health care offered within an organisation. The Department of Health document *A*

TERM	EXPLANATION
	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 ıff	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.
collaborative rehabilitation	several different organisations and individuals working together to plan a patient's rehabilitation. This

TERM	EXPLANATION
	often includes the GP, the hospital, social services and the voluntary sector.
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.
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.
consent	permission, from a patient or sometimes a patient's nearest relative, to allow a health treatment or investigation to happen.
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
controlled drugs	drugs whose use is restricted (by an act of law). They can only be given in certain circumstances and by certain groups of health professionals.
defibrillator	a piece of equipment which sends an electric current through the heart to restore the heart beat.
diamorphine	technical name for heroin
discharge planning	a thorough assessment of the needs of the patient when they leave hospital

TERM	EXPLANATION
	and return to their home, or another place. It often includes joint work between the hospital and social services to plan how patients can leave hospital as soon as possible to continue their rehabilitation in the community.
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.
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 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.
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.

TERM	EXPLANATION
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.
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.
incidents	something which has happened that is out of the ordinary which may be harmful to patients.
independent review panel	the panel of people chosen to run the review (see independent review)
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.
Level four PCT	brings together commissioning of secondary care services and primary

TERM	EXPLANATION
	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.
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.
locum consultant	A temporary specialist physician who stands in for a permanent one
medical	the branches of medicine concerned with treatment through careful use of drugs 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	A water soluble drug that is used as a minor tranquilliser
multidisciplinary meetings	Meetings involving people from different professional backgrounds
Multidisciplinary, multiprofessional team	a group of people who are from different professional backgrounds concerned with the treatment and care of patients, who meet regularly to discuss patient treatment and care.
National Service Framework (NSF)	guidelines for the health service from the Department of Health on how to manage and treat specific

TERM	EXPLANATION
	conditions, or specific groups of patients e.g. Coronary Heart Disease NSF, Mental Health NSF. Their implementation across the NHS is monitored by CHI.
neuroleptic medicines	Used to quieten disturbed patients
neurology	a branch of medicine concerned with medical treatment of disorders of the nervous system.
NHS regional office	offices responsible for the strategic management of the NHS and monitor the performance of health authorities, trusts and primary care trusts in England. They are part of the Department of Health and the people who work there are civil servants. There are eight regional offices of the NHS executive in England.
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. Acute trust –provides medical and surgical services usually in hospital. Community trust – provides local health services, usually in the community, eg district nurses, chiropodists etc. Combined trust – community and acute trust services under one management.
non executive directors	a director of a commercial company who is not a full-time employee of the company
nursing director or chief nurse or chief nursing officer	the term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing

TERM	EXPLANATION
	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 preparation of opium
opiate analgesia	A preparation of opium that soothes, deadens or induces sleep
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. Pain management is often done as an outpatient service to help people at home.
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 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

TERM	EXPLANATION
	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.
primary care groups (PCG)	groups of GPs, nurses and other health professionals working together to improve the health of local people, develop primary and community services and to contract secondary care. Primary care groups are formally constituted subcommittees of the health authority.
primary care trust (PCT)	New organisations that are evolving from primary care groups. They will have the same functions as primary care groups but will also commission some secondary health care services for their population and directly provide some community health services. They will be able to provide care usually available from general practitioners and their teams.
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.

TERM	EXPLANATION
rheumatology	the branch of medicine concerned with treatment of disorders of the joints, bones and muscles.
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 doctor	A role in which duties include the day to day medical care of patients, communicating with relatives
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.

TERM	EXPLANATION
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 combined administration	an injection of more than one drug beneath the skins surface
swallowing assessments	the technique to access the ability of the patient to swallow safely
syringe drivers	A device that gives a subcutaneous infusion, which can provide good control of symptoms with little discomfort or inconvenience for the patient
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
waiting lists	the number of people waiting for a planned procedure at an acute or community hospital.
ward rounds	
Wessex palliative	

TERM	EXPLANATION
care guidelines	
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